STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LANCE FANCHER,

Petitioner,

17IWCC0772

vs. 13 WC 40045

STATE OF ILLINOIS – BIG MUDDY CORRECTIONAL CENTER,

Respondent.

DECISION AND OPINION ON REVIEW PURSUANT TO §§19(h)/8(a)

This matter comes before the Commission on Petitioner's Petition for Review Pursuant to §§19(h)/8(a). A hearing was held in Mt. Vernon on July 11, 2017 before Commissioner Simpson. The parties were represented by counsel and a record was taken.

Findings of Fact & Conclusions of Law

1. Petitioner testified that his claim was adjudicated on July 8, 2015. An alleged injury to his right knee was a part of the claim. After the decision was issued, Petitioner continued to have symptoms in his knee including grinding, popping, and giving out. His symptoms were gradually getting worse. He sought treatment from Dr. Mall who prescribed physical therapy and anti-inflammatories, but eventually performed surgery after conservative treatment did not improve his condition. The surgery helped but he still had problems with his knee that were worse than when the decision was issued.

2. Currently, he has difficulty bending or standing for extended periods of time. He is employed as a correctional officer at Vienna Correctional Center, and stands for 2/3 of his work day. His knee aches after work and he takes 800 milligrams of Aleve once a day. He also lost endurance and strength and cannot stand as long while fishing. He had no new injuries since the time of the accident. He was off work for about six months and received non-occupational disability.

3. On cross examination, Petitioner testified he first sought treatment for his current knee pain on April 25, 2016. He saw Physician Assistant, Heather Rice, at Marshall Browning Hospital Clinic, which was his primary care physician at the time. He told her he was mowing his lawn when he got up to pick up some sticks and after walking five or six steps, his knee gave out. He eventually saw Dr. Mall. He previously had shoulder surgery with Dr. Mall. Dr. Mall also treated his right knee conservatively during that time for an accident in 2013. His lawyer initially referred Petitioner to Dr. Mall, but he made the appointment "for this injury."

4. Petitioner testified that besides fishing, he also hunts deer. He last hunted deer probably in 2015. He uses a compound bow and does not have a crossbow permit. He is not a professional fisherman but could be called semi-professional. He fished "back then quite a bit." The last tournament he competed in was May 1, 2017. He took second place. He fishes the Illinois team trail. Petitioner's surgery was at the end of August 2016 and by September 10, 2016, he was able to stand in a boat to fish, but "not very long." He used a brace and sat most of the time. His partner did most of the standing/fishing.

5. Currently, Petitioner was back at his previous job, was able to perform his work duties, and was earning the same salary. He had not had any adverse performance evaluations. He has not applied for a deer-hunting permit for this year, and probably would not.

6. On redirect examination, Petitioner testified that in the mower incident he was just walking. His knee had given out prior to that incident. While he was fishing, he was not violating any doctor restrictions.

7. In the decision issued on February 8, 2016, the Arbitrator noted that Petitioner suffered injuries to his cervical spine, right knee, and right shoulder. The cervical condition resolved after injections and an MRI of the knee showed that he had a patellar defect without meniscal tear. Petitioner's knee symptoms improved significantly with physical therapy, "concluding his treatment." When conservative treatment did not resolve his shoulder symptoms, Petitioner had surgery consisting of partial-thickness rotator cuff tear repair, distal clavicle resection, and biceps tenodesis. The Arbitrator awarded Petitioner 66.45 weeks of permanent partial disability benefits representing loss of 12% of the person-as-a-whole and loss of 3% of the right leg.

8. The medical record shows that On April 25, 2016, Petitioner presented to Physician Assistant Heather Rice, with a history of two to three-day right knee pain. He stepped off his mower, took about two steps, his knee gave out, and he fell. He had a prior history of knee injuries and meniscus removal. He was wearing a pull-on knee brace. Ms. Rice prescribed Norco, a trial of physical therapy, and took Petitioner off work for a week.

9. Petitioner began physical therapy on May 2nd and at that time he indicated he had been told he would need knee arthroplasty sometime in the future, but he was too young to have it now. He treated with medication and physical therapy with little improvement in pain, but reported increased strength. On May 12, 2016, Ms. Rice ordered an MRI.

10. The MRI taken on May 16, 2016, showed grade 2 intrasubstance tear in the body and posterior horn of the medical meniscus, sprain of ACL, mild arthritic changes, grade 3 chondromalacia patellae, minimal synovial effusion, and mild subcutaneous edema around the knee joint.

11. On May 23, 2016, Petitioner returned to review the MRI and discuss orthopedic referral. He had stopped physical therapy "due to cost issues" but was exercising at home. He still had significant pain and instability. He could not tolerate climbing stairs, squatting, or putting pressure on the knee. He was still wearing his brace. Petitioner reported he had an appointment with Dr. Mall later that day.

12. Petitioner also presented to Dr. Mall for follow up of his right knee. Dr. Mall noted he had prior knee problems and an MRI at that time showed intrasubstance signal within the meniscus. He had some underlying structural change in the medial meniscus, but they were able to treat it conservatively, which resolved his knee pain. Currently, he reported increase in pain and recurrent feeling of instability. Dr. Mall noted that the MRI showed a medial meniscus tear. He diagnosed quadriceps weakness and intrasubstance tearing of the medial meniscus with likely completion of the medial meniscus tear. He opined that Petitioner's condition was caused by the initial injury because he had similar symptoms and findings when he saw him previously. He would treat the condition conservatively and hope it responded like it did earlier.

13. After about three months of conservative treatment including medication and physical therapy, Dr. Mall concluded conservative treatment failed. On August 30, 2016, Dr. Mall performed right chondroplasty of the trochlea and patella, lysis of scar tissue, and 2-compartment synovectomy (medial and patellofemoral plica excision) for trochlear/patellar cartilage defects, scar tissue, and synovial plica.

14. After post-operative physical therapy, on November 2, 2016, Dr. Mall noted that Petitioner was doing extremely well and was very happy with his progress. Dr. Mall placed him at maximum medical improvement, released him from physical therapy to a home exercise program, released Petitioner to work full duty, and released him from treatment on a per needed basis.

15. After Dr. Mall released Petition from treatment, Petitioner continued to treat with Ms. Rice for ankle and hip pain which she attributed to compensation due to his knee condition.

16. The records of the Commission establish that claim 08 WC 123217, was settled for $29,418.93 representing permanent loss of 20% of the right leg and 5% of the right foot. Claim 10 WC 30352 was settled for $13,937.80, representing loss of 10% of the right leg. Finally, on February 23, 2016, the Commission issued a decision, 16 IWCC 128 in which it unanimously affirmed and adopted the Decision of the Arbitrator finding that Petitioner did not prove a compensable repetitive trauma accident, did not prove causation of his right elbow condition, and compensation was denied.

17. Dr. Mall testified by deposition on December 19, 2016. He initially saw Petitioner on November 20, 2013 and treated him prior to the arbitration decision. Petitioner returned on June 23, 2016 reporting an accident on August 25, 2015. An MRI which showed "mostly intrasubstance meniscal signal, but could have represented a tear" which could be consistent with his symptoms. He also had cartilage injury to his patella and was very symptomatic over the medial plica. These three conditions could all cause his pain.

18. Dr. Mall noted that when he released Petitioner from treatment for his previous injury, he had full strength and "was basically relatively asymptomatic." He was able to perform his activities without real limitation. When he returned in 2016 he was much more symptomatic and developed quadricep weakness again. Dr. Mall tried to rehabilitate him as he did for his previous condition earlier, which was successful. However, after this rehabilitation he remained symptomatic and Dr. Mall performed surgery.

19. Dr. Mall opined that the condition for which Petitioner presented to him on May 23, 2016 was still related to his original accident/injury. He explained that the MRI from 2013 and 2016 looked fairly similar. He did not see any dramatic change like he had a new injury. Petitioner likely had a flap of cartilage that got bigger from normal wear and tear. While the rehab worked previously when the defect was small it did not work after the defect got larger. Dr. Mall also noted that the after an injury the plica thickens "and it can be very sensitive to any sort of increase in inflammation."

20. During surgery, Dr. Mall noted a "very thickened synovial plica and he had flaps of cartilage on the patella and a small cartilage flap on the trochlea." Petitioner did really, really well after surgery. Literally, within a couple of weeks of surgery he had full strength and was back to normal.

21. When he last saw him on November 2nd he reported no symptoms and was pain-free. Dr. Mall did not believe the act of stepping off the mower "would necessarily dramatically worsen patellar cartilage injury." A twist could damage the meniscus, but the meniscus was not torn at the time of his surgery.

22. On cross examination, Dr. Mall agreed that Petitioner had right-knee surgeries in 2008 and 2010. Dr. Mall did not perform surgery in his treatment for Petitioner's condition in 2013. When asked whether Petitioner had arthritis, Dr. Mall indicated that while cartilage loss can technically be called arthritis, Petitioner's defect was more focal, traumatic in nature than from generalized arthritis.

23. He also explained that patellofemoral arthritis is not very common among men, it is more common among women. Patellofemoral arthritis in men typically comes from a traumatic injury. Just performing arthroscopy would not increase the risk for arthritis, as long as the surgeon is careful and was not "scuffing up the cartilage." He would not comment on the surgeries previously performed by other surgeons.

24. Dr. Mall agreed he initially treated Petitioner's knee from November 2013 to May 2014 and continued to treat Petitioner's shoulder beyond that date. In the five visits between July 2014 and November 2014, Petitioner did not report knee symptoms. While Dr. Mall agreed that Petitioner did not actively seek treatment for his knee between May 2014 and May 2016, that did not mean he was asymptomatic during that period.

25. Dr. Mall had previously informed Petitioner that he might need surgery at some point in the future, but there was no reason while the condition was tolerable. Petitioner did not tell Dr. Mall about the mower incident and he learned of it in Dr. McIntosh's report. Dr. Mall agreed that Petitioner only sought treatment after the mower incident.

26. Dr. McIntosh testified by deposition on April 4, 2017. On October 5, 2016, Dr. McIntosh performed an examination pursuant to §12 of the Act and reviewed some of Petitioner's medical records. He did not "think there were too many records from surgeries that he had prior to" his accident, though there was some mention of the procedures. On examination, Petitioner's range of motion of the knee was within normal limits and he had mild tenderness. There was also mild atrophy in the knee. The ligaments appeared intact.

27. Dr. McIntosh reviewed an MRI from May 16, 2016. He agreed with the radiologist's interpretation that the MRI showed "mild changes of arthritis" and that there were some changes in the cartilage and some swelling. There was also some signal change in the ACL, but Dr. McIntosh did not believe it showed any tear.

28. Dr. McIntosh noted that cartilage loss is measured in grades 1-4, with 4 being almost complete loss of cartilage. According to the MRI, Petitioner had grade 3 changes to the underside of his kneecap, "which means that has a significant amount of cartilage damage underneath his kneecap." Dr. McIntosh also noted that Petitioner's prior knee injuries and subsequent surgery increased his risk of developing arthritis.

29. Dr. McIntosh also testified Dr. Mall's operative report indicated Petitioner then had Grade 4 defects in the trochlea and patella, but the "medial and lateral joint compartments were the meniscus lives really showed no significant damage in the articular cartilage that aligns the femur and the tibia." Most of the damage was in the patellofemoral joint. Petitioner had recovered quickly after surgery, as evidence by his condition at the time of his examination, a little more than a month after surgery, and the fact that he was returning to work. Dr. McIntosh's diagnosis was significant patellofemoral arthritis, which he believed was the source of his pain.

30. Dr. McIntosh also noted that the 2013 MRI showed Petitioner already had developed fairly significant chondromalacia, which would not have developed if the injury he sustained in the initial accident/injury was the primary cause of his patellofemoral arthritis. He believed the accident certainly could have irritated the knee and caused an increase in symptoms. However, the symptoms did improve over time and he did not seek treatment in 2014 or 2015.

31. The new MRI taken because of the increased symptoms, showed that the knee had become more arthritic. Dr. McIntosh did not believe the surgery Dr. Mall performed in 2016 was secondary to the 2013 injury. He also opined that if Petitioner had not had the mower incident irritating his knee again, he probably would not have had the procedure.

32. On cross examination, Dr. McIntosh testified he was not provided a preoperative MRI from October 2013 or the postoperative MRI from November 27, 2013. He only had the one from 2016. Therefore, he could not comment on a comparison between them. At the deposition, Dr. McIntosh was asked to review the initial treatment note of Dr. Mall on May 23, 2016. He testified that it appeared from the note that Petitioner had had ongoing symptoms. However, if that were the case, Dr. McIntosh did not know why Petitioner did not seek medical treatment previously, especially in a workers' compensation context.

33. Dr. McIntosh also testified that although he could not compare MRIs, the "arthroscopic documentation" indicates the arthritis worsened between 2013 and 2016. When asked whether the 2013 was a cause among many for his 2016 condition, Dr. McIntosh again testified he thought the 2013 accident/injury irritated the knee. However, he improved and he was "sure that yet another injury or insult to the knee, now this being the third, contributed to the acceleration or exacerbation of the patellofemoral arthritis."

34. On redirect, Dr. McIntosh testified he believed Dr. Mall performed surgery because the MRI suggested there was a meniscus tear. There is not much arthroscopic surgery can do for patellofemoral arthritis. Dr. McIntosh theorized that Petitioner may have recovered so well, not specifically because of the arthroscopy, but rather his "peace of mind because there was no cartilage damage."

In looking at record before us, the Commission concludes that Petitioner's current condition of ill-being and the precipitating factor for his treatment in 2016, was the natural progression of his underlying arthritis and not his work-related accident in 2013. The Commission notes that Petitioner had two previous knee surgeries on his right knee in 2008 and 2010, for which he received settlements, and the 2013 injury resulted only in limited treatment of the knee and a relatively low permanent partial disability award (loss of 3% of the right leg). The Commission also notes that Dr. Mall placed him at maximum medical improvement for his knee as of May 2014, there is no indication that he actually indicated that Petitioner might need surgery for his knee condition in the future despite his maximum medical improvement determination, and Petitioner did not seek medical treatment for his knee for two years after Dr. Mall's release from treatment in 2013, undermining Petitioner's testimony that he had ongoing significant and worsening symptoms in his knee after the arbitration decision was issued.

Finally, the Commission finds relevant the initial physical therapy note of May 2, 2016, indicating that Petitioner stated he had been told that he would likely need arthroplasty in the future, which certainly evidences the severity of his underlying arthritis. Therefore, the Commission concludes that Petitioner's current condition of ill-being is not related to his initial work-accident and his petition pursuant to §§19(h)/8(a) is denied.

17IWCC0772

IT IS THEREFORE ORDERED BY THE COMMISSION, that Petitioner's Petition for relief pursuant to §§19(h)/8(a) of the Act is denied.

DATED: DEC 1 - 2017

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/dw
O-11/2/17
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STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CORIE PUGH,

Petitioner,

17IWCC0773

vs.

NO: 12 WC 25168

UNIVERSITY 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 issues of jurisdiction, accident, notice, causation, temporary total disability, permanent partial disability, benefit rate, medical expenses, and the denial of Respondent's request for a continuance, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Findings of Facts & Conclusions of Law

1. Petitioner testified that in June of 2012, she was working for Respondent as transportation manager and had for about a year. On June 7, 2012, "Theresa Fletcher Brown, the director, shut down the services – shut the whole daily operations down and called a staff meeting" in the parking office. Besides her and Ms. Brown, Ms. Brown's administrative assistant, two parking monitors, the Assistant Director of Parking and Transportation, were also present. There was no advanced notice or agenda for the meeting.

2. Petitioner also testified that Ms. Brown "geared the meeting towards" her. Her tone was very loud; she was yelling about Petitioner's inability to perform her day-to-day responsibilities. Petitioner did not believe the criticism was justified. Nothing besides Ms. Brown's disappointment with Petitioner was discussed. Ms. Brown was standing "hovering over" Petitioner; "a few inches from her face." She "physically tapped" Petitioner's mid-forehead several times.

3. Petitioner "felt humiliated," she "felt belittled" when Ms. Brown poked her in the face. The parking monitors that were present were under Petitioner's supervision and she did not believe there was any reason for them to be present at that meeting. She felt that both the monitors and the administrative assistant were brought into the meeting to see Petitioner humiliated in front of her boss. The meeting lasted 30 to 45 minutes and the atmosphere was "very tense," "hostile."

4. Petitioner left the meeting feeling humiliated and in tears. She immediately went to the Human Resources office, which was about two blocks away. She "was sweating," "reduced to tears," and "at a loss of words, racing thoughts." She informed Mr. Fournier about the incident. To her knowledge, Mr. Fournier did not open an investigation, follow up with Petitioner, and Ms. Brown was not disciplined. Nobody contacted Petitioner or followed up on her complaints. That made her feel that she "wasn't a priority, or valued." Petitioner went home and the next day she called in sick.

5. Petitioner went to her primary care physician at the time, Dr. Dudkiewicz, three weeks after the incident. In those three weeks, she had "called off work a few times, sick with migraines." She wasn't focused. "Mentally, [she] couldn't perform [her] day to day responsibilities the way they were performed before the incident." She felt like she was being judged by both her boss and her subordinates because of the things they heard at the meeting. She wasn't able to look at the Assistant Director or monitors in their faces. Also "there were patrons in the area that heard the conversation." She had "periods of anxiety, nausea, migraine headaches." During the periods of nausea, she had "light-headedness, dry mouth, heart palpitations." She had these symptoms while at work.

6. Dr. Dudkiewicz released her to work at the end of July, but referred her to a specialist, Dr. Francis, a Ph.D. at the University of Illinois Department of Psychiatry. Petitioner also testified she saw Dr. Francis for three to four months. She never had headaches, nausea, or counseling prior to the meeting. Petitioner considered the sessions with Dr. Francis helpful. Petitioner was prescribed Amitriptyline from an MD through Dr. Francis. That medication is for anxiety disorder and depression. She was currently on a similar medication, Celexa. She was not on medication prior to the incident.

7. Petitioner testified that currently she was "not focused," "frazzled," "not timely." She did not have these problems prior to the incident. She did not return to work after the release from Dr. Dudkiewicz and stayed home, "indoors." She communicated with her office through e-mail. She used up all her vacation/sick time. She felt she could not go back to work because she was humiliated. She also felt unable to perform her responsibilities. She was currently unemployed. She has been trying to look for work, but "it hasn't been going so well."

8. On cross examination, Petitioner testified this incident was the first time she had "heated interactions" with Ms. Brown and she had no previous disciplinary problems with her. She continued working on June 7, 2012 and two or three times a week after the incident.

9. Petitioner also testified that when she saw Dr. Dudkiewicz on June 29th she mentioned that her boss yelled at her and the "finger pointing in [her] forehead." She also saw Dr. Dudkiewicz on that date for unrelated heavy menses.

10. Petitioner stated she saw Dr. Dudkiewicz on July 5th, after he discharged her. He recommended she go to the "Woman Health Clinic," which she did on July 12, 2012. She agreed to counseling and she saw Dr. Francis three times in September 2012. She cancelled an appointment with Dr. Francis that was scheduled for September 25th. She never contacted Dr. Francis after October 31, 2012. Her new primary care physician was currently prescribing her Celexa.

11. The medical records reveal that on June 29, 2012, Petitioner presented to Dr. Dudkiewicz, who noted that she presented for several reasons. She reported frontal pressure headaches for about two weeks. She had a history of migraines many years ago. "She mentions that she is very stressed from work." She had an altercation with her boss at work and the boss yelled at her. He started her on Imitrex and took her off work until July 5th. He also recommended stress management/counseling and referred Petitioner to the "WHA."

12. On July 5, 2012, Petitioner returned to Dr. Dudkiewicz for follow up after hospital admission for unrelated issues on June 30th. She took Imitrex for two days with no improvement with headaches. Dr. Dudkiewicz noted that the headaches were likely related to "stress/tension headaches" and prescribed Elavil. He also referred Petitioner to WHA for the menses and recommended stress management/counseling and she agreed. Finally, he issued an open letter releasing Petitioner to return to work as of July 20, 2012, and she "was not able to participate from: 6/29/12 until and including 7/19/12."

13. Petitioner saw Dr. Dudkiewicz on July 17, 2012 and August 1, 2012, primarily regarding her headaches. She thought the headaches were responding to the Elavil. In the last treatment note from August 1st, Dr. Dudkiewicz noted she was trying to be transferred to another department, presumably at work.

14. On September 6, 2012, Petitioner presented to Dr. Francis for evaluation of anxiety on referral from Dr. Dudkiewicz. Petitioner reported her female boss had anger management difficulties and verbally and physically abused her. She screamed at her, threw personal possessions off her desk, and had been physically aggressive. Petitioner had the "full support of HR and superiors" and an investigation was proceeding. She had not been able to work since the end of June 12 and used vacation/sick days and was on FMLA. Petitioner reported "onset of limited symptom panic attacks in May 2012 in context of her work environment." She had her first "out of the blue full blown panic attack at the end of June 2012" while driving. She called 911 and was diagnosed with anemia and anxiety. She reported another five panic attacks since. In one episode, she felt she was losing her mind. She also reported "severe headaches in the context of her stress." After the initial panic attack, Petitioner had exhibited agoraphobic avoidance for fear of a panic attack. Petitioner also reported depressed mood beginning in May 2012.

15. On September 10, 2012, Petitioner returned and reported going to a grocery store alone and experiencing nausea, numbness/tingling, and limited symptom panic attack for 20 minutes. She left and went home to bed. Dr. Francis educated Petitioner on fight or flight response and "introduced formulation for panic." Petitioner seemed to understand.

16. Eight days later, Petitioner reported she was doing fine that day but reported significant distress from an episode at Target in which had a panic attack when she thought she lost her purse and had urinary incontinence. Dr. Francis noted that this was not unusual but Petitioner was "very worked up" when discussing the episode. Dr. Francis also noted that Petitioner's BDI was "49 (suggestive of severe depression)."

17. On October 26, 2012, Petitioner sent Dr. Francis an e-mail noting that she unfortunately missed their appointment. She was continuing to suffer from depression and anxiety and the attacks were getting worse. While Dr. Francis' treatment was helpful, Petitioner believed she might need more extensive and intense treatment. She wanted to talk to Dr. Francis or another doctor to see if she should continue therapy or get medication.

18. 5 days later, Dr. Francis responded to Petitioner's e-mail. She noted that Petitioner had not returned phone calls after she cancelled the appointment and her e-mail indicated she was still having symptoms. She hoped Petitioner was doing OK and recommended she continue treatment. If she did not hear from Petitioner by November 14, 2012, her file would be closed.

The Arbitrator denied Respondent's request for a continuance based on its alleged "surprise" that Petitioner testified to physical contact in the altercation with her supervisor and alleged inability to obtain certain medical records. The Arbitrator noted that the case had already been bifurcated for the parties to obtain witnesses and additional evidence and the last hearing date was deemed the "drop dead" date. In addition, the Arbitrator noted that she found Petitioner proved accident and causation to a psychological condition of ill-being irrespective of whether or not there was physical contact. Under the circumstances in this case, the Commission finds that the Arbitrator did not abuse her discretion in denying Respondent's motion for continuance.

The Arbitrator awarded Petitioner "$29,423.12" in permanent partial disability benefits representing loss of 12.5% of the person-as-a-whole. She did not explain the basis of the award other than noting that she found the incident caused panic disorder with agoraphobia, and major depressive disorder. The Commission finds that the Arbitrator was in the best position to assess Petitioner's overall credibility regarding sustaining a psychological injury from the encounter. In addition, Dr. Francis did apparently attribute her condition to her work stress and that assessment was not specifically rebutted. Therefore, the Commission affirms the Decision of the Arbitrator regarding the issues of accident and causation.

17IWCC0773

However, the Commission finds the permanent partial disability award is excessive. The Commission notes that Petitioner was taken off work for a total of three weeks and had only three psychological counseling sessions after which she apparently eschewed further treatment. While she may have felt that she could not return to employment in her previous department, she did not show that she was unable to work at another department or for another employer or any loss of earning potential. In looking at the records as a whole, the Commission concludes that a permanent partial disability award of loss of 7.5% of the person-as-a-whole is appropriate for this claim and modifies the Decision of the Arbitrator accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $523.07 per week for a period of 3 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $470.77 per week for a period of 37.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of 7.5% of the person-as-a-whole.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $19,000.00. The party commencing the proceeding for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: DEC 1 - 2017

David L. Gore

Stephen J. Mathis

DLS/dw
O-11/9/17
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DISSENT

I respectfully dissent from the majority. While I would not have reversed the Decision of the Arbitrator on the issues of accident and causation, I believe the permanent partial disability award is still excessive, even as modified by the Commission.

17IWCC0773

I am apparently more concerned about Petitioner's credibility than either the Arbitrator or the majority. While Petitioner testified that her supervisor repeatedly poked her in the forehead, the medical records do not corroborate that scenario. In her initial visit with her primary care provider after the incident, she reported that she was very stressed from work and that she had an altercation with her boss the boss yelled at her. There is absolutely no mention of any contact or any aggressive physical behavior. In fact, there was no mention of any physical touching until her testimony at arbitration and the first mention of any "physical abuse" and/or "aggressive behavior" was at her first session with Dr. Francis, which was only after she filed her Application for Adjustment of Claim.

In addition, Petitioner testified that Human Resources did not pursue her allegations which made her feel that she "wasn't a priority, or valued." However, she reported to Dr. Francis that she had the "full support of HR" and an investigation was proceeding. Similarly, contrary to the assertion of the Arbitrator that there was no evidence that Petitioner had any prior psychological issues, Dr. Dudkiewicz' records from her initial visit noted that she had "depressive mood" since May 2012, the month before the incident.

Finally, Petitioner's indication that she had not been able to work for four years since the incident further clouds her credibility. It is simply not believable that the incident she described would have caused that level and duration of disability, especially in light of the fact that Dr. Dudkiewicz released her to work after only three weeks, Dr. Francis apparently did not take her off work at all, she voluntary ceased psychological treatment after only three sessions, and she did not seek any such treatment in the past four years of unemployment. In looking at the entire record, I do not think any award greater than the loss of 3% of the person-as-a-whole is appropriate in this claim. Therefore, I respectfully dissent.

Deborah L. Simpson

DLS/dw
O-11/9/17

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0773

PUGH, CORIE
Employee/Petitioner

Case# **12WC025168**

UNIVERSITY OF CHICAGO
Employer/Respondent

On 12/6/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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17IWCC0773

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

CORIE PUGH
Employee/Petitioner

v.

UNIVERSITY OF CHICAGO
Employer/Respondent

Case # **12** WC **25168**

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 **Lyn Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago, Illinois**, on September 27, 2016 and **October 24, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **June 7, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$40,800.00**; the average weekly wage was **$784.61**.

On the date of accident, Petitioner was **34** years of age, ***married*** with **1** dependent child.

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

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability for 3 weeks, from June 29, 2012 through July 21, 2012 at a rate of $523.07, totaling $1,569.21 as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner $29,423.12 as her injury caused a loss of 12.5% 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.

FINDINGS OF FACTS

This matter was initially heard on September 27, 2016 however, it was bifurcated and given the date of October 24, 2016, to allow Respondent to bring in witnesses and any additional evidence deemed necessary. On October 24, 2016, the respondent filed and argued a Motion for Continuance stating that additional time was needed to attain witnesses. Said motion was denied and the case was heard. The disputed issues in this matter are 1) accident; 2) notice; 3) causal connection; 4) temporary total disability; and 5) the nature and extent of Petitioner's injuries. *See,* AX1 and Transcript.

Petitioner's testimony

Petitioner Corie Pugh testified that on the date of her injury, she was 34 years old and married with one child. She was employed by the University of Chicago in June, 2012, as a transportation manager. Her duties and responsibilities were to track the day-to-day activities of the University shuttle bus system. She also testified to a rate of pay of $3,400.00 per month and the parties stipulated to an average weekly wage of $784.61.

The physical location of her job was the parking office at 55th & Ellis on the University of Chicago campus. This was a space she shared with others. Her supervisor was Theresa Fletcher Brown, the director of parking and transportation.

On June 7, 2012, Theresa Fletcher Brown shut down all services and activities and called a staff meeting. The petitioner was there; also present were two parking monitors, Douglass and Dwight; Brandon Dodd, the Assistant Director of Parking and Transportation; and an administrative assistant who reported to Ms. Fletcher Brown. No advance notice or agenda for the meeting were provided and the petitioner stated that this was an unusual occurrence. The entire meeting consisted of Ms. Fletcher Brown berating and belittling the Petitioner concerning her duties. Nothing else was discussed. Petitioner was seated and Ms. Fletcher Brown hovered over her, yelling at her from a few inches in front of her face and repeatedly poking Petitioner's face with her finger.

Following the meeting, Petitioner felt humiliated. She questioned the purpose of having all of her coworkers present to see her belittled and left the parking office in tears.

Petitioner went directly from the meeting in the parking office to Human Resources, where she reported the event to James Fournier. The Arbitrator finds this to be adequate notice of injury.

Petitioner called in sick the day after the meeting. Over the following three weeks, she returned to work but called in sick periodically. She began suffering from migraines, anxiety and inability to focus on work. She became unable to look at her subordinates and coworkers directly in the eye and was unable to communicate with or direct the other employees effectively. Physically, she began to suffer nausea and headaches, dizziness, light-headedness and heart palpitations.

Three weeks after the incident in the parking office, Petitioner saw her primary care physician, Dr. Brian Dudkiewicz. Her doctor held Petitioner off work for the next three weeks and suggested counseling; referring her to a specialist. Petitioner began counseling with Dr. Jennifer Francis at the University of Illinois, Department of Psychiatry. Petitioner stated that she felt that the counseling was helpful however, she continued to suffer panic attacks and at one point had an attack and lost control of her bowels in a public place.

Petitioner never returned to work, even after being authorized to return by Dr. Dudkiewicz. She felt that after the way she had been humiliated in front of everyone, she no longer had the respect of her subordinates and could not return to work at the University of Chicago. Since then, she has continued to suffer from nervousness, takes medication for anxiety; and is not working.

Trial was held more than four years from the date of the event, and no witnesses for the Respondent appeared. Respondent's counsel explained that she was told that there would be no testimony regarding the petitioner being touched by anyone and therefore thought that she did not need any rebuttal witnesses however, once the petitioner testified that her supervisor had continuously poked her, respondent felt that witnesses were needed. Proofs were held open for an additional 3 and 4/7 weeks to allow Respondent to bring in witnesses. On the final date of trial, Respondent's request for more time was denied and the case was heard. The Arbitrator finds the unrebutted testimony of the petitioner to be credible as to all matters.

Medical records

Certified records from the University of Illinois show that Dr. Brian Dudkiewicz ordered Petitioner off work, from June 29, 2012 to July 19, 2012. Petitioner's history, as recorded in the records, was that she had an altercation with her boss at work and since, was suffering from frontal pressure headaches, panic attacks, nausea and sensitivity to light. Dr. Dudkiewicz felt that the headaches were related to stress and suggested counseling.

Certified records from the University of Illinois, Department of Psychiatry show that Petitioner was a patient of Dr. Jennifer Francis, PhD, having been referred by Dr. Brian Dudkiewicz. On her initial visit, Petitioner reported having been the subject of verbal and physical harassment from her boss at work.

Dr. Francis' assessment listed the onset of anxiety and panic attacks in the context of a workplace stressor. Her diagnosis listed "Occupational Problems." When Petitioner returned to Dr. Francis, she reported a panic attack that had occurred in a Target Store and included urinary incontinence. Dr. Francis continued to list "anxiety and panic attacks in the context of a workplace stressor" as her assessment. Her diagnosis was "panic disorder with agoraphobia" and "major depressive disorder, mild, single episode."

The Arbitrator finds these records corroborate Petitioner's testimony and are indicative of a compensable workplace injury.

17IWCC0773

CONCLUSIONS OF LAW

C.

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

It is Petitioner's burden to prove by a preponderance of the credible evidence all elements of her claim, including whether an accident arose out of and in the course and scope of her employment. *See, Hannibal v. Industrial Commission*, 38 Ill.2d 473, 231 N.E.2d 409, 410 (1967); *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d 236, 369 N.E.2d 853, 12 Ill.Dec. 146 (1977).

Decisions by the Commission cannot be based upon speculation or conjecture, *Deere and Company v. Industrial Commission*, 47 Ill.2d 144, 265 N.E. 2d 129 (1970). A petitioner seeking an award before the commission must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a causal connection between work and alleged condition of ill-being, compensation is to be denied. *Id.* The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v. Industrial Commission*, 198 Ill. App.3d 43, 556 N.E.2d 261, 144 Ill.Dec.794 (4th Dist. 1989).

The burden is on the petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin v. Industrial Commission*, 91, Ill.2d 288, 63 Ill. Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v. Industrial Commission*, 8 Ill.2d 407, 134 N.E.2d 307(1956). It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d.207, 214, 254 N.E.2d 522 (1969); see also *Hansel & Gretel Day Care Center v. Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

The Illinois Supreme Court has made clear that psychological harm is compensable under the Act, even where there is no significant physical injury: "We must conclude that an employee who, like the claimant here, suffers a severe emotional shock traceable to a definite time, place and cause which causes psychological injury of harm has suffered an accident within the meaning of the Act, though no physical trauma or injury was sustained." *Pathfinder Company v. The Industrial Commission, 62* Ill.2d 556, 343 N.E.2d 913 (1976).

This case fits within the parameters of *Pathfinder* and is compensable. Petitioner testified to a single, unusual, unexpected, shocking, traumatic event, after which she was unable to work and in need of medical care and counseling. No evidence was provided as to any other event, ongoing issues or alternative cause of the clear psychological trauma that Petitioner has suffered. The unrebutted medical evidence from Dr. Jennifer Francis is that Petitioner's psychological injuries resulted from a "single episode."

Petitioner testified that she was repeatedly poked by her supervisor during the encounter on June 7, 2012. Prior to *Pathfinder*, it was universally accepted in Illinois that mental disability was compensable only if it was precipitated by physical contact or injury traceable to a definite time, place and date. *City of Springfield v. Industrial Comm'n*, 685 N.E.2d 12, 291 Ill.App.3d 734, (1997). Such cases are still compensable. Petitioner's unrebutted testimony is sufficient to establish compensability under either standard.

The Arbitrator finds that the petitioner has proven, by a preponderance of the evidence, that she sustained accidental injuries that arose out of and in the course of her employment and that her injuries are compensable under the Act.

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

Timely notice was given when Petitioner informed James Fournier in Human Resources of the event.

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

The Arbitrator finds that the petitioner has proven, by a preponderance of the evidence that her current condition of ill-being is causal connected to the accidental injury. Her medical records support her testimony.

K. What temporary benefits are in dispute?

Unrebutted evidence shows that Petitioner was held off work by her primary care physician from June 29, 2012 through July 21, 2012. Respondent disputed temporary total disability ("TTD") solely on the basis of compensability. With compensability having been established, Petitioner is awarded three (3) weeks TTD. Based upon the stipulated AWW of $784.61, the TTD rate is $523.07, and the award for TTD is $1,569.21.

L. What is the nature and extent of the injury?

The Arbitrator finds that Petitioner has suffered psychological trauma, including panic disorder with agoraphobia; and major depressive disorder as a result of the episode at work on June 7, 2012. Petitioner is awarded 12.5 percent MAW for these injuries. Based upon the stipulated AWW of $784.61, the applicable PPD rate is $470.77; and the award for PPD is $29,423.12.

17IWCC0773

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
12WC25168
SIGNATURE PAGE

Signature of Arbitrator

December 6, 2016
Date of Decision

DEC 6 - 2016

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERT KOEHLER,

Petitioner,

17IWCC0774

vs.

14 WC 20820

STATE OF ILLINOIS – VIENNA CC,

Respondent.

DECISION AND OPINION ON REVIEW PURSUANT TO §§19(h)/8(a)

This matter comes before the Commission on Petitioner's Petition for Review Pursuant to §§19(h)/8(a). A hearing was held in Mt. Vernon on July 11, 2017 before Commissioner Simpson. The parties were represented by counsel and a record was taken.

Findings of Fact & Conclusions of Law

1. Petitioner testified that his claim was adjudicated on January 17, 2016. The only issue at the time was the nature and extent of his right-shoulder injury. Petitioner is right-handed. He had no subsequent injuries to his shoulder. Nevertheless, he continued to have difficulties and his shoulder "continued to get worse." He had fatigue in the shoulder with activity and had difficulty doing many things, including anything overhead.

2. His primary care physician took an MRI and Petitioner went to see Dr. Mall. He performed surgery on January 26, 2017. Petitioner was placed at maximum medical improvement the day prior to the hearing. He was taken off work on September 27, 2016 and returned to work on May 26, 2017. He received non-occupational disability during that period. Both the surgery and subsequent physical therapy helped his condition. Nevertheless, he still had reduced range of motion, fatigue, soreness, and weakness; he can do not "near as much as what" he could and can't do prolonged overhead activities. He takes a prescription anti-inflammatory and Ibuprofen. He is a corrections officer and there are no permanent light duty jobs. After 90 days "you're off work."

3. On cross examination, Petitioner testified his condition worsened after his second surgery, but it was better now after the third surgery. He went to his primary care physician after the prior arbitration and she referred him to Dr. Mall. He treated with Dr. Paletta after the arbitration decision was issued. His shoulder got worse in the time between the hearing and when he saw Dr. Paletta. He did not hunt ducks that year, or last year, but planned on hunting this year, if his shoulder is better.

4. On redirect examination, Petitioner testified Dr. Paletta placed him at maximum medical improvement in October 2015 and released him from treatment but the February 15, 2016 note indicates he came to the office with recurrence of shoulder pain.

5. The arbitration decision was issued on February 8, 2016. The heading of the decision specifies it deals with "Nature and Extent Only." The Arbitrator awarded Petitioner 65 weeks of permanent partial disability benefits representing loss of 13% of the person-as-a-whole. The decision indicates that Petitioner suffered a previous right-shoulder injury in 2011 or 2012, which was treated conservatively. He returned to work at full duty and received a settlement.

6. The accident involved an altercation with an inmate. Petitioner heard a pop and felt immediate pain in his right shoulder. On November 18, 2014, Dr. Paletta performed extensive debridement of the subacromial bursa and open distal clavicle excision. He continued to have pain, and on April 17, 2015, Dr. Paletta performed arthroscopy with extensive debridement and excision of the heterotopic ossification of the AC joint, revision of the distal clavicle excision, and further debridement of the subacromial bursa.

7. The medical records reveal that on February 15, 2016, Petitioner presented to Dr. Paletta for continued follow up for his right shoulder. He was last seen in October. At that time, he was doing relatively well, with good motion and strength, and only mild residual discomfort. He was declared at maximum medical improvement and discharged from treatment at that time. He now returned with recurrence of right shoulder pain with no intervening trauma or injury; "it just got gradually worse." It now hurt more than it did before the second surgery. He was unable to pull back his bow for hunting.

8. After his examination, Dr. Paletta opined that all of the limitations regarding his range of motion and strength were due to "pain inhibition." He had recurrent pain and some "vague neurologic symptoms," but there was no evidence of adhesive capsulitis. He recommended an MRI and EMG to rule out cervical radiculopathy. He restricted Petitioner to five-pounds lifting with no overhead reaching/work.

9. An MRI showed supraspinatus tendinosis with a significant partial or full thickness tear of the tendon, and previous resection of the lateral clavicle. The rest of the rotator cuff was intact, there was no glenoid tear, and the biceps tendon was normal.

10. On March 21, 2016, Petitioner presented to Dr. Phillips for an EMG/NCV on referral from Dr. Paletta. Petitioner reported he was doing well after his second surgery but dull/aching pain in the right shoulder returned. In November of 2015, he had "new onset of intermittent global right hand numbness and more persistent numbness and a longitudinal rectangular distribution from the middle of his right trapezius down the anterior and posterior midlines of his arms and then transversely only across the lateral epicondyle."

11. Dr. Phillips' examination appears to have been normal, except it is noted that Petitioner's "numbness is exacerbated by palpitation over the anterior shoulder/bone." In summary, Dr. Phillips indicated that "despite the symptoms reported, the study is not impressive for active cervical radiculopathy, brachial plexopathy, suprascapular or distal entrapment neuropathy."

12. On July 25, 2016, Petitioner presented to Dr. Mall apparently on referral from his lawyer. He reported persistent right shoulder pain since an "inmate-related accident" despite two surgeries. After his examination, Dr. Mall diagnosed AC joint anterior-posterior instability and biceps tendonitis. He administered an injection, recommended shoulder reconstruction surgery, and restricted Petitioner's work activities. He opined Petitioner's condition was caused by the accident.

13. On January 26, 2017, Dr. Mall performed reconstruction of the coracoclavicular ligament, open AC joint reconstruction, subacromial decompression/acromioplasty, limited debridement of the superior labrum/glenohumeral joint, and open biceps tenodesis, for AC joint instability and biceps tendonitis.

14. On May 23, 2017, Dr. Mall noted that Petitioner was doing quite well and was making significant improvement in physical therapy. Dr. Mall indicated Petitioner had some inflammation in his shoulder from a recent fall. He prescribed Medrol Dosepak and Mobic. On July 20, 2017, Dr. Mall released Petitioner from treatment at maximum medical improvement and released him to work at full duty.

15. Dr. Mall testified by deposition on June 12, 2017 that he is a board-certified orthopedic surgeon and independent medical examiner. He first saw Petitioner on July 25, 2016. He had had two surgeries on his right shoulder and was having persistent pain in the top of his shoulder. He had not gotten full resolution of his symptoms since the inmate-related injury on May 28, 2014.

16. On examination, Petitioner had symptoms consistent with biceps tendonitis. Dr. Mall believed most of Petitioner's pain seemed to be emanating from the AC joint in the biceps. He injected the area to allow a better examination of the shoulder. Dr. Mall confirmed that he also had anterior-posterior joint instability. That instability did not show up in the x-rays. He believed that Petitioner's joint instability and tendonitis were related to his initial work accident.

17. Dr. Mall also testified that Petitioner came to him for a second opinion because he wanted to return to work at full duty and was not where he wanted to be in terms of recovery. After the injection confirmed that the AC joint was the source of the pain, Dr. Mall recommended shoulder reconstruction surgery and biceps tenodesis. He last saw Petitioner on May 23, 2017, about four months post-surgery and he was making very good progress in physical therapy. He still felt weak and wanted to build up his strength. Dr. Mall noted that the type of front-to-back instability Petitioner had would not show up on an MRI.

18. During surgery, Dr. Mall noted there was a substantial amount of synovitis around the biceps tendon. Normally, the biceps tendon is difficult to see during arthroscopy. However, in this instance, he was able to pull the tendon out of its groove during the tenodesis. Therefore, he was able to get a better look at the tendon.

19. On the issue of AC joint instability, Dr. Mall noted the complicated nature of shoulder resection surgery. Surgeon's generally aim at taking off a centimeter of the distal clavicle, but patients' anatomy is all different. Sometimes if the resection is not absolutely correct, the surgery could result in instability. In addition, after repair of the AC joint capsule, "if that doesn't heal completely or it stretches out a little bit, that can lead to some instability as well." "It's just that it happens fairly infrequently, but it happens, and it's based on basically patient anatomy in terms of whether or not that can occur." Petitioner developed the instability after the surgeries and the persistent anterior shoulder pain was caused by the biceps tendon.

20. On cross examination, Dr. Mall explained that an MRI is static, "so you're not really seeing instability necessarily." Sometimes you can detect structural issues that can lead to instability, but you cannot assess stability. He thought Petitioner would be able to return to work at full duty soon because his rotator cuff looked quite good; that's the game-changer. If he had three rotator cuff surgeries, Dr. Mall would not think he could ever return to work at full duty. Dr. Mall noted that he was pretty certain that the recent fall he noted on May 23rd, was post-surgery while he was in the sling. He thought Petitioner hit the shoulder in the incident. Petitioner was concerned about the stability, but the stability and the bicep looked fine. Therefore, Dr. Mall didn't think the accident undid any of the surgical repairs.

21. In responding to Dr. Nogalski's (Respondent's Section 12 medical examiner) report, Dr. Mall agreed that it would have been reasonable for Dr. Paletta to look at the biceps tendon in his surgeries. However, most of the tendon that is in the groove is "where it's in that sort of really inflammatory area, you would never be able to pull completely into the joint;" "it's too far down." In explaining his causation opinion, Dr. Mall noted that the first two "surgeries that were performed were to address the AC joint, and this was the same issue [he] was addressing on the third surgery." Dr. Mall did not believe it was unusual to get a second opinion. He often sends patients for second opinions when the patient is not progressing like he would like.

22. On redirect examination, Dr. Mall testified that he was not sure that he reviewed telephone notes in which Dr. Paletta was seeking a second opinion. However, often the doctors within his practice refer patients to each other for evaluations.

23. Dr. Nogalski testified by deposition on May 15, 2017 that he is a board-certified orthopedic surgeon and currently performed four to eight surgeries a week. He predominantly treats shoulders and knees. Respondent asked him to perform an examination on Petitioner's shoulder. His examination was limited because Petitioner declined to remove his sling and shirt.

24. Dr. Nogalski noted that Petitioner had two arthroscopic debridements with Dr. Paletta. He then had ongoing pain and subsequently, Dr. Mall performed third surgery to treat AC joint instability. Dr. Nogalski had not been able to review Dr. Mall's operative report at the time of his examination, but saw it immediately prior to the deposition. He opined that the work accident which required the first two surgeries did not cause the need for Dr. Mall's third surgery. He explained that the information he reviewed about the two previous surgeries indicated Petitioner had a stable AC joint. In addition, there was no indication of any biceps tendon issues in the previous treatment notes. Therefore, the conditions for which Dr. Mall treated Petitioner were documented as normal in the operative reports. He believed Petitioner's prognosis was good and he should be able to perform his normal work activities.

25. On cross examination, Dr. Nogalski agreed that Dr. Mall's statements "appears to provide reasonable indications" for the shoulder reconstruction. Dr. Nogalski was not given a copy of the previous arbitration decision. He was not aware of any traumatic injury Petitioner had between his return to work and his examination. He disagreed with the premise that while the third shoulder surgery was related to the original injury, the biceps injury may not be.

26. Dr. Nogalski also opined that anything after Dr. Paletta released him was not caused by the work-accident. He attributed Petitioner's complaints to postoperative pain issues without any specific instability. He noted that in an operative report, Dr. Paletta indicated the clavicle was stable. The previous records do not support the premise that Petitioner had continuing pain and symptoms after Dr. Paletta's surgery. He reviewed the February 15, 2016 note of Dr. Paletta, at which time he ordered an MRI and EMG. He thought that was reasonable despite the lapse between when he released Petitioner and when Petitioner returned. He believed those tests were related to the work accident.

Petitioner argues he proved that his current condition of ill-being, and the treatment he received from Dr. Mall, was necessitated by the work-related accident. He stresses that Petitioner continued to complain of pain after his second surgery and on February 15, 2016, Dr. Paletta indicated Petitioner returned for "recurrence" of shoulder pain and not for "new" shoulder pain. In addition, he argues the testimony of Dr. Mall was more persuasive than Dr. Nogalski.

Respondent argues "it stretches credulity Petitioner could have been doing so well in October of 2015 when released by Dr. Paletta on October 30th, when it was noted he was doing quite well and had outstanding motion and within a week of a decision seek treatment for the very same shoulder." It also stresses that Dr. Nogalski testified credibly that Petitioner's third surgery was not causally related to the accident. It asks the Commission to deny all additional benefits.

Initially, the Commission notes that the parties both refer to treatment prior to the arbitration hearing. However, none of those records were submitted at the review hearing. In looking at the records that have been submitted, Dr. Nogalski seemed to rely mostly on the records of Dr. Paletta in that he never noted instability and his operative reports did not indicate there were any problems with the biceps tendon. However, Dr. Mall testified that the instability he found could have been caused by the prior surgeries needed to correct the initial injury and the biceps tendon is not always exposed for observation unless surgery is actually performed on it. Therefore, even assuming that Dr. Nogalski's recitation of Dr. Paletta's records is absolutely correct, that does not really rebut the opinions of Dr. Mall. On the issue of whether Petitioner's current condition and the need for the third surgery was causally related to the initial accident, the Commission finds the testimony of Dr. Mall more persuasive than that of Dr. Nogalski.

Based on our determination that Petitioner's current condition was still causally related to the initial work accident, the Commission finds that Petitioner is entitled to be awarded medical expenses incurred, temporary total disability benefits for the period he was off work for medical treatment, and an additional permanent partial disability. Petitioner demonstrated he was off work between September 26, 2016 to May 26, 2017 for a total of 34&5/7 weeks. On the issue of additional permanent partial disability, the Commission notes that Petitioner was able to return to his previous occupation of correctional officer, the occupation of correctional officer involves substantial physical activity, he has shown no loss of earning potential, and his current complaints were relatively minor. Petitioner testified he still had reduced range of motion, fatigue, soreness, and weakness; he can do not "near as much as what" he could, and can't do prolonged overhead activities. He takes a prescription anti-inflammatory and Ibuprofen. In addition, although he had not yet been able to bow-hunt, he hoped to that year if his shoulder improved. In looking at the entire record before us, the Commission finds an additional award of 5% of the person-as-a-whole is appropriate in this case.

IT IS THEREFORE ORDERED BY THE COMMISSION, that Petitioner's Petition for relief pursuant to §§19(h)/8(a) of the Act is granted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $883.33 per week for a total of 34&5/7 weeks, that being the additional 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 $795.00 per week for a period of 25 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the additional loss of 5% of the person-as-a-whole.

17IWCC0774

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the medical expenses identified in Petitioner's Exhibit 4, under §8(a) of the Act pursuant to the applicable medical fee schedule.

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

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

DATED: DEC 1 - 2017

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/dw
O-11/2/17
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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 SANGAMON	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sandra Delahunt,

Petitioner,

vs. NO: 15WC 16999

17IWCC0775

State of Illinois,

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 Statute of Limitations, 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. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 10, 2017 is hereby affirmed and adopted.

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

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

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

No bond or summons required on State of Illinois cases.

DATED: DEC 1 - 2017
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LEC/jrc
043

Charles J. DeVriendt

Joshua D. Luskin

DISSENT

"[A]n employee suffering from a repetitive-trauma injury must still point to a date within the limitations period on which both the injury and its causal link to the employee's work became plainly apparent to a reasonable person. [citation omitted]." *Durand v. The Industrial Commission*, 224 Ill. 2d 53, 65, 862 N.E.2d 918 (2006). Petitioner failed to establish a manifestation date within the statute of limitations period as Petitioner's injury manifested itself on April 9, 2012. As such, I would deny the claim in its entirety. Therefore, I respectfully dissent.

Petitioner sought treatment on April 9, 2012 from Dr. Mark Greatting. Dr. Greatting diagnosed bilateral cubital and carpal tunnel syndromes. As to causation, Dr. Greatting's medical records memorialize the following: "I do think her work activities are a significant causative or contributing/aggravating factors of the symptoms she is having in both of her hands." PX4.

Petitioner testified Dr. Greatting recommended surgery, and she submitted a work-related claim to Respondent requesting authorization for surgery which Respondent denied. T. 21. A Form 45 was completed on June 21, 2012 listing the date of injury as February 13, 2012, and memorializing "Worker has been diagnosed with Carpal Tunnel Syndrome in both wrists, due to repetitive motion of typing." RX3. Thereafter a denial letter was sent to Petitioner on August 6, 2012 indicating the matter was denied under the provisions of the Illinois Workers' Compensation Act and further advising Petitioner "[t]he decision does not preclude your right to file a claim with the Illinois Workers' Compensation Commission." RX3.

The manifestation date is April 9, 2012. It was plainly apparent to Petitioner her conditions were work related as 1) she was advised accordingly by her treating physician; and 2) she believed such condition was work related as evidenced by her submission of a claim for a work-related injury. Petitioner failed to pursue her claim in a timely manner despite being advised of such right and/or remedy. Accordingly, I dissent.

L Elizabeth Coppoletti

L. Elizabeth Coppoletti

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

DELAHUNT, SANDRA
Employee/Petitioner

Case# **15WC016999**

STATE OF ILLINOIS
Employer/Respondent

17IWCC0775

On 2/10/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1727 LAW OFFICES OF MARK N LEE LTD
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SPRINGFIELD, IL 62704

5002 ASSISTANT ATTORNEY GENERAL
JOSEPH P BLEWITT
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0498 STATE OF ILLINOIS
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0499 CMS RISK MANAGEMENT
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SPRINGFIELD, IL 62794-9208

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

FEB 10 2017

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

17IWCC0775

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)

Sandra Delahunt
Employee/Petitioner

v.

State of Illinois
Employer/Respondent

Case # **15 WC 016999**

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on **1/17/2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **5/14/2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**54,712.32**; the average weekly wage was $**1052.16**.

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

Petitioner has not received all reasonable and necessary medical services.

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

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

ORDER

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

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the proposed bilateral carpal tunnel release and bilateral cubital tunnel release.

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.

D. Dylan McEntee

Signature of Arbitrator

2/2/2017
Date

ICArbDec19(b)

FEB 10 2017

Findings of Fact

Petitioner filed an amended Application for Adjustment of Claim alleging repetitive trauma injuries arising out of and in the course of her employment for Respondent. The Application was filled out on May 18th, 2015. Petitioner is 39 years old, married and has 2 dependent children.

Petitioner began working for Respondent in 2006. Her current job title is a Caseworker, which she did not become until 2008. Petitioner works somewhat abnormal hours for a state worker. Petitioner works every other Monday and extends her hours the remaining days to remain full time. Typically, Petitioner works 7:30 to 5:30 P.M. on the weeks she has Monday off and 7:30-4:30 P.M. on the weeks she works a full five days. Petitioner has two 20-minute breaks and one hour lunch. Prior to working as a Caseworker, Petitioner's first job for Respondent was a Hotline Data Specialist from 2006 until 2008. Petitioner testified that her first job was essentially data entry and we she would be required to answer phone calls and enter data via the computer all day. She estimated that she took 60 to 80 calls per day.

At Petitioner's current position of a Caseworker, she testified that she answers phone calls and enters the information she receives into a computer. On each call, she must go through multiple computer programs, entering data as she takes the call. Petitioner testified she averaged 20-30 calls per day. Besides taking calls, the Petitioner would process paperwork, again using the computer. Petitioner testified that this work has remained fairly consistent since she began work as a Caseworker. Petitioner estimated that 80% of her day is typing/computer work, 10% is reviewing paperwork and 10% would be faxing and organizing paper work. Petitioner's testimony was consistent with the self-made job description entered into evidence as Petitioner's Exhibit 3.

Petitioner's Exhibit 2 also contained a job description created by the Respondent. The first page of this exhibit is a CMS demand of the job report from 7/3/2012. Petitioner verified the accuracy of this report and testified that the demands of her job have not changed greatly since this report. In said report the Arbitrator notes that under line 25 Petitioner was noted as having six to eight hours of her day requiring use of hands for fine manipulation (Typing, good finger dexterity).

Petitioner testified that she began to notice symptoms in her hands in 2010. She went to her family doctor, Dr. Kiel on June 8, 2010. (RX 2) His notes indicate that she was having numbness and tingling in the fingers on both hands. She also told the doctor that she was a caseworker and spent a lot of time on her computer. Nerve studies were performed on June 30 and she returned to Dr. Kiel's office, where she was seen by Dr. Sinha. His notes indicate that the nerve tests were negative for both carpal and cubital tunnel. After his exam, Dr. Sinha indicated that the Petitioner had some mild nerve compressions which could be at either the wrists or elbows. He recommended conservative care. (Id)

Petitioner reported her symptoms to her employer, and a Form 45 was completed on June 14, 2010. (RX 1) The report, prepared by the Respondent's workers compensation provider, CareSys Inc., says that the Petitioner stated that her problem was due to the repetitive motion of typing. On October 13, 2010, Tammy Roberts of the Respondent's Workers Compensation Unit authored a denial of claim letter, stating that after a thorough review of her file, the Petitioner's medical condition did not appear to have arisen out of her employment. (Id) Petitioner testified that as her claim was denied, she did not pursue it, and she continued to perform her job.

Petitioner said that her symptoms gradually worsened and in early 2012 she apparently returned to her family doctor. His records were not introduced into evidence. Dr. Trudeau did perform another set of nerve tests on February 27, 2012, and those records were introduced. (PX 5) The Petitioner's history to Dr. Trudeau was consistent with her testimony at arbitration, and his tests showed bilateral carpal tunnel syndrome, mild to moderately severe on the right and mild and neurapraxic on the left. No evidence of ulnar neuropathy was noted. (Id) Petitioner was then seen by Dr. Greatting, an orthopedic surgeon, on April 9, 2012. She reported that her condition was brought on by work, the amount of keyboarding she does at work and that it increased her symptoms. Dr. Greatting reviewed her EMG and found that Petitioner was positive at that time for bilateral carpal tunnel and recommended surgical intervention at that time. Petitioner followed up with Dr. Greatting on May 23, 2012, and he again recommended surgical intervention regarding her carpal tunnel condition. (PX 4)

Once again, the Petitioner reported her injury to her employer. Another Form 45 was prepared by CareSys, this time on June 21, 2012, and once again Ms. Roberts investigated the claim and denied it in a letter to the Petitioner dated August 6, 2012. (RX 3) Petitioner testified that she again dealt with her symptoms and continued to work and that her symptoms continued to worsen.

On May 14, 2015, Petitioner again made a report of injury to her supervisor. (PX 1) This time, she complained of having pain and numbness in her hands and arms. In Petitioner's first report of injury she describes the injury came from her desk and typing and the repetitive motion with the place of injury being at her desk

Petitioner underwent a third set of nerve tests on June 4, 2015, having been referred back to Dr. Trudeau by Dr. Kiel. (PX 6) According to the notes of Dr. Trudeau, Petitioner had continued to perform repetitive work since 2012 and noticed a worsening of her symptoms. The tests showed that the Petitioner's carpal tunnel was now deemed moderately severe on both sides, the right greater than the left. Dr. Trudeau indicated that the condition had increased on the tests since those performed back in 2012. He also found bilateral cubital tunnel syndrome, mild and neurapraxic on both sides which was new since the 2012 studies. (Id)

Petitioner was then seen by Dr. Greatting on August 6, 2015. Dr. Greatting's notes indicate that he had not seen Petitioner for over 3 years but that Petitioner was suffering from bilateral hand complaints and had been previously diagnosed with bilateral carpal tunnel. Dr. Greatting noted that Petitioner's condition would increase at work and as the work day went on. Also, that her condition would not bother her significantly when she was off work, on the weekends, or on vacation. Petitioner then gave the doctor a brief description of her job with Respondent and how she spends a great majority of her day typing. Dr. Greatting diagnosed Petitioner with bilateral cubital tunnel and bilateral carpal tunnel on that date and stated while they were not caused by her work but that her work aggravated her conditions based upon this history intake. He then recommended she undergo bilateral carpal and cubital tunnel releases. (PX 4) Petitioner testified she did not go through with the surgery due to another denial from the State of Illinois, but continued to work for Respondent.

Petitioner underwent a section 12 examination with a Dr. Nash Naam on May 10, 2016. Dr. Naam reviewed the medical history of Petitioner and confirmed the diagnosis and treatment plan of Dr. Greatting. Dr. Naam found the patient to be very reasonable and believable but he did not find a causal relationship between Petitioner's work and her conditions of bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome. (RX 5)

Dr. Mark Greatting was deposed on September 26th, 2016. (PX 4) Dr. Greatting reviewed his medical records to date. When asked if Petitioner's job could have accelerated the development of her bilateral cubital tunnel and bilateral carpal tunnel, Dr. Greatting responded he thought Petitioner's work did actually accelerate her conditions. (PX-4 pg. 14) He noted that the Petitioner's symptoms increased significantly when she was at work as opposed to when she was on vacation or off for the week-ends. He also said that she spent the majority of her day on the computer. (Id at 11) Dr. Greatting was then presented with a prepared job description that was also entered into evidence on the date of trial, and an additional hypothetical of Petitioner's job that was consistent with the testimony of Petitioner on the date of trial. (Id at 12-13) He also explained that her cubital tunnel syndrome was also causally related to her work, noting that she typed with her elbows flexed at a 90 degree angle. (Id at 14) Dr. Greatting also said that the fact that she was not diabetic, had no weight problems and no thyroid disease were factors in his opinion on causation. (Id at 18) Upon reviewing these statements and his medical history, Dr. Greatting opined that Petitioner's condition was accelerated and aggravated by her employment with Respondent. (PX-4 pg. 18-19)

Conclusions of Law

Date of Accident and Statute of Limitations

Petitioner is claiming injuries to her hands and arms as the result of repetitive traumas which occurred as she worked for many years for the Respondent. Though she admits that her symptoms began back in 2010, she alleges an accident date of May 14, 2015. While she acknowledges that she was aware of her condition prior to that date, it is appropriate because it was then that her work production became impacted by her injuries. Respondent contends that the proper accident date would be either June 14, 2010, when she filed her initial accident report involving her hands or April 9, 2012, when she was initially seen by Dr. Greatting. It argues that under either scenario, the Petitioner's claim was time barred under the statute of limitations because the application for adjustment of claim was filed more than three years after either date. The Arbitrator believes the Petitioner's accident date is proper under the law, and declines to adopt the Respondent's arguments.

Respondent relies upon the Supreme Court's decision in Peoria County Bellwood Nursing Home v. Industrial Commission, 115 Ill. 2d 524 (1987) in support of it's argument. In that case, the Court for the first time held that an injured worker could maintain a claim for benefits from an injury resulting from a repetitive trauma rather than from a specific accident occurring at a specific time on a specific date. In repetitive trauma injuries, the Court said that the accident date to be used was the date on which the fact of the injury and its causal relationship to work would have been plainly apparent to a reasonable person. (Id at 531)

The Court did not, however, say that the above standard was the only standard to use in determining the accident date. In Durand v. Industrial Commission, 224 Ill.2d 53, 862 N.E.2d 918, 308 Ill. Dec. 715 (2006) the Supreme Court listed what factors to consider when determining manifestation date of repetitive trauma cases. "In short, courts considering various factors have typically set the manifestation date on either the date on which the employee requires medical treatment or the date on which the employee can no longer perform work activities. (Id at 72) The Court went on to say that many factors were relevant in determining the appropriate accident date. "However, because repetitive trauma injuries are progressive, the employee's medical treatment, as well as the severity of the injury and particularly how it affects the employee's performance, are relevant in determining objectively when a reasonable person would have plainly recognized the injury and its relation to work. See Oscar Meyer, 176 IllApp.3d at 610." (Id)

It should also be noted that in Durand, the Court stated: "We decline to penalize an employee who diligently worked through progressive pain until it affected her ability to work and required medical treatment." (Id at 74)

Durand as well as Oscar Meyer involved Petitioners who knew of their injuries prior to the dates of accident which were selected by the Courts, but tried to faithfully work through their injuries before filing an application. In such an instance, where causation was proven, both Courts

concluded that it would be wrong to penalize the petitioners by time barring their claims. In the instant case, while it is clear that the Petitioner suspected that she had nerve entrapments due to her work, it is also clear that she continued to perform her repetitive work and her symptoms and objective exam results from those entrapments got progressively worse. She testified that the problems really began to interfere with her ability to do her job in 2015 and that is when she filed her application. Her testimony was unrebutted.

Also, it is important to the Arbitrator that the Respondent is in no way prejudiced by the Petitioner choosing an accident date in 2015. Twice before, the Petitioner reported problems which she felt were due to her job duties and, twice before, the Respondent conducted an investigation and denied the claims.

Therefore, the Arbitrator finds that Petitioner's manifestation date was on May 14, 2015. It was on this date that Petitioner reported her injury after diligently working for Respondent until her conditions became so unbearable she filed a workers' compensation claim with the Commission. This contention is supported by the fact that from early 2010 through May 2015 her condition was objectively noted as getting worse, with her first EMG being negative, her second EMG was positive for bilateral carpal tunnel, and her third EMG being positive for bilateral cubital and carpal tunnel.

Accident and Causation

The Arbitrator concludes that Petitioner sustained a repetitive trauma injury arising out of and in the course of her employment with Respondent that manifested itself on May 14, 2015.

In support of this conclusion the Arbitrator notes the following:

Petitioner appeared both truthful and credible during her testimony. The Petitioner also gave detailed and un-rebutted testimony concerning her employment duties while working for the Respondent. Her testimony regarding the amount of typing she did per day was corroborated by the internal job demands report prepared by the Respondent stating that the Petitioner would be expected to type six to eight hours a day.

Petitioner has a long history of reporting her conditions to her doctor going back to 2010. On all three occasions when she was seen by her physicians, Petitioner reported that her condition was made worse by her employment with Respondent. The Arbitrator also finds significant that the Petitioner's condition objectively worsened over the course of five years. It was this progression of symptoms, backed by objective testing, that made Dr. Greatting's opinion that Petitioner's employment accelerated her cubital tunnel and carpal tunnel conditions to the point where theyy required medical treatment credible.

Dr. Greatting, it should be noted, based his opinions on the assumption that the Petitioner keyboarded a large amount of time with her elbows flexed at 90 degree angles on her desk. Besides the Petitioner's testimony, the Respondent's own job description corroborated the doctor's understanding of the Petitioner's job. (See PX 2.)

On the other hand, Dr. Naam, who did not testify, said nothing about causation with respect to cubital tunnel. He also failed to provide a detailed basis for his opinion that the carpal tunnel was not work related.

Based upon the above, the Arbitrator finds that the Petitioner's carpal and cubital tunnel syndromes were causally related to her employment.

In regard to disputed issue (J), the Arbitrator makes the following conclusions of law:

The medical bills admitted into evidence as Petitioner's Exhibit 7, are awarded consistent with the findings above on accident and causation, subject to any Section 8(j) credit and subject to the fee schedule.

In regard to disputed issues (K), the Arbitrator makes the following conclusions of law:

Both Dr. Greatting and Dr. Naam agreed that Petitioner suffered from bilateral hand carpal and cubital tunnel and the treatment regarding these conditions. Having determined both conditions to be related to Petitioner's work activity for Respondent, the Arbitrator finds the proposed surgeries necessary and orders Respondent to pay for same, subject to the fee schedule.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Teresa Johnson,
Petitioner,
vs.

NO: 13WC 25345

17IWCC0776

Wal-Mart Associates, Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner, herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, notice, 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 December 28, 2016, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: DEC 1 - 2017
MJB/bm
o-11/21/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JOHNSON, TERESA
Employee/Petitioner

Case# **13WC025345**

WAL-MART ASSOCIATES INC
Employer/Respondent

17IWCC0776

On 12/28/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.66% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0352 LaMARCA LAW OFFICES, PC
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0560 WIEDNER & McAULIFFE LTD
MATTHEW J ROKUSEK
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

17IWCC0776

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

Teresa Johnson
Employee/Petitioner

v.

Wal-Mart Associates, Inc.
Employer/Respondent

Case # 13 WC 25345

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 **Springfield**, on **12/17/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **5/23/13**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was not*** given to Respondent.

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

In the year preceding the injury, Petitioner earned **$30,035.20**; the average weekly wage was **$577.60**.

On the date of accident, Petitioner was **54** 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 **$N/A** for TTD, **$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

Because Petitioner has failed to sustain her burden of establishing that she sustained an accident which arose out of and in the course of her employment, failed to provide proper notice of the alleged accident, and failed to sustain her burden of establishing that her current condition of ill-being is causally related to the alleged accident, benefits are denied.

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

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

Signature of Arbitrator

12/13/16
Date

DEC 28 2016

BACKGROUND

Petitioner had a prior disputed claim for an injury to her right shoulder, case number 09 WC 01494, which was settled on July 5, 2011. As a result of her prior claim, the Petitioner received "permanent" work restrictions of no lifting more than 10 pounds. (PX 14, RX 2 p. 4)

Respondent submitted a copy of the Petitioner's associate statement for the earlier claim into evidence. It shows that Petitioner alleged an injury date of August 25, 2008 which was reported on October 17, 2008, the date the associate statement was completed. (RX 9, pp. 1-2) An Employer's First Report of Injury form was completed by the Respondent that same day. (*Id.*, at 3).

FINDINGS OF FACT

Petitioner is a dry grocery GM stocker for Wal-Mart in Springfield, Illinois. She alleges a repetitive trauma injury to her left (non-dominant) shoulder manifesting on May 23, 2013. At the time of her alleged injury, she had been employed with the Respondent for 14 years. She worked in a few departments including electronics, stationary, and toys. At the time of the alleged injury she remained under the 10 pound lifting restriction which resulted from her earlier injury to the right shoulder.

The Petitioner testified that her job duties included removing freight from delivery trucks using pallet jacks, taking the pallets onto the floor of the store, picking up boxes off the pallet, removing the product from the boxes, and placing product on the shelf. She estimated that the weight of objects she was required to lift ranged from five to fifty pounds, depending on the department that she was working. Petitioner testified she was sometimes required to lift objects overhead to place them on high shelves. She further testified that at times she would be required to lift objects weighing twenty to in excess of thirty pounds overhead, or climb a ladder with freight overhead.

Petitioner testified that she began to experience left shoulder symptoms in April of 2013. She indicated that the onset of these symptoms was a "gradual thing" and that it "started hurting really bad," especially when she was working different freight and pulling things. Petitioner further testified that she began seeing her primary physician, Dr. Rull, in May of 2013 about stabbing pain in her left arm, particularly her shoulder and that she began noticing symptoms in her left shoulder in April of 2013. She stated that Dr. Rull placed restrictions on her work activities after her visit and that Walmart accommodated those restrictions by putting her "up front as a greeter." She indicated that at various times before her surgery in May of 2014 she was both off-duty and working with restrictions but she was "real unclear on the dates."

The medical records in evidence indicate that Petitioner first sought treatment for her alleged work injury on May 23, 2013. On that date, she was evaluated by Dr. Neziroski at SIU Healthcare. (PX 1) [1] Dr. Neziroski recorded complaints of left shoulder and right leg pain. The doctor noted that her complaints began after she "fell on a pallet at work." The doctor noted decreased ROM in the arm and pain with lifting her arm

[1] The Arbitrator notes that PX 1, according to Petitioner's exhibit list, purports to be the records of Dr. Rull. In actuality, however the exhibit consists of the records of SIU Healthcare which contain entries of various healthcare providers, including Dr. Rull and Dr. Neziroski.

up. On that same date Petitioner was provided restrictions of no lifting greater than 5 pounds, with no reaching, stooping, or climbing signed by Dr. Rull. (RX 6, p. 6)[2]

An x-ray of the Petitioners left shoulder was obtained on May 24, 2013, and interpreted to show degenerative changes. (PX 2)

Petitioner testified that before seeing Dr. Rull on May 23, 2013, she spoke with her managers about the condition of her shoulder. She said she first spoke with Jasen Driver, letting him know her arm was hurting pretty bad and that she believed the cause of the pain to be heavy lifting in the departments that she was working. She also testified that she spoke to Shawn Arthur and Amber Yarborough about the condition of her shoulder and her belief that her work activity was a causative factor.

On May 24, 2013, Petitioner returned to the store after receiving restrictions from SIU Healthcare. At that time, she requested a leave of absence. Petitioner testified that she obtained some FMLA paperwork from Jim Hashman. She recalls filling out the "Request for leave of absence-FMLA" form, but claims that in the "reason for leave request" category, she checked three boxes for "medical leave," "workman's compensation," and "own serious health condition." (*see* PX 16 p. 4) She says that at the time the form was filled out, she and Mr. Hashman got into a "confrontation" about whether the injury was workman's compensation related. Petitioner testified that she does not recall ever seeing the copy of the form without "workman's compensation" checked as a reason for the leave. The original "Request for leave of absence-FMLA" form was submitted as RX 16. The Arbitrator notes that the original form does not have "workers' compensation" checked as a reason for her requested leave. The Arbitrator further notes that RX 16 is a two sided document which contains Petitioner's signature on the back of the form. RX 16 shows no indication that a check from the box corresponding to workman's compensation has been removed. It appears that PX 16 has been altered to include "workers' compensation" as a reason the leave was requested. Petitioner had been involved in a car accident in May of 2013 resulting in an injury to her hip which, she claimed, was the reason for checking "own serious health condition" as well. Additional FMLA forms were completed by Petitioner on or about July 12, 2013 on which the Petitioner again failed to list "workers' compensation" as a cause for her leave of absence. (RX 2, pp. 21-22, RX 8, pp 17-18)

Petitioner called Dr. Rull's office on May 30, 2013, and reported that she had been involved in a motor vehicle accident on "Monday morning" and that she was now having pain from that accident. Her specific complaints are not addressed in that record. (PX 1). Although the Petitioner did not submit any office visits from Dr. Rull, the doctor placed her on work restrictions from June 10, 2013, through June 23, 2013. (PX 1)

Physical therapy was provided at Memorial Industrial Rehab from June 17, 2013 to June 28, 2013. (PX 3) Petitioner returned to SIU Healthcare on July 16, 2013, with ongoing left shoulder complaints that "started in April." Noting that the Petitioner completed therapy without relief, the doctor advised the Petitioner to attend an orthopedic evaluation on July 23, 2013.

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[2] After reviewing PX 1, and RX 6 a comparison of the two strongly suggests that PX 1 is an incomplete copy of the records of SIU HealthCare. For example, the 5/23/13 note of Dr. Neziroski contained in PX 1 consists of pages 1 and 2 as noted on the upper right of the pages. RX 6, however contains pages 1,2, and 3 for this same visit. (PX 6 pp. 9-11) It further appears to the Arbitrator that the records regarding the 5/23/13 visit in PX 6 is incomplete as it does not contain an electronic signature as do other entries. See e.g. PX 1 7/16/13 note of Dr. Balanga.

On July 23, 2013, the Petitioner was evaluated by Patricia Lacy, MSPA-C at SIU HealthCare Division of Orthopedic Surgery. Petitioner reported left shoulder pain since April 2013. (PX 4) No work injury was recorded at that time. Ms. Lacy recommended an MRI of the left shoulder and instructed the Petitioner to remain off work until her follow-up appointment.

On July 25, 2013 Petitioner completed an associate incident report indicating that she was injured on May 2, 2013, while lifting heavy merchandise overhead. (PX 15, RX 2, p. 8) She further indicated that she reported this accident on May 22, 2013, to Shawn Arthur, Jasen [Driver] and Amber [Yarborough]. After the report was submitted, the Respondent completed the Employer's First Report of Injury for this Claim. (RX 1, p. 1) A written statement was also completed by Mr. Hashman stating that the Petitioner previously denied a work related shoulder injury on May 24, 2013. Mr. Driver was identified as a witness to that conversation. Mr. Hashman further reported that the Petitioner first came in to file a workers' compensation claim on July 25, 2013. (RX2, p.5)

An MRI was obtained on July 31, 2013 at Memorial Medical Center. (PX 5) Ms. Lacy reviewed the study on August 13, 2013, and provided an assessment of left shoulder impingement, labrum tear, and tendinosis. She recommended a follow-up with Dr. El-Amin, physical therapy, and instructed the Petitioner to remain off work. (PX 4)

Additional physical therapy was provided at PhysioTherapy Professionals; however, the Petitioner was only seen on August 16, 2013 and October 10, 2013. (PX 6)

On October 4, 2013, the Petitioner was evaluated by Dr. Karolyn Senica at the Orthopedic Center of Illinois. (PX 7) Dr. Senica noted that the Petitioner denied any specific injury or trauma but complained of left shoulder pain since May 2, 2013. The Petitioner claimed that she has to constantly lift 50-60 pounds while stocking during her shifts. Dr. Senica reviewed the diagnostic imaging and conducted a physical examination. She provided an impression of left shoulder pain, left shoulder impingement, left shoulder tendinosis, partial thickness rotator cuff tear. She recommended conservative measures including medication, physical therapy, and injections; however, the Petitioner refused injections. Dr. Senica released the Petitioner to return to work light duty with no lifting at or above shoulder level.

The Petitioner received additional therapy from Midwest Rehab on referral from Dr. Senica. (PX 8) The records show that therapy began on October 10, 2013, and that the Petitioner attended 7 visits through October 31, 2013, with no relief. The Petitioner returned to Dr. Senica's office on November 12, 2013. It was noted that she had not yet returned to work. (PX 7) As the Petitioner once again refused to try an injection, Dr. Senica referred her to Dr. Herrin for surgical intervention and continued the work restrictions of no lifting at or above shoulder level.

Dr. Herrin evaluated the Petitioner on November 25, 2013. (PX 9) He noted that the Petitioner "works at Wal-Mart and has to lift heavy objects" and that "she does not remember a specific injury, but she does note repetitive lifting." The doctor did not document anything further regarding the alleged mechanism of injury. Following his examination and review the diagnostic studies, Dr. Herrin recommended surgical intervention including a rotator cuff repair versus debridement, and subacromial decompression. He advised that this may

not resolve all of the Petitioner's complaints and expressed concern that some of her complaints could be due to the cervical spine. He continued the Petitioner's restrictions at that time.

At the request of Petitioner's attorney, Dr. Senica completed a narrative report on January 6, 2014, in which she opined that most tears are degenerative in nature and occur gradually with normal wear and tear of the tendon as one ages over time. (PX 10) While she opined that it was "possible" that the Petitioner's job duties "may have contributed" to her left shoulder injury, she further reported that "[s]everal factors can contribute to degenerative rotator cuff tears including stress, poor blood supply to the tendon, and extrinsic compression." (*Id.*)

Dr. Michael Milne conducted a section 12 examination on March 3, 2014. (RX 13, pp. 75-78) He recorded that the Petitioner reports that her shoulder began hurting in May 2013. She works as an overnight stocker for Wal-Mart and had worked there for 12 years. (*Id.*, at 76) She claimed that she had a repetitive job and that she frequently lifts 25-50 pound boxes eight hours per day and 40 hours per week. (*Id.*) Dr. Milne reviewed copies of the Petitioner's medical records and diagnostic studies, as well as the letter from the Petitioner's attorney to Dr. Senica and Dr. Senica's narrative report. He diagnosed the Petitioner with left shoulder pain, left shoulder impingement syndrome, left shoulder acromioclavicular joint arthrosis, and left shoulder rotator cuff tendinosis versus a partial tear. (*Id.*, at 77) He felt that there was aging and a degenerative component to the Petitioner's injuries without a specific injury and that her need for additional medical treatment was not related to her work at Wal-Mart. (*Id.*, at 77-78)

Petitioner returned to Dr. Herrin's office on April 17, 2014, at which time surgery was scheduled. (PX 9) On May 30, 2014, Dr. Herrin performed a left shoulder arthroscopy with arthroscopically assisted repair of the bursal-sided tear of the supraspinatus, debridement of the articular-sided tear of the supraspinatus, arthroscopically assisted subacromial decompression and debridement of the superior labrum. (PX 11)

Dr. Herrin continued to provide post-surgical care to the Petitioner. (PX 9) Following an appointment on June 5, 2014, he released her to return to work light duty with no use of the left upper extremity. On June 30, 2014, he noted that the Petitioner had returned to work in a light duty capacity, continued her restrictions, and ordered physical therapy. Petitioner's final course of physical therapy was conducted at Midwest Rehab from July 15, 2014 through October 13, 2014.

The Petitioner continued working light duty for the Respondent. Dr. Herrin last saw the Petitioner on February 9, 2015, at which time he released her for full duty and discharged her from his care.

At the request of the Respondent, the Petitioner returned to Dr. Milne on April 20, 2015 for a second section 12 examination. (RX 13 pp. 82-84) On exam, Petitioner had full active range of motion and 5/5 strength. She had minimal tenderness to palpation and was neurovascularly and neurologically intact. (*Id.*, at 83) Although he once again opined that the Petitioner's condition was not causally related to her job duties, he opined that the treatment received was reasonable and necessary, although he would like to review the surgical photographs. (*Id.*) He opined that Petitioner did not require any restrictions for her injury and provided a rating of 1% impairment of the left upper extremity. (*Id.*). In a report dated July 27, 2015, Dr. Milne opined that he reviewed the surgical photographs and that his opinion remained unchanged from his prior reports.

Amber Yarborough testified at the hearing. She is presently employed by Respondent at the Freedom store but at the time of Petitioner's alleged injury she was employed at the Dirksen store. At that time, she was employed as an overnight assistant manager. Ms. Yarborough was aware of the Petitioner's prior right shoulder injury resulting in permanent restrictions. She testified that as a result of those restrictions, the store usually kept Petitioner in the electronics department where the merchandise was lighter, and Petitioner was advised that she did not need to work outside of her restrictions. She indicated that the store had other employees who could take care of heavier lifting. They averaged 27-35 overnight stockers. She testified that Petitioner did not report a new injury to her left shoulder prior to July 25, 2013. She indicated that had she done so, Petitioner would have been instructed to fill out the paperwork immediately.

Shawn Arthur testified at the hearing as well. He is presently employed at the store on Dirksen where the Petitioner is employed. At the time of the alleged work injury, he was employed as an assistant manager and would work overnight 4 days per week. Mr. Arthur testified that Petitioner reported an injury to him but that accident occurred the week prior to the hearing in this matter. After that accident was reported, Mr. Arthur had her fill out an accident report. He testified that prior to the accident in December 2015, Petitioner has never reported any accident to him, and that if Petitioner testified that she had reported her left shoulder injury to him that would be inaccurate. Mr. Arthur was aware of her prior restrictions from the right shoulder injury and testified that following receipt of those restrictions she was given work in lighter areas and instructed not to work outside her restrictions. He stated that Petitioner was not asked to stock merchandise weighing more than 10 pounds and would not have been penalized for failing to lift heavier merchandise. While he was aware that Petitioner would have occasional shoulder complaints, at no point did the Petitioner report that her complaints were related to her left shoulder or related to any new on the job injury.

Jasen Driver also testified. He is a co-manager at Wal-Mart on Dirksen. He has worked with Petitioner for several years. He testified that Petitioner has reported right shoulder pain due to her prior work related injury, but did not report an injury to her left shoulder. He was aware that the Petitioner requested an FMLA leave beginning May 23, 2013. It was his testimony that he and Jim Hashman actually had a conversation with Petitioner in which she was asked if her condition was "related to workmen's comp" and she told them no. He stated that it was at that point that Mr. Hashman started to "get the FMLA stuff going with her." He testified that if Petitioner had reported it was a work injury, he would have had an assistant manager take an accident report and if an assistant manager was not available he would have taken the report himself.

Mr. Driver testified that he has been familiar with the merchandise stocked in the store. He indicated that Wal-Mart does not stock merchandise weighing more than 25 pounds above shoulder level in the toy or electronics departments. Electronics will have heavier merchandise but such merchandise is stocked in "low boys" that he described as counters below shoulder level. The only low boys with merchandise stocked above shoulder level have ink and DVD players. When asked whether the Petitioner is required to lift more than 10 pounds Mr. Driver responded "absolutely not" and explained that "she's continually told not to do that." If he sees things on her pallet along those lines he encourages the Petitioner to make sure that she gets someone to help her lift them. He testified that they have upwards of 25 overnight stockers employed at the store.

James Hashman was Respondent's final witness at the hearing. Mr. Hashman is the personnel coordinator at the store where Petitioner is employed. He is responsible for keeping accident reports, work slips, and FMLA forms. He is familiar with the FMLA forms in the Petitioner's file. Mr. Hashman reviewed

the FMLA form submitted at trial as PX 16 and testified that it was "not the same" as the form in his records. Specifically he testified that the forms in the Petitioner's files had "own serious health condition" checked as the reason for the leave of absence, not "workers' compensation." He then identified RX 2 as a fax he sent to Claims Management on July 26, 2013. He further identified RX 2, p. 9 as a copy of the leave of absence form for the period of May 23, 2013 through June 13, 2014. Mr. Hashman pulled the original form from his file and presented it to the Arbitrator. He identified the original ink and markings on the form. The original form was admitted as RX 16. Mr. Hashman testified that prior to the date of hearing he had never seen a copy of the altered FMLA form. Mr. Hashman further testified regarding his meeting with Petitioner on May 23, 2013. He stated that she was requesting time off work for a surgery that was not work related. He testified that Petitioner also requested an extension of her leave of absence and did not report that the extension was for a work related injury. Mr. Hashman first became aware that the Petitioner was alleging a work related injury to her left shoulder on July 25, 2013, at which time the workers' compensation paperwork needed to be completed. At that time, he made a statement of his own reporting the fact that she was now reporting an injury as work related but that it was not previously reported that way. He identified RX 2, p. 5, as the statement he wrote.

Dr. Rodney Herrin testified by way of deposition on May 15, 2014. (PX 12) He initially evaluated the Petitioner on November 25, 2013 on referral from Dr. Senica. (*Id.*, at 5-6) According to his records the Petitioner "works for Walmart and has to lift heavy objects. She does not remember a specific injury but does note repetitive lifting." (*Id.*, at 8) Dr. Herrin opined that the Petitioner had an injury to her left shoulder and that it "was a reasonable option to proceed with surgical intervention, perform arthroscopy in the shoulder, potentially proceed with a subacromial decompression, and then evaluate a rotator cuff." (*Id.*, at 15) At the time of his testimony, the Petitioner had not yet undergone surgery. (*Id.*, at 17) Dr. Herrin was asked to review a letter sent by the Petitioner's attorney to Dr. Senica, requesting a causation opinion for this claim. (*Id.*, at 19) Based on his review of that letter, Dr. Herrin testified:

> Well, if she's doing activities that are involving signficant weights, which I will say 10 to 15 pounds and definitely 20 to 50 pounds worth would be, and they're overhead or over shoulder level, I think that could at least irritate or aggravate or cause problems with the rotator cuff . . .

(*Id.*, at 21) However, on cross examination, Dr. Herrin admitted that he did not have a copy of the Petitioner's accident report or job description. (*Id.*, at 30) He testified that Petitioner did not describe what she meant by heavy lifting, did not state how often she had to lift heavy objects. He did not know if she would lift at waist level, below chest level, or at shoulder level, and further did not know how much she lifts on any given day at work. (*Id.*, at 31) Further, she did not describe what she meant by repetitive lifting. He did not know how often she would lift merchandise, whether she would lift merchandise throughout her shift, and did not know how much she would work in a given week. (*Id.*, at 32) Dr. Herrin admitted that it would be fair to say that the knowledge he gained of the Petitioner's job duties from the Petitioner was limited to her statement that "she works at Wal-Mart and that she claims she has to lift heavy objects" and that "[s]he does not remember a specific injury but does note repetitive lifting." (*Id.*, at 32, see also *Id.*, at 8, 30)

Dr. Michael Milne testified by way of deposition on December 14, 2015. He evaluated the Petitioner on March 3, 2014 (RX 13, p. 75) and April 20, 2015 (*Id.*, at 82), and also completed an addendum report on July 27, 2015. (*Id.*, at 85) Dr. Milne obtained a history from Petitioner stating that she works as an overnight

stocker, which she described as a repetitive job that requires her to frequently lift 25-50 pound boxes 8 hours per day and 40 hours per week. (*Id.*, at 10, 76) Dr. Milne conducted an examination, reviewed diagnostic imaging, and reviewed copies of Petitioner's medical records as well as copies of her accident report and a statement from James Hashman (*Id.*, at 12, 76) It was his opinion that Petitioner had left shoulder pain, left shoulder impingement syndrome, left shoulder acromioclavicular arthrosis, and left shoulder rotator cuff tendinosis versus a partial tear. (*Id.*, at 15, 77) However, he did not believe that the Petitioner's injuries had any specific relationship to her employment, noting the lack of any specific injuries and the aging and degenerative components of her condition. (*Id.*, at 17, 77)

When Petitioner returned to Dr. Milne's office on April 20, 2015 he reviewed her updated treatment records noting the surgery performed by Dr. Herrin, her post-surgical care, and the fact that she was released at maximum medical improvement on February 9, 2015. (*Id.*, at 20, 83-84) He conducted a physical examination and opined that Petitioner was status post left arthroscopic subacromial decompression and rotator cuff repair with one anchor. (*Id.*, at 22, 84) However, it remained his opinion that Petitioner's condition was not causally related to her job duties. (*Id.*, at 24, 27, 84) Dr. Milne provided a rating of 1% impairment of the whole person. (*Id.*, at 28-30, depo. Exhibit G)

Petitioner last saw Dr. Herrin on February 9, 2015. She has not sought any medical treatment for her left shoulder since that date. She was released to full duty with respect to her left shoulder, but continues to have 10 pound lifting restrictions for her right shoulder. She continues to work for the Respondent as an overnight stocker in the electronics department. Petitioner testified that she is no longer lifting anything heavy.

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?

These issues are somewhat overlapping, therefore the Arbitrator will address them jointly. *Elizabeth Boettcher v. Spectrum Property Group and First Merit Venture*, 99 I.I.C. 0961 (1999) A claimant must prove by the preponderance of credible evidence all elements of the claim in order to receive compensation under the Act. *Orisini v. Industrial Commission*, 509 N.E.2d 1005 (1987)

The Petitioner in this case is relying upon a repetitive trauma theory rather than one of traumatic injury. The Petitioner must still show the injury arose out of and in the course of his employment. *Peoria County Bellwood Nursing Home v. Industrial Commission*, 505 N.E.2d 1026 (1987) In such cases the claimant generally relies on medical testimony to establish causal connection between the claimant's work duties and the condition of ill-being. *Id.* When the question at issue is one specifically within the purview of experts, expert medical testimony is required to show that the work activities caused the condition of which the employee complains. See, e.g., *Nunn v. Industrial Commission*, 157 Ill. App. 3d 470, 478 (4th Dist. 1987). The right to recover benefits cannot rest upon speculation or conjecture. *County of Cook v. Industrial Commission*, 68 Ill. 2d 24 (1977)

The Petitioner does not dispute the fact that at the time of her alleged accident in this case she was subject to a 10 pound lifting restriction from a prior claim. However, it was her testimony that she was forced to

lift merchandise weighing 30 pounds despite her restriction and as a result that she "overcompensated" by using her left arm. Her testimony was rebutted by the testimony of Respondent's witnesses, who testified that the Petitioner was not required to exceed her 10 pound lifting restrictions from her prior claim. Furthermore, Ms. Yarborough and Mr. Driver testified that there were 25 or more stockers in addition to management whom the Petitioner could have called to move heavy merchandise. The Arbitrator does not find the testimony of Petitioner that she would have to lift merchandise weighing 5-30 pounds at or above shoulder level to be persuasive, as it was rebutted by the testimony of multiple witnesses at hearing. Absent supporting evidence or testimony, the Arbitrator concludes that the Petitioner failed to prove that she was required to lift merchandise weighing 30 pounds at or above shoulder level.

The record in this case contains testimony from Petitioner's surgeon, Dr. Herrin, which is in contrast to the testimony from Respondent's independent medical examiner, Dr. Milne. Petitioner also presented a written statement from Dr. Senica, one of the Petitioner's treating physicians, who did not testify in this matter.

While Dr. Herrin opines that Petitioner's condition is causally related to her employment with Respondent, the medical records and Dr. Herrin's own testimony clearly establish that the doctor did not have a copy of the Petitioner's accident report or job description. He admitted he did not know what Petitioner meant by heavy lifting, did not know how often she had to lift heavy objects, did not know whether the lifts were at waist level, chest level, or at shoulder level, and further did not know how much she lifts on any given day at work. He did not know what Petitioner meant by repetitive lifting. He did not know how often she would lift merchandise. Dr. Herrin admitted that the knowledge he had of Petitioner's job duties was limited to her statement that "she works at Wal-Mart and that she claims she has to lift heavy objects" and that "[s]he does not remember a specific injury but does note repetitive lifting."

Dr. Senica opined that most tears are degenerative in nature and occur gradually with normal wear and tear of the tendon as one ages over time. While she opined that it was "possible" that the Petitioner's job duties "may have contributed" to her left shoulder injury, she further reported that "[s]everal factors can contribute to degenerative rotator cuff tears including stress, poor blood supply to the tendon, and extrinsic compression." Dr. Senica did not provide an opinion indicating which factors were present in this case or what actually caused or aggravated the Petitioner's injury, only that it may be a cause. Further, the Arbitrator notes that the assumptions provided to Dr. Senica by Petitioner's counsel in soliciting her opinion did not provide an accurate description of Petitioner's duties.

Dr. Milne was of the opinion that Petitioner had left shoulder pain, left shoulder impingement syndrome, left shoulder acromioclavicular arthrosis, and left shoulder rotator cuff tendinosis versus a partial tear. However, he did not believe that the Petitioner's injuries had any specific relationship to her employment, noting the lack of any specific injuries and the aging and degenerative components of her condition. In addition to being provided with all of the information and materials possessed by Dr. Herrin, Dr. Milne had access to Petitioner's job description and accident report. He was also aware of the 10 pound restriction Petitioner was working under at the time of this alleged accident.

An expert's opinion is only as valid as the bases and reasons for the opinion." *Gyllen v. College Craft Enterprises*, 260 Ill. App. 3d 707, 715 (2nd Dist. 1994). It is well established that the Commission can disregard unreliable medical opinions based on unproven, incomplete, or inaccurate information. See, *Horath v.*

Industrial Comm'n., 96 Ill. 2d 349 (1983). In *Horath*, the Court found that the Commission did not err when rejecting the opinion of a medical expert contradicted by other evidence, even though there was not an opposing opinion in the record. 96 Ill. 2d at 357. The Commission denied a claim for permanent total disability benefits in *Gregor v. City of Chicago*, where it was shown that the claimant's examiner had incomplete information. 99 I.I.C. 686, 1999 Ill. Wrk. Comp. LEXIS 976 (1999). Finally, and directly on point with the current claim, is the Commission's decision in *Moore v. St. Elizabeth's Hospital*, 05 I.W.C.C. 427, 2005 Ill. Wrk. Comp. LEXIS 349 (2005), where the Commission reversed an arbitration award finding that the treating physician did not have a complete and accurate understanding of the Claimant's job duties sufficient to support a repetitive trauma claim.

In this case, Dr. Milne's knowledge of the job duties of Petitioner is far more extensive than that of Dr. Herrin and Dr. Senica and therefore, Dr. Milne's opinion is given more weight regarding causal connection. The Arbitrator finds the testimony and opinions of Dr. Milne more persuasive than those of Dr. Herrin and Dr. Senica.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has failed to prove that she sustained accidental injuries which arose out of and in the course of her employment or that her condition of ill-being is causally related to her employment. Benefits are therefore denied.

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

The Illinois Supreme Court has held that Section 6(c) of the Workers' Compensation Act prohibits any claims under the Act unless the employee gives notice of his injury within 45 days of the accident. *Lambert v. Industrial Comm'n.*, 79 Ill. 2d 243, 247 (1980) The giving of notice to the employer within 45 days of the accident pursuant to section 6(c) of the Workers' Compensation Act is jurisdictional and a prerequisite of the right to maintain a proceeding under the Act. *Ristow v. Industrial Comm'n*, 39 Ill. 2d 410, 413 (1968)

In this case, the Petitioner's trial testimony regarding notice is contradicted by the testimony of Respondent's witnesses. Petitioner alleges a repetitive trauma injury to her left shoulder manifesting on May 23, 2013. The undisputed facts establish that the Petitioner first completed an associate incident report on July 25, 2013, sixty-three (63) day later. The Arbitrator concludes that the Petitioner's associate incident report, completed 63 days after the alleged injury, is not sufficient to establish that she complied with the notice requirement of the Act.

In support of her claim, the Petitioner offered her own testimony that she had provided notice of this injury to several managers at her store, whom she identified as Jasen Driver, Shawn Arthur, and Amber Yarborough. The Petitioner also submitted a copy of a Walmart Leave of Absence Policy Request for Leave of Absence – FMLA form, completed on May 30, 2013, on which she claims that she advised the Respondent that she required a leave due to "Workers' Compensation."

Petitioner's own testimony was inconsistent with respect to the oral notice she allegedly provided to the various managers at the store. On most occasions she described the alleged notice as simply advising that her shoulder was hurting or that her shoulder was hurting from lifting and stocking. Although she alleges at a couple of points that she indicated it was her left shoulder, she never advised that she had sustained a new injury to her shoulder. Each of the managers listed above testified that Petitioner did not report a left shoulder injury and furthermore that had she done so they would have documented that report in the Petitioner's file. In support

of that testimony, the Arbitrator notes that Respondent offered copies of the Petitioner's accident report from her prior right shoulder claim, which showed that after Petitioner reported an alleged injury to her right shoulder, Respondent completed an Illinois Form 45:Employer's First Report of Injury immediately. (RX 9, p. 3) The Arbitrator notes that the Respondent completed an Illinois Form 45: Employer's First Report of Injury for the current alleged work injury on July 25, 2013, the same date the Petitioner completed her associate incident report. (RX 1, p. 1) Although Respondent's witnesses admitted that they were aware of vague shoulder complaints, the Arbitrator notes that at the time of this alleged injury Petitioner was working under permanent restrictions from prior injury to her right shoulder which is unrelated to this claim. In a factual situation such as this, Petitioner's vague complaints of shoulder pain from lifting stock is not sufficient to place Respondent on notice of a new injury to the opposite shoulder and therefore fails to meet the notice requirement of the Act.

The Petitioner submitted a copy of that FMLA form as part of PX 16; however, the Arbitrator notes that a copy of the same form was also submitted by the Respondent as RX 7, p. 3. The original of that document is RX 16. The Arbitrator notes that the Petitioner's copy is inconsistent with the original document marked as RX 16. Despite the Petitioner's sworn testimony that she never signed a copy of this form which did not indicate "workers compensation" as a reason for her leave of absence, the original of the form, which contains Petitioner's signature on the reverse side, clearly does not indicate "workers compensation" as a reason for her leave of absence. It appears to the Arbitrator that PX 16 has been altered to include "workers compensation" as a reason for the leave of absence. Further, additional FMLA forms were completed by Petitioner on or about July 12, 2013. Likewise these forms fail to indicate "workers' compensation" as a cause for her leave of absence.

The testimony of Mr. Driver and Mr. Hashman are also consistent with the statement competed by Mr. Hashman on July 25, 2013 wherein he reported the when the Petitioner sought FMLA paperwork on May 24, 2013, she specifically denied that it was due to a work related injury.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds

Petitioner failed to meet her burden of proof to establish proper notice for this claim as required by section 6(c) of the Act.

Issue (J): **Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?**
Issue (K): **What temporary benefits are in dispute?**
Issue (L): **What is the nature and extent of the injury?**
Issue (N): **Is Respondent due any credit?**

Having found in favor of Respondent with respect to issues C – F above, all remaining issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF Madison)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Frank Gavlic,
Petitioner,
vs.

NO: 16WC 13848

IDOT,
Respondent.

17IWCC0777

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner, herein and notice given to all parties, the Commission, after considering the issue of nature and extent, and being advised of the facts and law, 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 28, 2017 is hereby affirmed and adopted.

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

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

DEC 1 - 2017

DATED:
MJB/bm
o-11/21/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GAVLIC, FRANK
Employee/Petitioner

Case# **16WC013848**

IDOT
Employer/Respondent

17IWCC0777

On 4/28/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.95% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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WORKERS' COMPENSATION MANGER
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CERTIFIED as a true and correct copy
pursuant to 820 ILCS 306/14

APR 28 2017

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

17IWCC0777

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Frank Gavlic
Employee/Petitioner

v.

IDOT
Employer/Respondent

Case # **16** WC **13848**

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 **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **March 23, 2017**. By stipulation, the parties agree:

On the date of accident, **August 21, 2014**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$86,929.44**, and the average weekly wage was **$1,671.72**.

At the time of injury, Petitioner was **56** years of age, ***married,*** with **0** dependent children.

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

Respondent shall be given a credit of **$1,273.76**for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$1,273.76**.

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

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

ORDER

Respondent shall pay Petitioner the sum of **$735.37/week** for a further period of **0** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **0% loss of use of the person-as-a-whole.**

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

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

Signature of Arbitrator

4/26/17
Date

APR 28 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Frank Gavlic
Employee/Petitioner

Case # **16** WC **13848**

v.

Consolidated cases: **N/A**

IDOT
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he is currently 57 years of age and works for IDOT. He testified that he has worked there for 27 years and is a Highway Maintainer/Lead Worker. He testified that he lays asphalt and concrete, does brush and tree removal and moves ice and snow. He testified that on August 21, 2014, he went to pick up part of an engine and felt a pull in his right side down near the belt line. He testified that he thought he had a hernia. He denied having any issues in this area before the accident and further denied having any injuries to this area since the accident. He testified that he went to Anderson Hospital and that his employer directed him to Concentra Medical Center.

Petitioner testified that he has returned to work in the same position. He testified that if he lifts something heavy, sometimes he feels a pull. He testified that this can happen 1-3 times per week.

On cross examination, Petitioner testified that the date of accident was a Thursday and that he went to work the next day, which was a Friday. He testified that he first reported to the Emergency Room on August 25, 2014, which was a Monday. He testified that he was told that he had an abdominal strain, for which he was prescribed Vicodin (which he did not fill). Petitioner denied having any swelling and stated that he just had a shooting pain.

On cross examination, Petitioner agreed that he next sought treatment on September 2nd at St. Elizabeth's Urgent Care. He testified that he reported pain and that he had never filled his prescription, and that he was taking Aleve. He agreed that he was next seen at Concentra Medical Center on September 9th and that he was off work at that time. He testified that he had worked up until that date. He testified that he was recommended to undergo physical therapy which he did. He agreed that on September 12th he was discharged from physical therapy and that he had met all of his goals, was released from care and was given a full duty to return to work.

On cross examination, Petitioner agreed that his last treatment was on September 12, 2014 when he saw Dr. Patel at Concentra Medical Center. He agreed that he had no plans to seek any additional treatment. He agreed that he returned to the same job, was still a Lead Worker and was still laying asphalt, concrete, etc. He denied taking any medications but testified that he takes Aleve when needed.

The medical records of Anderson Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Petitioner was seen in the Emergency Department on August 25, 2014 at which

time he complained of abdominal pain after some heavy lifting at work on Thursday. It was noted that Petitioner stated he was lifting a 200+ pound manhole form and plate by himself when the pain occurred. It was noted that Petitioner noted that the pain was at the right lower quadrant and radiated to his right testicle. Petitioner denied noticing any lumps or symptoms of hematuria and denied a past medical history of kidney stones or an appendectomy. It was noted that Petitioner's abdominal pain was aggravated by bending over. The clinical impression was noted to be that of abdominal muscle strain and Petitioner was discharged home. (PX1).

The medical records of Concentra Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. Petitioner was seen on September 12, 2014, at which time it was noted that he had been working within the duty restrictions and had been taking his medications and noted improvement. It was noted that Petitioner did not have any pain and that he could not identify any exacerbating factors. It was noted that Petitioner denied abdominal pain, urinary incontinence, shortness of breath, difficulty breathing and radicular symptoms. Petitioner was assessed with a right groin/right thigh adductor strain. Petitioner was released full duty and instructed to continue his home exercise program. (PX2).

The records of Concentra Medical Center reflect that Petitioner was discharged from physical therapy on September 12, 2014, at which time he reported 0/10 pain. The physical therapy records reflect that Petitioner stated that he only felt his pain become aggravated when lifting 70 pounds at home, and that his pain was otherwise stable and not problematic. It was noted that Petitioner stated he felt like therapy was no longer necessary in order to get back to work and that he felt "100% improved" from initial therapy. (PX2).

The records of Concentra Medical Center reflect that Petitioner was seen on September 9, 2014, at which time it was noted that he was a 55-year-old employee of IDOT who complained about his groin which was injured on August 21, 2014. It was noted that Petitioner stated that he was lifting an iron manhole. It was noted that Petitioner went to Anderson Hospital and had a CT done (which was negative) and that he was given a prescription for Vicodin which he had not yet filled. It was noted that the following week Petitioner went to St. Elizabeth Hospital and was given Ibuprofen and a muscle relaxant, and that he then followed up with his personal physician. It was noted that Petitioner had been off work since the incident and that he stated that he was slowly recovering. The assessment was noted to be that of right groin strain, improving. Petitioner was instructed to continue Ibuprofen, was given work restrictions and was ordered to undergo physical therapy. (PX2).

The Radiology Report for a CT of the abdomen/pelvis performed on August 25, 2014 was entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The report reveals that the films were interpreted as revealing (1) diffuse hepatic steatosis; (2) 3 mm pulmonary nodule. (PX3).

The medical records of Anderson Hospital were entered into evidence at the time of arbitration as Respondent's Exhibit 1. The records were effectively duplicative of those as contained in Petitioner's Exhibit 1. (RX1; PX1).

The medical records of St. Elizabeth's UrgiCare Center were entered into evidence at the time of arbitration as Respondent's Exhibit 2. The records reflect that Petitioner was seen on September 2, 2014 with a complaint of right groin pain since lifting a manhole cover on August 21, 2014. It was noted that Petitioner had been seen at Anderson Hospital on August 25, 2014 with a normal CT of the abdomen, that he was discharged home with a diagnosis of groin strain and was given Norco which he reportedly had not filled. It was noted that Petitioner was using Ibuprofen for comfort, that his pain was worse with walking, standing and climbing, and that he reported he was unable to perform his regular work. It was noted that Petitioner was referred back to his primary care physician from Anderson, but that Petitioner reported that his primary care physician did not accept workers' compensation cases. It was noted that

Petitioner was assessed with a groin strain. Petitioner was instructed to consider using his previously-prescribed pain medication, at least for bedtime/sleep. Petitioner was also issued work restrictions. (RX2).

The medical records of Concentra Medical Center were entered into evidence at the time of arbitration as Respondent's Exhibit 3. The records were effectively duplicative of those as contained in Petitioner's Exhibit 2. (RX3; PX2).

CONCLUSIONS OF LAW

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that no AMA rating was offered by either party. The Arbitrator places no weight on this factor when making the permanency determination.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that the record reveals that Petitioner was employed as a Highway Maintainer/Lead Worker at the time of the accident and that he has been able to return to work in his prior capacity after the completion of his treatment. The Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 56 years old on his date of accident. Given the advanced age of Petitioner and the fact that his treating physician, Dr. Patel, has placed him under no restrictions, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that, following his work injury, Petitioner returned to his pre-accident employment with Respondent. As there was no direct evidence of reduced earning capacity contained in the record, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that if he lifts something heavy, sometimes he feels a pull and that this can happen 1-3 times per week. At the time of the September 12, 2014 visit with Dr. Patel, it was noted that Petitioner did not have any pain and that he could not identify any exacerbating factors. It was noted that Petitioner denied abdominal pain, urinary incontinence, shortness of breath, difficulty breathing and radicular symptoms. Petitioner was assessed with a right groin/right thigh adductor strain. Petitioner was released full duty and instructed to continue his home exercise program. (PX2). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely his continued complaints and limitations, were not corroborated by his treating records at the conclusion of his treatment with Dr. Patel. 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 **0% loss of use of the person-as-a-whole** as provided in Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Bonnie F. Holland,

Petitioner,

vs.

NO: 13 WC 35612

Murray Developmental Center,

17IWCC0778

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 wages, causal connection, TTD, medical expenses and prospective medical treatment, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below, and otherwise affirms and adopts 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).

"In a workers' compensation case, the claimant has the burden of establishing his or her average weekly wage." *S&C Elec. Co. v. Ill. Workers' Comp. Comm'n*, 42 N.E.3d 69, 397 Ill. Dec. 443 (1st Dist. 2015), citing *Kawa v. Ill. Workers' Comp. Comm'n*, 2013 IL App. (1st) 120469, 991 N.E.2d 430. "The determination of an employee's average weekly wage is a question of fact for the Commission, which will not be disturbed on review unless it is against the manifest weight of the evidence." *Id.* Although overtime wages are generally excluded from the calculation of an employee's compensation, an exception exists where the overtime hours are consistent and required by the employer. 820 ILCS 305/10 (West 2010); *Airborne Express v. Ill. Workers' Comp. Comm'n*, 372 Ill.App.3d 549, 554, 865 N.E.2d 979, 983, 310 Ill.Dec. 259 (2007).

The Commission finds that Petitioner failed to prove that claimed overtime should be included in the calculation of her average weekly wage. More to the point, the Commission finds that Petitioner failed to prove by a preponderance of the credible evidence that the alleged overtime worked was both consistent and required by the employer. In support of this holding, the Commission notes that Petitioner submitted no evidence to support her self-serving claim that roughly 50% of the overtime hours she worked were mandated by her employer. Indeed, when presented with a copy of her wage statement for the year preceding the accident, Petitioner was unable to identify which hours were mandatory and which were voluntary. Furthermore, there is absolutely no evidence to show that Petitioner worked a set number of overtime hours per week. Instead, Petitioner was forced to speculate as to the breakdown of her overtime hours. The Commission finds this insufficient proof that said overtime wages should be included in the calculation of Petitioner's average weekly wage and hereby strikes their inclusion in the Arbitrator's determination of wages.

Therefore, the Commission finds that Petitioner's average weekly wage, excluding overtime, was equal to $817.54. This is based on the wage records which show Petitioner earned $34,336.67 between the pay periods ending 3/31/12 and 3/15/13 (RX1) as well as Petitioner's testimony and the attendance records which show she worked a total of 42 weeks and parts thereof during the year preceding the accident. (T.36-37; RX10).

The Commission also notes that in calculating the period of TTD benefits, the Arbitrator mistakenly found that the total number of weeks was equal to 9-6/7 weeks. The Commission hereby corrects the Arbitrator's decision to find that Petitioner was temporarily totally disabled from 6/14/13 through 8/4/13 (7-3/7 weeks) and from 4/29/14 through 5/13/14 (2-1/7 weeks), for a total period of 9-4/7 weeks.

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 5/13/16 is affirmed with changes as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $545.03 per week for a period of 9-4/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $28,980.60 for necessary medical expenses, as provided in §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for prospective medical services in the form of treatment recommended by Dr. Bonutti, as provided in §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner additional compensation in the amount of $37,988.35, as provided in §19(k) of the Act.

17IWCC0778

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.

DATED: DEC 4 - 2017
o:10/3/17
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

HOLLAND, BONNIE
Employee/Petitioner

Case# **13WC035612**

WARREN G MURRAY DEVELOPMENTAL CENTER
Employer/Respondent

17IWCC0778

On 5/13/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.38% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0384 NELSON & NELSON
NATHAN C LANTER
420 N HIGH ST
BELLEVILLE, IL 62220

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

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

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

MAY 13 2016

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

17IWCC0778

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Bonnie F. Holland
Employee/Petitioner

v.

Warren G. Murray Developmental Center
Employer/Respondent

Case # **13** WC **035612**

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 **Mt. Vernon**, on **06/04/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **03/18/13**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$38,271.10**, in the 43 weeks actually worked; the average weekly wage was **$890.01**.

On the date of accident, Petitioner was **47** 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 is entitled to a credit for all TTD benefits paid. Respondent is entitled to a credit under Section 8(j) of the Act. Respondent is entitled to a credit for all medical bills paid.

ORDER

Respondent shall pay reasonable and necessary medical services of $28,980.60, as set forth in Petitioner's Exhibit 5, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall also authorize and pay for prospective medical services as recommended by Dr. Bonutti pursuant to Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $593.35/week for 9 6/7 weeks, commencing 6/14/13 through 8/4/13 (7 4/7 weeks), and 4/29/14 through 5/13/14 (2 2/7 weeks),as provided in Section 8(b) of the Act.

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

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

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

Signature of Arbitrator

5/2/16
Date

ICArbDec19(b)

FINDINGS OF FACT

On the date of hearing Petitioner was 49 years old, married, and had one dependent child. She worked for the Respondent for 22 years. In March 2013 Petitioner was a Mental Health Tech II. Her job involved taking care of mentally handicapped individuals, making sure they didn't harm themselves or others, and helping them with their daily routines (feeding, grooming, bathing, etc.). Prior to 03/18/13 Petitioner had no left knee symptoms, complaints of pain or discomfort. She had not received any treatment or been under any restrictions with regard to her left knee before 03/18/13.

On 3/18/13 an aggressive individual pulled Petitioner to the ground by her hair causing Petitioner's left knee to hit the concrete floor. She felt a sharp burning pain go through her knee. The pain was 10/10. The knee was red and swollen. Petitioner had never felt left knee pain like this before. She told her supervisor and Tech III, Jim Woods, about her injury. Petitioner completed a written report of injury.

On 04/01/13 Petitioner sought treatment at the Work Safety Institute. She was prescribed Celebrex, referred to Dr. Jeff McIntosh and allowed to return to light duty work. X-rays showed mild degenerative changes in the medial joint complex.

On 04/04/14 Petitioner saw Dr. McIntosh. He took a history consistent with Petitioner's testimony. Physical exam found swelling and diffuse tenderness to palpation in the patellofemoral joint and the medial and lateral joint compartments. His assessment was a contusion and possible internal derangement. He recommended a MRI and kept her on light duty.

On 04/08/13 Petitioner underwent a left knee MRI. On 04/18/13 she returned to Dr. McIntosh who believed the MRI showed evidence of chondromalacia, medial meniscus tear, and a small popliteal cyst. He noted she was not much better, so he aspirated the knee, administered a corticosteroid injection, prescribed physical therapy three times a week for two weeks, continued her anti-inflammatory medication, and kept her on light duty.

On 05/09/13 Petitioner returned to Dr. McIntosh. He noted she had failed to improve. Petitioner rated her pain 9/10 and had to stop physical therapy due to increasing discomfort. He noted the knee was swollen. She walked with a limp and was having significant pain in the medial joint line and pain with patellofemoral compression. He recommended arthroscopic evaluation and kept her on light duty.

On 06/14/13 Dr. McIntosh performed arthroscopic surgery. His post-operative diagnosis was a fairly significant chondral injury to the medial femoral condyle, medial tibial plateau, and a small lateral meniscus tear. There was no mention of advance arthritis.

On 06/18/13 Petitioner returned to Dr. McIntosh. He told her to start physical therapy. He kept her off work. On 07/11/13 Petitioner returned to Dr. McIntosh. He noted she was still having some swelling and pain. He aspirated the knee and administered another injection. He continued her on anti-inflammatories and analgesic medication. He kept her off work.

On 08/01/13 Petitioner returned to Dr. McIntosh. He noted she was making progress in therapy but was still having some discomfort and pain with prolonged walking. He allowed her to return to work light duty.

On 08/23/13 Petitioner returned to Dr. McIntosh. He believed she was making good progress. She was anxious to return to full duty. He refilled her analgesic and anti-inflammatory medication. He allowed her to return to work full duty.

On 10/03/13 Petitioner returned to Dr. McIntosh. He noted she was still having a fair amount of discomfort especially in the medial joint line, which was the same area where she had a lot of pathology according to the x-rays and MRI. He encouraged her to lose weight by trying a combination of exercise, medication, and dietary changes. He administered another injection to help relieve her discomfort. He refilled her medication and prescribed a knee brace. He kept her working full duty.

On 11/14/13 Petitioner returned to Dr. McIntosh. He noted she continued to have a fair amount of pain in the medial joint line, difficulty walking, and stiffness. On physical exam he found swelling and tenderness in the medial joint. X-rays showed progression of the degenerative changes in the medial joint compartment. He administered a corticosteroid injection. He continued anti-inflammatory medication, encouraged weight loss and continued exercise.

On 02/13/14 Petitioner returned to Dr. McIntosh. On physical exam he found swelling, tenderness to patellofemoral compression, and some pain on range of motion. He believed that she was at MMI. He told her use the brace if she needed it. He thought she may continue to have difficulty with her knee due to arthritis.

Petitioner testified the arthroscopic surgery provided "a little bit" of relief. Before the surgery her left knee pain was 9-10/10, she couldn't bend the knee, and she had to keep it elevated a lot. After the surgery, her left knee pain was 5-6/10.

On 03/25/14 Petitioner sought treatment at Bonutti Orthopedic Clinic in Effingham, Illinois. She was examined by Nickolas Williams, PA-C, who took a history consistent with Petitioner's testimony about the March 2013 work incident and the surgery performed by Dr. McIntosh and subsequent treatment. He noted Petitioner had stabbing and throbbing left knee pain, aggravated by walking and standing, and the knee would lock and swell. Petitioner rated the pain at 8/10. On physical exam, he noted significant tenderness anywhere the knee was palpated but more so on the medial side, lateral side down the distal tibia, and proxmal on her femer. X-rays showed near complete loss of the medial joint line with mild subchondral sclerosis and moderate patellofemoral disease more so off the medial facet. He was concerned about a medial femoral condyle osteochondral defect that was noted during arthroscopy, so he recommended Petitioner get a second left knee MRI and to return to discuss her treatment options.

On 04/04/14 Petitioner underwent the second left knee MRI. The impression was degenerative joint disease in all 3 compartments, especially the medial compartment. There was a slight prominence of joint fluid and no definite meniscal or ligamentous tear suggested. He did not keep Petitioner off work.

On 04/15/14 Petitioner returned to the Bonutti Orthopedic Clinic. Her left knee pain was 10/10. Mr. Williams noted the radiologist's MRI results but, upon his own interpretation of the MRI, believed there was a small area of the medial tibial plateau in addition of the medial femoral condyle consistent with an osteochondral defect. He believed she would not benefit or would have little relief from another arthroscopy because of the defect in the medical femoral condyle and patellofemoral disease. He recommended a left total

knee replacement as the only way to get her back to working. He returned her to work with restrictions of limited walking with her left leg.

On 04/26/14 an aggressive individual grabbed her around her neck, took her to the floor, and her left knee hit the floor. Petitioner testified the March 2012 injury was the more severe when compared to the April 2014 event.

On 04/29/14 Petitioner returned to the Bonutti Orthropedic Clinic for a recheck of her left knee. Mr. Williams noted she reinjured the knee at work on 04/26/14 when she an aggressive individual took her to the floor. Petitioner was unable to bear weight on the knee because it feels like it is going to give out and is incredibly painful. He noted these symptoms were basically the same for which she had been seen previously at the clinic. Physical exam noted marked tenderness on the medial and lateral joint lines. X-rays showed complete loss of the medial joint line and subchondral sclerosis and advanced patellofemoral disease. Mr. Williams kept Petitioner off work until 05/13/14. He again recommended a left total knee replacement.

Petitioner testified she underwent bypass surgery on 05/20/14. Petitioner has since lost 105 pounds. Her left knee pain has not improved after losing that weight.

On 09/30/14 Dr. Peter Bonutti examined Petitioner. He took a history consistent with Petitioner's testimony and medical records. He noted she was experiencing significant pain and discomfort, as well as grating and grinding. On physical exam he noted her left knee had decreased ROM and significant patellofemoral crepitus. X-rays showed advanced medial compartment degenerative changes bilaterally with moderate patellofemoral disease bilaterally. Dr. Bonutti reviewed the 04/14/14 left knee MRI as showing evidence of patellofemoral plus medial compartment degenerative changes with edema in the medial compartment and extruded meniscus. He noted Petitioner failed history of conservative care. He believed her remaining options were more anti-inflammatories, injections, and bracing or a left total knee replacement.

Petitioner testified In October 2014 she began working as Mental Health Tech III. This is a more supervisory position than a Mental Health Tech II but her job duties include those of a Tech II when another Tech III is in charge.

Petitioner is currently working full duty. She is not taking any medication for her left knee. The level of left knee pain is 8-9/10. She has trouble walking short distances and standing on her feet for long periods of time. Going up steps causes the knee to hurt a lot. At work, if there's an individual on the floor, she can't get down on the floor to help because of left knee tenderness. The knee is painful at night. In bed, she has to position her left knee in a certain way. She cannot lie on her left side because the knee throbs. She further testified that since 03/18/13 her left knee has not been completely free from pain and discomfort. She's not had any significant pain or symptoms in her right knee. She wants to have the left total knee replacement.

The deposition testimony of Dr. Bonutti was admitted into evidence. He opined the trauma of Petitioner falling onto her left knee could aggravate the underlying pre-existing osteoarthritis and had been was minimally or asymptomatic prior to March 18, 2013. (PX 6, p. 15) He opined Petitioner's work injuries were a cause for the need for treatment he recommended, including the total knee replacement. (PX 6, p. 16) He also believed the arthroscopic surgery contributed to the progressive degenerative joint disease because the condition of Petitioner's left knee was worse after the surgery when compared to before the surgery. (PX 6, p. 16) He

testified Petitioner had not yet reached MMI. (PX 6, p. 17) He reviewed Dr. McIntosh's operative report. (PX 6, p. 19) He noted the reported stated there was a lateral meniscus tear and medial femoral condyle injury consistent with a direct blow to the knee. (PX 6, p. 19-20) He also noted the operative report did not describe advanced arthritis. (PX 6, p. 20) This allowed him to conclude the arthroscopic surgery was meant to treat traumatic injuries to Petitioner's left knee. (PX 6, p. 20) Dr. Bonnuti also reviewed the first MRI of 04/08/13. (PX 6, p. 47) He noted that MRI said she had mild condromalicia or very early arthritis. (PX 6, p. 47) When the 04/08/13 MRI was compared to the 04/14/14 MRI, he noted there was marked progression of Petitioner's left knee degenerative joint disease, bone edema, and effusion. (PX 6, p. 47-48) He opined this meant Petitioner had rapid progression of the left knee arthritis since the 04/08/13 MRI. (PX 6, p. 48) He opined a cause of Petitioner's rapid progression of arthritis was the accident of 3/18/13 and/or the arthroscopic surgery. (PX 6, p. 48, 50) He opined the degenerative condition of Petitioner's left knee had clearly become much worse since the arthroscopic surgery. (PX 6, p. 50) Dr. Bonutti testified that a heavy person falling directly on her knee can accelerate degenerative joint disease. (PX 6, p. 39)

Dr. Richard Lehman examined Petitioner pursuant to Section 12 of the Act. Dr. Richard Lehman testified by way of deposition as well. Dr. Lehman examined Petitioner on 07/01/14. His diagnosis was significant degenerative arthritis. (RX 7, p. 7) He didn't believe there was a causal connection between the condition of Petitioner's left knee and the March 2013 work-related incident. (RX 7, p. 7) He didn't believe Petitioner had suffered any injury except a contusion. (RX 7, p. 8) He opined the mechanism of injury was not a mechanism that stresses the intra-articular structures in the knee and it only bruised her knee. (RX 7, p. 8) He didn't believe there was a causal connection between the 2013 incident and the surgery performed by Dr. McIntosh. (RX 7, p. 9) He didn't believe a recommendation for a total knee replacement was appropriate for Petitioner and would not be related to her work injury. (RX 7, p. 12) He didn't believe the underlying degenerative arthritic condition of Petitioner's knee was caused or aggravated by the March 2013 work accident. (RX 7, p. 13) He provided an AMA impairment rating of zero, however Dr. Lehman is not certified perform such ratings. (RX 7, p. 14, 18) He admitted that there was no evidence indicating Petitioner experienced any left knee pain, had any trouble fully performing her job duties, or received any left knee treatment before the March 2013 incident. (RX 7, p. 17-18)

Petitioner testified that in the 52 weeks prior to 03/18/13 she was paid $22.36 per hour, was scheduled to work 37.5 hours per week. She indicated she worked a significant amount of overtime, and 50% of the overtime was mandated. Petitioner testified that she missed approximately two months from work, from middle December 2012 through middle February 2013 because she was held off work due to stress. The evidence in the record indicates she was off from work from 12/15/12 through 2/15/13 (9 weeks)). Respondent introduced into evidence Petitioner's wage statement for the 52 weeks before 03/18/13. (RX 1) It confirmed her hourly rate was $22.36. Petitioner's straight time earnings during this period were $34,336.67. It indicated Petitioner did work overtime in each pay period except for the pay periods ending in 10/15/12, when she was on vacation, and the periods corresponding to the time missed from mid-December, 2012 through mid-February, 2013. (RX 1) Respondent introduced Petitioner's attendance and overtime record for the year preceding 03/18/13. (RX 10) It indicated the total number of overtime hours worked were 351 hours 55 minutes. It also confirmed that Petitioner did not work for two periods of time: approximately two weeks in October 2012 and from 12/15/12 through 02/15/13.

Petitioner testified she received extended benefits from the Respondent from 06/14/13 to 08/04/13.

CONCLUSIONS

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

Petitioner has the burden of proving that her injuries are work related and not the result of a normal degenerative process. *Gilster Mary Lee Corp. v. Industrial Comm'n*, 326 Ill. App. 3d 177, 182, 759 N.E.2d 979, 983 (2001). She has to prove that there was some causal relationship between her employment and her conditions of ill-being. *Absolute Cleaning/SVMBL v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 463, 469, 949 N.E.2d 1158, 1165 (2011). She is not, however, required to prove that the conditions of employment were the sole or principle cause of her injury. *Brady v. Louis Ruffolo & Sons Construction Co.*, 143 Ill. 2d 542, 548, 578 N.E.2d 921, 924 (1991). A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. *International Harvester v. Industrial Comm'n*, 93 Ill. 2d 59, 63-64, 442 N.E.2d 908, 911 (1982). Although a claimant's arthritic knee condition was preexisting, it is self-evident that "employers take their employees as they find them." *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 205, 797 N.E.2d 665, 672 (2003).

The Arbitrator finds the testimony of Petitioner with regard to the acute injury and progression of her symptoms to be credible. Petitioner also testified credibly about having no prior left knee symptoms, no prior left knee treatment, and no prior left knee restrictions. She testified that since the undisputed accident on 03/18/13 her left knee has never been pain free.

Dr. Bonutti opined the combination of the acute traumatic injury and the subsequent arthroscopic surgery was a cause of the rapid progression of degenerative arthritis in Petitioner's left knee. He indicated that the progression is apparent when comparing the 04/08/13 MRI with that of 04/14/14. Dr. Lehman didn't believe there was a causal connection between the 2013 incident and the surgery performed by Dr. McIntosh. He didn't believe a recommendation for a total knee replacement was appropriate for Petitioner and would not be related to her work injury. (RX 7, p. 12) He didn't believe the underlying degenerative arthritic condition of Petitioner's knee was caused or aggravated by the March 2013 work accident.

The Arbitrator finds the testimony and opinions of Dr. Bonutti more persuasive than those of Dr. Lehman. Further, the Arbitrator finds it significant that Petitioner had not experienced any left knee pain, had no trouble fully performing her job duties, and had not received any left knee treatment before the March 2013 incident. In addition, the dramatic progression of the degenerative changes in Petitioner's knee is objectively demonstrated in the two MRIs.

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

Issue (G): What were Petitioner's earnings?

Petitioner was paid $22.36 per hour. During the 52 weeks prior to 03/18/13 Petitioner earned $34,336.67 in straight time earnings. She also worked a total of 351 hours 55 minutes of overtime. Petitioner worked overtime in each pay period except for the pay periods ending on 10/15/12, when she was on vacation,

and the periods corresponding to the time missed from mid-December, 2012 through mid-February, 2013. Petitioner testified approximately 50% the overtime was mandatory. Her testimony in this regard was unrefuted. Therefore, the Arbitrator finds the Petitioner's earnings in the year preceding the accident were:

$34,336.67	(straight time earnings)
+ 3,934.43	(overtime earnings at the straight time rate (351.917 hours x 50% x 22.36/hour)
$38,271.10	(includable earnings)

The Arbitrator further finds that in the 52 weeks prior to 03/18/13 Petitioner worked 43 weeks or parts thereof. (52 weeks minus the 9 weeks Petitioner missed due to unrelated illness from 12/15/12 through 2/15/13.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner's average weekly wage is $890.01. ($38,271.10, includable earnings, divided by 43 weeks or parts thereof worked).

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

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

The Arbitrator finds the medical care provided to Petitioner thus far has been both reasonable and necessary. The medical expenses corresponding thereto, as set forth in Petitioner's exhibit 5, are both reasonable and necessary as well.

Dr. Bonutti opined that as a result of the work injury and subsequent surgery Petitioner is in need of a total knee replacement. Petitioner has undergone extensive and ultimately unsuccessful conservative care and arthroscopic surgery. Having found Dr. Bonutti to be the more persuasive expert, the Arbitrator concludes Petitioner is entitled to prospective medical care as recommended by Dr. Bonutti, including a left total knee replacement and all concurrent and subsequent related treatment.

Respondent shall pay reasonable and necessary medical services of $28,980.60, as set forth in Petitioner's Exhibit 5, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall also authorize and pay for prospective medical services as recommended by Dr. Bonutti pursuant to Sections 8(a) and 8.2 of the Act. Respondent shall receive a credit for all medical bills previously paid.

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

The Arbitrator concludes Petitioner is entitled to TTD from 06/14/13 to 08/04/13 and from 04/29/14 to 05/13/14 as her treating physicians kept Petitioner off work. However, the parties agreed that no TTD was owed because Petitioner received extended benefits from the Respondent during these periods of time for which credit is allowed under Section 8(j) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

THOMAS SANTANGELO,

Petitioner,

17IWCC0779

vs.

NO: 10 WC 025060

PEPSI BEVERAGES CO,

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

The Commission modifies the Decision of the Arbitrator only to the extent that it corrects what it finds to be a scrivener's error.

Arbitrator Bocanegra, in the "Findings" section as well as in the "Conclusions of Law" section of the Decision of the Arbitrator, noted Respondent was to be credited $130,575.63 for maintenance benefits that have already been paid to Petitioner. Arbitrator Bocanegra, however, in the "Orders" section of the Decision of the Arbitrator, wrote that Respondent was to be credited $30,575.63.

The Commission concludes the correct amount that Respondent is to be credited for maintenance benefits already paid to Petitioner is $130,575.63. The Commission arrives at this

amount as it is the amount the parties stipulated to in the Request for Hearing.

The Commission, as noted above, affirms and adopts, all other aspects the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $781.89 per week for a period of 48-6/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $781.89 per week for a period of 135-6/7 weeks, that being the period Petitioner was entitled to maintenance under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $669.64 per week for a period of 200 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 40% loss of 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 in the amount of $38,200.91 for temporary total disability benefits that have been paid to Petitioner for temporary total benefits under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit in the amount of $130,575.63 for temporary total disability benefits that have been paid to Petitioner for maintenance benefits under §8(a) 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. 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: DEC 4 - 2017
KWL/mav
O: 10/24/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0779

SANTANGELO, THOMAS
Employee/Petitioner

Case# **10WC025060**

10WC025058
10WC025059

PEPSI BEVERAGES CO
Employer/Respondent

On 8/25/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0328 LEWIS & DAVIDSON
RICHARD SCHOLLENBERGER
ONE N FRANKLIN ST SUITE 1850
CHICAGO, IL 60606

2337 INMAN & FITZGIBBONS LTD
G STEVEN MURDOCK
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

17IWCC0779

THOMAS SANTANGELO,
Employee/Petitioner

v.

PEPSI BEVERAGES, CO.,
Employer/Respondent.

Case # 10 WC 25060

Consolidated cases: 10 WC 25058
10 WC 25059

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **6/9/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **4/5/10**, 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 **$60,987.68**; the average weekly wage was **$1,172.84**.

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 **$38,200.91** for TTD, **$0.00** for TPD, **$130,575.63** for maintenance, and **$0.00** for other benefits, for a total credit of **$68,776.54**. 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 **$781.89/week** for **48-6/7th** weeks, commencing **5/26/10** through **5/2/11**, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **5/26/10** through **5/2/11**, and shall pay the remainder of the award, if any, in weekly payments. Respondent shall be given a credit of **$38,200.91** for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner maintenance benefits of **$781.89/week** for **135-6/7th** weeks, commencing **10/25/13** through **6/1/16**, as provided in Section 8(a) of the Act. Respondent shall pay Petitioner the maintenance benefits that have accrued from **10/25/13** through **6/1/16**, and shall pay the remainder of the award, if any, in weekly payments. Respondent shall be given a credit of **$30,575.63** for maintenance benefits that have been paid.

Respondent shall pay Petitioner permanent partial disability benefits of **$669.64/week** for **200 weeks**, because the injuries sustained caused the **40%** loss of the person as a whole, as provided in **Section 8(d)2** of the Act.

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

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

Signature of Arbitrator

8-17-16
Date

17IWCC0779

FINDINGS OF FACT

A. Date of accident September 23, 2008 claim number 10 WC 25058

Thomas Santangelo ("Petitioner) and Pepsi Beverage Co. ("Respondent") stipulated to an accident of 9/23/08, arising out of an in the course of his employment with Respondent. Ax1. At trial, the parties disputed the issues of causal connection and nature and extent. *Id.* On this date, Petitioner testified that he was removing a heavy frame from a fork lift. The piece began to fall. Petitioner held the frame to prevent it from falling and twisted his low back. After the accident, he felt an onset of low back pain.

Petitioner was seen the same day at Respondent's direction at Concentra Medical Center by Dr. Peter Sorokin and would continue to treat here through 2/20/09. Px1:2-105. Diagnosis was lumbosacral strain and lumbar pain. Petitioner was prescribed medications, light duty and therapy. Therapy for his low back commenced at Concentra on 9/25/08. Thereafter, Petitioner came under the care of Dr. Dan Paloyan at Concentra, who monitored Petitioner's condition while in therapy. Dr. Paloyan diagnosed lumbar strain. On 10/2/08, Petitioner saw Dr. Kathuria, who diagnosed lumbar strain and recommended continued light duty and therapies. Px1:17.

On 10/14/08, Dr. Payolan noted Petitioner had improved symptoms but low back pain was about the same with continued pain down both legs. Petitioner's medical history was positive for prior low back pain 10-20 years earlier requiring therapy. The doctor diagnosed lumbar strain and lumbar radiculopathy. The plan was for an MRI of the lumbar spine. *Id.* at 27. Petitioner was released to light duty and to continued therapies. MRI of the lumbar spine showed minimal disc bulging and early degeneration at L5-S1 and early degenerative changes in the facet joints. Dr. Payolan then referred Petitioner to Dr. Barbara Heller. *Id.* at 40.

On 11/7/08, Petitioner first saw Dr. Heller. Px1:43-44. She noted Petitioner injured his back when he tried to prevent a 160-pound back rest from falling. Petitioner related back pain radiating to the posterior thigh, calf and upper back. He had no numbness or tingling. On exam, lumbar flexion and extension were mildly decreased by left sided low back pain. She noted pain emanated from the left sacral sulcus and positive Patrick's on the left. She noted that lumbar flexion and extension was mildly reduced by left-sided low back pain emanating from the left sacral sulcus. She interpreted the MRI to show mild disc desiccation at L5-S1. Diagnosis was left sacroiliac (SI) joint strain. An injection was recommended. Petitioner was given light duty. Petitioner returned to Dr. Heller and reported relief with the SI joint injection. Dr. Heller recommended regular duty and continued therapy through the end of 2008.

On 1/2/09, Petitioner returned to Dr. Heller. Px1:63. Petitioner's low back symptoms were improved with residual discomfort but had secondary upper back and neck myofascial pain. Assessment was improving SI joint strain and persistent secondary myofascial pain. Additional therapy and full duty was prescribed.

On 1/30/09, Petitioner returned to Dr. Heller. *Id.* at 83. Dr. Heller noted improvement with conservative care and ongoing stiffness. Petitioner completed his physical therapy on 2/19/09. On 2/20/09, Dr. Heller released Petitioner from care, placed him at maximum medical improvement and released him to regular work duties. Px1:105. Petitioner no longer has any low back pain but would continue home exercise. On exam, lumbar flexion and extension were full without discomfort, range of motion was full, Patrick's was negative bilaterally, strength, sensation and reflexes were normal and gait was without deficit. Assessment was resolved SI joint strain.

By stipulation Petitioner lost no time from work as a result of this accident. Petitioner testified that as a result of this accident, he continues to suffer low back pain with bending and extended periods of sitting, standing and walking.

B. Date of accident August 31, 2009 claim number 10 WC 25059

The parties stipulated to an accident of 8/31/09, arising out of an in the course of Petitioner's employment with Respondent. Ax2. At trial, the parties disputed the issues of casual connection, medical bills, and nature and extent of the injury. *Id.* Petitioner testified that on this date he struck his head on a metal beam, fell to the ground and may have lost consciousness. He saw the onsite nurse, where he rested then returned to work. When he attempted to return to work, he felt dizzy and left for the day. Petitioner testified he took personal time off without improvement of symptoms.

On 9/18/09, Respondent sent Petitioner to Concentra Medical Center for treatment by Dr. Rolando Garces. Px1:106. It was noted Petitioner did not lose consciousness but was dazed for 15 seconds. Petitioner complained of lower neck pain into the left shoulder, without radiation. Symptoms were exacerbated with neck movement and there was associated stiffness and dizziness. The plan was for cervical spine x-rays, physical therapy and regular duty. Dr. Garces assessed cervical strain.

On 9/22/09, Petitioner followed up at Concentra with Dr. Paloyan. Px1:109. Petitioner reported continued moderate pain in the left side of the neck down to the left shoulder area, aggravated by movement, continued dizziness and blurred vision. He denied radicular symptoms, paresthesias, numbness or weakness. Dr. Paloyan diagnosed cervical strain and possible concussion syndrome. He recommended an MRI of the cervical spine, continued physical therapy and a CT scan if head symptoms continued. That same date, Petitioner began physical therapy for a diagnosis of cervical strain, which would continue through 12/4/09. Px1:111-167. Petitioner reported hitting the left side of his head, decreased range of motion, pain in the left side of the neck and occasional dizziness. The therapist noted that "examination is consistent with the medical diagnosis." Further, the therapist noted that impairments were preventing Petitioner from performing standard activities of daily living and work activities and that therapy was indicated to address same.

On 9/25/09, Dr. Paloyan noted Petitioner remained unchanged and the doctor again recommended an MRI of the cervical spine. Exam showed moderate tenderness to palpation at C5-6, positive Spurling's, pain on extension and lateral flexion and reduced range of motion. Diagnosis was cervical strain, possible post-concussion syndrome and cervical radiculopathy. Petitioner continued with therapy.

On 10/7/09, Petitioner returned to Dr. Paloyan. Petitioner was minimally improved with continued moderate pain on the left side of the neck but with no radicular component. MRI of the cervical spine was negative for herniation and impingement. Petitioner continued with mild dizziness. On 10/12/09, Petitioner returned to Dr. Paloyan stating his pain was slightly improved with physical therapy. He continued with moderate stiffness, aggravated by movement with pain localized to the left side of the neck. Assessment was cervical strain. Dr. Paloyan continued therapy and referred Petitioner to a neurosurgeon.

That same date, Petitioner was seen by neurosurgeon, Dr. Leonard Cerullo. Px1:139. Petitioner described ongoing pain aggravated by hip motion especially left lateral bending and left rotation. He also complained of intermittent left interscapular pain radiating to the left shoulder. He reported constant dizziness

exacerbated by movement and exercise, which Dr. Cerullo stated was true vertigo. Petitioner reported word-finding difficulties and feeling "out of it." Dr. Cerullo suspected concussion, post-traumatic syndrome including post-traumatic vertigo. The plan was for therapy and an MRI of the brain. Therapists again noted Petitioner's condition related to the presenting diagnosis. *Id.* at 146. On 11/4/09, Dr. Cerullo diagnosed post-concussion syndrome with vertigo. He again recommended a brain MRI, possible neurotologic consultation, continued therapy and home exercise.

On 11/11/09, Dr. Cerullo concluded Petitioner's brain MRI was normal. The doctor prescribed medication for unresolved vertigo and recommended continued physical therapy. Petitioner's last physical therapy visit at Concentra was on 12/4/09. At that time, Petitioner's lifting ability was 25 pounds and that he had not met his lifting goal of 50 pounds. Further treatment was held pending medical consultation.

On 12/3/09, Petitioner received a neurotology consult by Dr. Richard Wiet at Rush University Medical Center. Px2. Petitioner provided a history of striking his head on a beam, followed by neck stiffness and unusual visual symptoms. He described that when he looks at an object the background objects move and he experiences imbalance. Petitioner stated that on occasion the symptoms caused him to vomit. He also described occasional slurred speech, memory problems, constant pain in the back of his head and intermittent pain in the left ear. Dr. Wiet recommended an MRI of the internal auditory canals, a contrast MRI of the brain, an audiogram, a VGN, a posturography and rotational chair testing. Contrast MRI of the brain showed nonspecific punctate area of T2 signal change in the left frontal subcortical white matter. Approximately seven months later, on 7/12/10, Petitioner returned to Dr. Wiet and was largely unchanged. The doctor recommended the same tests and flexible laryngoscopy.

On 9/20/10, Petitioner saw Dr. Marcello Cherchi for otoneurology consult at the referral of Dr. Wiet. Px3. Petitioner related he hit his head at work and went down for about 10 minutes. Symptoms included blurred vision, poor concentration, memory loss, fatigue and neck pain with radiation to the left upper extremity. Dr. Cherchi reviewed prior audiogram and noted normal bilateral hearing in low and mid frequencies. In high frequencies, there was asymmetrical hearing loss, right greater than left. Normal canal volume and ear pressure was noted. The doctor noted that prior videonystagmography (VNG) was found to be normal but Dr. Cherchi noted 18% left unilateral caloric weakness. Concomitant with exam, the doctor conducted several tests. A distortion product optoacoustic emissions (DPOAE) test showed some high frequency hearing loss bilaterally, right greater than left, consistent with prior audiogram. Vestibular evoked myogenic potential (VEMP) tests showed 10% left sided weakness within the 35% upper limit of asymmetry. On 9/20/10, Dr. Cherchi performed a rotary chair test, which was normal. He also performed an electrocochleography (ECoG), which showed inconsistent results. Impression was head trauma, followed by exacerbation of pre-existing disequilibrium and by cognitive symptoms of impaired concentration, impaired memory, and fatigue, all in the context of an unremarkable physical examination and otovestibular testing. He suspected and diagnosed post-concussive syndrome as well as vertigo, disequilibrium and cervicalgia. Px3:2,7, 51. Consideration was given for cervical spine MRI, neuropsychological evaluation, therapy for gait, balance and neck and rehab for post-concussive syndrome.

On 11/22/10, Petitioner started therapy for vertigo/disequilibrium at Elite Physical Therapy. Px4. Petitioner reported persistent cervical pain referring to the left upper extremity, constant vertigo with imbalance and visual deficits and impaired short term memory. On 11/29/10, Dr. Cherchi recommended Petitioner avoid tasks and situations in which unanticipated loss of equilibrium would endanger him or others. Px3:62. On

2/16/11, Dr. Cherchi opined that his diagnosis of Petitioner is more likely than not related to the work accident. Px3:63-64.

On 11/24/10, Petitioner was seen by Dr. Richard Lazar at the request of Respondent. Rx6. After a review of history and records, Dr. Lazar documented current complaints of short-term memory loss, visual difficulties, dizziness, left sided neck pain, numbness, and loss of motion. He described his vision issues as normal central fixation with movement of the background field. Dr. Lazar stated that the treatment rendered to date had been reasonable and appropriate. Dr. Lazar stated that the only injury Petitioner sustained in the accident was scalp abrasions and a brief cerebral concussion of the most insignificant magnitude. He opined that Petitioner's current complaints were not related to the accident but caused by intense anxiety and personality traits. He recommended full duty work and no further treatment.

On 6/15/11, Petitioner was evaluated by Dr. Charles Slack at his attorney's request. Px6. Petitioner described his accident of 8/31/09, ongoing complaints of dizziness, vision difficulties, difficulty balancing, pain with sideways head motion, occasional numbness in the left upper arm, and low back stiffness. On examination, Dr. Slack found pain with lumbar flexion and markedly limited cervical rotation and tilt. Dr. Slack diagnosed cervical myofascial pain secondary to neck and head injury with what appears to have been diagnosed as post concussive syndrome. He stated the cervical pain was due to work accident. Regarding work, Dr. Slack stated the cervical symptoms would be problematic for return to work as a mechanic and deferred his opinion regarding work restriction for the post-concussive syndrome to Petitioner's neurologists.

Petitioner testified that he continues to experience neck pain and loss of cervical motion since the date of accident. He also testified that he continues to notice the movement of background objects and resulting dizziness.

C. Date of accident April 5, 2010 claim number 10 WC 25060

The parties stipulated to an accident of 4/5/10, arising out of an in the course of Petitioner's employment with Respondent. Ax3. At trial, the parties disputed the issues of casual connection, temporary total disability, maintenance and nature and extent of the injury. *Id.* On this date, Petitioner's right foot got stuck under a forklift and he lost his balance falling backward. He testified he felt an onset of pain on the top of his right foot.

On 4/6/10, Petitioner was sent by Respondent to Concentra and seen by Dr. Paloyan and would continue to treat there through 9/15/10. Px1:168-286. Dr. Paloyan noted Petitioner's accident and major crush injury with resulting searing pain. Dr. Paloyan found tenderness to palpation of the right foot with minimal swelling and erythema. Right foot x-rays at that time showed no fractures. He ordered physical therapy and work restrictions including 80% sitting. Assessment was right foot contusion. Petitioner returned on 4/8/10 and plans and recommendations were unchanged.

On 4/19/10, Petitioner returned to Dr. Paloyan stating he had been working within the restrictions and that his right foot remained moderately sore and was aggravated by movement. Petitioner was tender to palpation over the dorsal aspect of the 2nd metatarsal. The doctor assessed contusion with possible sprain. Dr. Paloyan again recommended therapy and work restrictions to 70% sitting. On 4/29/10, Petitioner described the same complaints and Dr. Paloyan changed his restrictions to 25% sitting. During this time, Petitioner continued to work within his duty restrictions.

On 5/11/10, Dr. Paloyan noted continued moderate tenderness to palpation on the dorsal aspect over the 2nd metatarsal. Petitioner reported he was on regular duty without any problems or pain. Px1:209. Exam was unchanged. The doctor assessed contusion with possible ligament or occult bone injury. Petitioner was released to modified duty with 25% sitting. X-rays were again negative. An MRI was ordered and showed suspected stress type fractures within the base of the 1st metatarsal with bone marrow edema. Bone marrow edema was identified in the 2nd metatarsal. Dr. Paloyan reviewed the MRI and diagnosed possible stress fractures to the right 1st and 2nd metatarsals. The doctor ordered an immediate orthopaedic consult. On 5/20, Petitioner was released to return to work with sitting 100% of the time.

On 5/26/10, Petitioner was seen at Concentra by orthopaedic surgeon, Dr. Christos Giannoulias. The doctor diagnosed 1st and 2nd metatarsal fractures. He ordered a cast shoe and 100% sitting work. Petitioner testified that as of this date work was no longer proved by Respondent.

On 6/23/10, Dr. Giannoulias ordered supervised physical therapy and continued sedentary duty. Assessment was metatarsal fracture. New x-rays failed to identify fracture. Petitioner began therapies for the right foot at Concentra through 7/19/10. Px1:242-257.

On 7/21/10, Petitioner returned to Dr. Giannoulias and reported 50-60% improvement but complained on neck and back pain. Exam of the foot showed stiffness with dorsiflexion of the great toe and mild tenderness of the 1st and 2nd ray. Dr. Giannoulias recommended continued therapy including therapy for the neck and back. Petitioner was released to modified duty with sitting 90% of the time. Therapy for the foot continued. Petitioner reported continued difficulty with weight bearing and that work could not be accommodated.

On 8/18/10, Dr. Giannoulias noted Petitioner had not started the recommended neck and back treatment. He also noted right foot problems including difficulty with plantar flexion and tenderness over the midfoot. Petitioner complained of pain and stiffness over the dorsum of the foot. Dr. Giannoulias recommended a consult with Dr. Simon Lee and possible cortisone injection. The doctor noted Petitioner appeared to have a healed fracture and that Petitioner had some degenerative changes in the midfoot which may be causing the pain he has. Assessment was midfoot pain and metatarsal fracture. Restrictions continued.

On 9/13/10, Dr. Simon Lee first saw Petitioner as a Section 12 doctor for Respondent. Px5:9-10. The doctor wrote that Petitioner's right foot was run over at work in May 2010. The doctor noted Petitioner's prior medical history and noted review of symptoms were non-contributory. Petitioner's right foot complaints at that time were significant pain and dysfunction of the right foot especially with prolonged weight bearing or ambulatory activity or flexion or extension of the foot. Exam of the right showed decreased medial longitudinal arch pronation of the hind-foot and full dorsiflexion, plantar flexion, range of motion of the ankle. Dr. Lee found significant pain with attempts at dorsiflexion, plantar flexion, or supination and pronation of the mid-foot. A majority of pain and discomfort was localized and specific to the medial mid-foot within the region of the TMT joints over the mid-foot, 1st and 3rd. X-rays showed concern for calcification within the base of the first and second TMT joint with possible minimal incongruity between the bases. Diagnosis was status-post right foot crush injury with possible Lisfranc injury or post-traumatic arthropathy. Dr. Lee also noted a component of neuritis, possibly related to the crush injury but he was unsure whether this was related to a deep peroneal nerve injury or superficial peroneal nerve as it was difficult to differentiate between traumatic arthropathy and injury to the TMT joint line without further study. On 9/15/10, Dr. Giannoulias released Petitioner to Dr. Lee. Px1:281.

On 9/28/10, Dr. Lee issued an addendum opinion after reviewing the May 2010 right foot/ankle MRI report and films. Px5. The doctor concluded it was consistent with edema and swelling within the base of the 1st and 2nd metatarsal consistent with crush injury, contusion and Lisfranc type injury. The doctor found the report consistent with symptoms and radiographs. Recommendations were unchanged and the doctor added recommendation for a cortisone injection.

On 12/14/10, Dr. Lee noted Petitioner's symptoms were unchanged and he continued to complain of pain with weight-bearing over the dorsal mid-arch of his foot and generalized sensitivity that radiated to the toes. Px5. He was not in active treatment and was not working. Exam was unchanged and the doctor noted pain with stressing, inversion, eversion, supination, pronation and direct palpation. He had positive Tinel's radiating to the digits. A cortisone injection was administered into the first and second TMT and inter-cuneiform joint line. Sit down sedentary work was continued.

On 1/24/11, Petitioner returned to Dr. Lee stating that initially he had no improvement after the injections but several days later notice 70% improvement. Px5, Rx1. Subsequently the pain returned while pushing off with his foot from a sitting to standing position. Petitioner continued with at least a first TMT instability. Dr. Lee stated that as a result of the continued significant functional limitations and pain, he recommended a custom orthotic with a turned toe plate for further stiffening and a CT scan. Petitioner remained on light duty. CT showed mild degenerative changes within the mid foot region and insertional posterior tibial tendonitis. Dr. Lee continued to recommend a custom orthotic. On 3/2/11, Petitioner's work restrictions were continued by Dr. Lee.

On 3/29/11, Petitioner was evaluated by Dr. Horak at the request of Respondent. Rx2. The doctor noted Petitioner presented with a frustrated victimized attitude. He noted Dr. Lee incorrectly noted a crush injury and stated the injury was in fact a plantar flexory injury. He noted Petitioner had an exaggerated response to light touch. Tinel's was non-specifically positive on all tested sites of the right lower extremity. Range of motion was normal and produced non-specific pain on testing. Dr. Horak diagnosed bilateral diffuse psoriatic/osteoarthritis of the TMT and ST joints, left worse than right. The doctor concluded Petitioner's right foot condition was unrelated to the accident of 4/5/10 and no work restrictions were indicated.

On 5/2/11, Petitioner returned to Dr. Lee. Px5. He had been using his orthotic for one month. Petitioner continued with post-traumatic degenerative changes through the midfoot and Lisfranc areas. Diagnosis was status post right foot crush injury with injuries to the right mid foot, first and second and Lisfranc TMT joints. The doctor opined directly causation between the condition and the work accident. Petitioner did not wish to pursue additional treatment and continued with some lower functional limitations and disability. Dr. Lee released Petitioner from care with restrictions of no lifting, carrying, pushing, pulling greater than 25 pounds, limited bending, stooping, squatting activity, and alternating sitting and standing 30 minutes per hour, ground level work only, limited ladder and stair climbing.

On 3/27/13, Petitioner was then evaluated by Dr. Kodros at the request of Respondent. Rx3. The doctor took Petitioner's accident history and reviewed records. Petitioner's chief complaint was balance issues. X-rays taken at exam failed to show any previous fractures. The doctor noted there was no evidence of a prior Lisfranc injury. He noted ongoing residual symptoms likely related to the soft tissue component of Petitioner's injury and the doctor offered that he had no ready explanation for Petitioner's ongoing residual right foot complaints.

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The doctor performed an exam and his impression was status post crush type injury to the dorsal aspect of the right forefoot and midfoot. He opined that the condition was causally related to the April 2010 accident. Dr. Kodros recommended use of stiff shoes with inserts and recommended against further injections, supervised therapy and surgery. With respect to activity, Dr. Kodros stated Petitioner can function within the restrictions of Dr. Lee's 5/2/11 note.

On 9/19/13, Sandra Brown ("Brown") of Brown Rehab Review performed a labor market survey without contact with Petitioner. Rx4. She contacted 8 potential employers and concluded Petitioner had an earning capacity of $68,740.00 and that the salary range for the jobs located was $26,807.00 to $68,740 with an average salary of $47,4773.50. On 10/7/13, Brown developed a vocational rehabilitation plan consisting of job seeking skills training, a documented job search, job development log sheets, following up on job leads, meeting with Brown, interviewing, establishing a resume, maintaining telephone contact with potential employers and accepting valid job offers.

Petitioner met with Brown from 11/2/13 through 4/10/16 for vocational evaluation and placement services with. Rx4. Petitioner stated he had sedentary restrictions and that due to union affiliations he could no longer work in the automotive industry. Ms. Horn noted both Dr. Horak's and Dr. Lee's return to work restrictions. She noted Petitioner had a high school education, auto industry certification and worked as a mechanic for the last 30 years, considered to be heavy. She concluded that based on transferrable skills, Petitioner could diagnose, read job orders and would still be capable of handling certain positions in his field which are still within his current physical demands. Based on this and a recent labor market survey, she concluded there was a good possibility Petitioner could find employment in his current field, physical demand level and skill level. She recommended job placement within his current field of expertise.

Starting 10/25/13, Petitioner and Brown met on a weekly basis for job placement. Rx4. Petitioner was given job seeking skills training and Brown submitted resumes for employment starting December 2013. In March 2014, Brown broadened the job search to include other employment opportunities and advised Petitioner about presentation, attire and preparation. Brown generated vocational progress reports showing that over 600 applications/resumes were submitted. During this time, Petitioner submitted some job leads, attending some job fairs and had several telephone or in-person interviews. Brown advised Petitioner about his role in the search process and asked him to provide leads. She also recommended he take free computer classes offered at the local library to aid in his job search efforts. Petitioner received some phone calls expressing interest and underwent some interviews. Brown generated a rehabilitation closure report and concluded that based on Petitioner's recent labor market survey and transferrable skills analysis, there was a good possibility he could establish gainful employment within his current expertise, physical demand level and skill level. Rx5. Petitioner last saw Brown on 6/1/16.

On 8/31/15, Petitioner was evaluated by his own vocational expert, David Patsavis. Px7. He confirmed that Petitioner graduated high school in 1971 and was then currently 63 years old. He noted that from 1980 to 2011 Petitioner worked for Pepsi as a lead mechanic. Mr. Patsavis concluded that given the fact that Petitioner has not worked during the past 5 years and has limited transferable skills, as well as unsuccessful Job Placement Activities for the past two years, it was his opinion that Petitioner would be an odd lot or permanently and totally disabled. He concluded that a viable and stable labor market does not exist for Petitioner.

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Petitioner testified that he continues to have pain in his right foot with extended standing and walking. He also testified that he continues to require a shoe orthotic.

CONCLUSIONS OF LAW

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

1. Date of accident September 23, 2008, claim number 10 WC 25058

The unrebutted evidence is that on 9/23/08, Petitioner caught a heavy frame falling from a fork lift and felt a sudden onset of low back pain. He was evaluated the same day at Respondent's direction by Dr. Sorokin at Concentra Medical Center who diagnosed a lumbosacral strain and lumbar pain. He continued to treat by way of conservative care in the form of physical therapy, medications, MRI and an injection. On 2/20/09, Dr. Heller released Petitioner from care at MMI to continue his regular work duties. The Arbitrator finds Petitioner's medical records for this accident consistent with one another and all repeatedly reference his work accident as the precipitating cause or factor. Petitioner's history of prior low back pain was far removed from the date of his accident and the Arbitrator finds Petitioner was in a state of good health relative to his low back immediately before this work accident. Respondent has presented no evidence to the contrary. Based on Petitioner's credible testimony and medical records and under a chain of events theory, the Arbitrator concludes that Petitioner's low back/lumbar spine condition is causally related to his work accident of 9/23/08 in case number 10 WC 25058.

2. Date of accident August 31, 2009, claim number 10 WC 25059

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The unrebutted evidence is that on 8/31/09, Petitioner struck his head on a metal beam causing him for either briefly lose consciousness or was dazed for 15 to 20 seconds. The parties did not dispute accident. Petitioner began complaining of cervical/neck pain into the left upper extremity area. Petitioner also began complaining of dizziness, blurred vision and stiffness. Concentra doctors diagnosed cervical strain with possible concussion syndrome. Therapists opined Petitioner's examinations were consistent with the stated diagnosis. Petitioner eventually came under the care of Dr. Cerullo, who suspected concussion, post-concussion syndrome and post-traumatic vertigo. As Petitioner continued to treat, his complaints were that of slurred speech, nausea, blurred vision, memory problems, poor concentration, fatigue and pain. Petitioner then came under the care of Dr. Cherchi, who suspected and diagnosed post-concussive syndrome, vertigo, disequilibrium and cervicalgia. The doctor believed Petitioner's diagnoses were most likely related to his work accident.

Petitioner offered the opinion of Petitioner's physician, Dr. Slack. Dr. Slack diagnosed cervical myofascial pain secondary to the neck and head injury of 8/31/09, with what appears to have been diagnosed as post concussive syndrome. He stated the cervical pain was due to the job injury. Respondent offered the opinion of Dr. Richard Lazar who stated that the only injury Petitioner sustained in the accident was scalp abrasions and a brief cerebral concussion of the most insignificant magnitude. He opined that Petitioner's current complaints were not related to the accident but caused by intense anxiety and personality traits.

In weighing the competing medical opinions, the Arbitrator concludes that Petitioner's current condition of ill-being is causally related to his undisputed work accident based on the credible medical opinions of Drs. Cerullo, Wiet, Cherchi and Slack. The Arbitrator, in adopting these opinions, finds these opinions more

credible and entitled to more weight than the opinions of Dr. Lazar. Petitioner treated extensively with his providers, who conducted a thoughtful and thorough work up of Petitioner's complaints and symptoms; doctors ruled out herniation, impingement and brain injury. They all similarly concluded Petitioner was likely suffering from vertigo and post-concussion syndrome. Post-concussion syndrome was suspected as early as Petitioner's treatment with Concentra as noted in his records. Therapists also believed Petitioner's presentation was consistent with his doctor's diagnoses. Dr. Cherchi reviewed a batter of examinations and concluded Petitioner was suffering from post-concussion syndrome, vertigo and disequilibrium, all likely the result of his work accident. Dr. Lazar, on the other hand, agreed that Petitioner suffered a concussion but declined to find that Petitioner also suffered from post-concussion syndrome. The Arbitrator finds that Petitioner's medical treatment record supports the opposite conclusion. To the extent Dr. Lazar concluded Petitioner's complaints were caused by anxiety and personality traits, the Arbitrator is not persuaded by these opinions as they are neither supported by any medical or psychological record(s) and, as a neurologist, the doctor failed to state how he reached these conclusions on exam and from a neurological point of view. For example, the doctor found no amnesia but failed to persuasively address this statement against Petitioner's documented complaints of memory loss. In another example, the doctor cited lexical processing errors but Petitioner described no word recognition problem. Regarding vertigo, the doctor noted an absence of objective and subjective vertigo but Petitioner gave specific examples of perceived subjective vertigo. Further, Dr. Lazar's opinion ignores VNG/caloric test results.

Based on the temporal course of and onset of symptoms, the circumstances surrounding the onset of symptoms, the character of symptoms, as well as Petitioner's credible testimony and medical record, the Arbitrator concludes Petitioner's current condition of ill-being as it relates to his cervical injury, post-concussion syndrome, vertigo and disequilibrium are causally related to his work accident 8/31/09.

3. Date of accident April 5, 2010, claim number 10 WC 25060

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The unrebutted evidence is that on 4/5/10, Petitioner's right foot was caught under a forklift when he lost his balance and fell backward experiencing immediate pain on the top of his right foot. The parties did not dispute accident at trial. Petitioner again sought treatment with Dr. Paloyan at Concentra who, after MRI, diagnosed possible stress fractures to the right first and second metatarsals and ordered an orthopaedic consult.

Dr. Christos Giannoulias performed the consult and also diagnosed first and second metatarsal fractures. Petitioner was referred to Dr. Simon Lee, who found the MRI was consistent with edema and swelling within the base of the first and second metatarsal consistent with a crush injury, contusion and possible Lisfranc type injury. Dr. Lee opined the MRI was consistent with Petitioner's reported symptoms and radiographs. Petitioner underwent a cortisone injection to the TMT area, was placed in a custom orthotic and CT revealed mild degenerative changes within the mid foot region and insertional posterior tibial tendonitis. In his final visit, Dr. Lee diagnosed post-traumatic degenerative changes through the midfoot and Lisfranc areas. Dr. Lee confirmed his prior diagnosis of status post right foot crush injury with injuries to the right mid foot, first and second and TMT joints. The doctor opined Petitioner's condition was causally related to his 4/5/10 work accident.

Respondent offered the opinions of Drs. Horak and Kodros. Dr. Horak disagreed with Dr. Lee stating that Petitioner suffered from bilateral diffuse psoriatic/osteoarthritis of the TMT and ST joints with left worse than right. He stated Petitioner's right foot condition was unrelated to the accident of 4/5/10. Dr. Kodros diagnosed status-post crush type injury to the dorsal aspect of the right forefoot and midfoot. He reported

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associated fractures of the first and second metatarsals by MRI. He stated some of Petitioner's residual complains may be related to a soft tissue component of the injury. He opined that the condition was causally related to the April 2010 accident.

In weighing the opinions, the Arbitrator finds and concludes that the medical opinions of Drs. Giannoulias and Lee are entitled to greater weight when compared to Dr. Horak. Of note, Dr. Lee was initially Respondent's examining doctor and causally related Petitioner's condition to the accident. Similarly, Dr. Kodros found a causal component between Petitioner's condition and the work accident, although he felt residual complaints were more associated with soft tissue injury. In rejecting Dr. Horak's opinion, the Arbitrator notes that Petitioner's right foot injuries and symptoms, whether degenerative as suggested by Dr. Horak, Petitioner was pain and symptom free prior to the date of his accident. Following the accident, Petitioner's immediate onset of symptoms were found consistent with MRI findings and treated accordingly. Accordingly, the Arbitrator finds that Petitioner right foot injuries are causally connected to the accident of 4/5/10.

ISSUE (J) Were the medical services that were provided to Petitioner reasonable and necessary?

1. Date of accident August 31, 2009, claim number 10 WC 25059

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Petitioner only alleged outstanding medical bills in case number 10 WC 25059. Ax2. Having found in favor of Petitioner on the issue of causal connection, the Arbitrator finds Petitioner's medical treatment for his post-concussion syndrome, cervical injury, vertigo and disequilibrium was reasonable and necessary to cure and otherwise relieve Petitioner from his injuries. In so concluding, the Arbitrator finds Petitioner's course of treatment was reasonable and necessary as shown by numerous referrals to specialists in order to specifically address and treat his post-concussion syndrome, vertigo, disequilibrium and cervical injury. Petitioner's medical records demonstrate a medical necessity for these various referrals, testing and treatment. The Arbitrator's conclusion is also supported by Respondent's doctor, Dr. Lazar, who opined that Petitioner's treatment was reasonable and appropriate.

Petitioner submitted a Rush University Medical Group bill for the 7/12/10 visit with Dr. Wiet in the amount of $122.00. Px2:11. Petitioner also submitted the Rush University Medical Center bill for the 9/6/10 audiology testing done by Dr. Wiet at Rush University in the amounts of $2,796.25. Px2:12. Petitioner also submitted the Chicago Dizziness and Hearing bill for an office visit and tests on 9/20/10 and 10/28/10 in the amount of $720.00. Petitioner also submitted the Elite Physical Therapy bill for rehabilitation services ordered by Dr. Wiet from 11/22/10-12/7/10 in the total amount of $2,733.04. The Arbitrator finds the bills contain all necessary data for processing of payment and all bills correspond to dates of service for medical services the Arbitrator has concluded to be reasonable and necessary. No contrary evidence by way of utilization review was presented on the reasonableness or necessity or the amounts charged/billed.

Accordingly, the Arbitrator concludes that Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$6,371.29**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of for medical benefits that have been paid against this award 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.

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ISSUE (K) What temporary benefits are in dispute?

1. Date of accident April 5, 2010, claim number 10 WC 25060

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. At trial, Petitioner only claimed entitlement to temporary benefits for date of accident 4/5/10 in case number 10 WC 25060. Ax3. Specifically, Petitioner claimed entitlement to temporary total disability (TTD) from 5/6/10 through 5/2/11 or 51-5/7th weeks. Respondent asserted Petitioner was only entitled to TTD through 4/14/11. Petitioner also claimed entitlement to maintenance benefits from 5/3/11 through 8/31/15 or 226 weeks. Respondent asserted Petitioner was only entitled to maintenance from 4/1/13 through the present time.

a. Temporary Total Disability Benefits

Medical evidence showed Petitioner was either placed off of work or on light duty restriction from 5/6/10 (date of accident) through 5/2/11, the last date in which Petitioner sought treatment with Dr. Lee. Petitioner testified that he began losing time on 5/26/10, the date on which Respondent no longer offered him work within the restrictions given by his treating doctors for this injury. Respondent asserts Petitioner is only entitled to TTD on through 4/14/11 but provides to evidence why TTD should only be paid through this date, as there is no date of service, no Section 12 exam occurring on this date. Ax3. The Arbitrator finds that Petitioner reached maximum medical improvement MMI for his right foot on 5/2/11, his late date of medical treatment with Dr. Lee and that thereafter; Petitioner's condition reached its state of permanency. The Arbitrator declines to adopt Dr. Horak's opinion that Petitioner has no restriction. Respondent shall pay Petitioner temporary total disability benefits of **$781.89/week** for **48-6/7th** weeks, commencing **5/26/10** through **5/2/11**, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **5/26/10** through **5/2/11**, and shall pay the remainder of the award, if any, in weekly payments. Respondent shall be given a credit of **$38,200.91** for temporary total disability benefits that have been paid. Ax3.

b. Maintenance Benefits

On 5/2/11, Dr. Lee released Petitioner to restrictions of no lifting, carrying, pushing or pulling greater than 25 pounds, limited bending, stooping, squatting activity and alternating sitting and standing 30 minutes per hour, ground level work only and limited ladder and stair climbing. These restrictions were subsequently endorsed by Dr. Kodros, Respondent's examining doctor. Again, the Arbitrator adopts these restrictions as Petitioner's permanent restriction and finds that Petitioner reached MMI on 5/2/11. Petitioner seeks maintenance benefits from 5/3/11 through 8/31/15. However, the Arbitrator notes that between Petitioner's release by Dr. Lee on 5/2/11and the start of vocational placement services on 11/2/13, there appears to have been no placement services implemented, no vocational rehabilitation plan and/or no job search. No explanation for this gap was provided at trial. The Arbitrator declines to award maintenance benefits for this time period.

The evidence further established that Petitioner began vocational rehabilitation services with Brown Rehab through Respondent in November 2013 through April 2016. During this time, over 600 resume/applications were submitted. Petitioner testified did what he was told. The vocational records show that several potential employers expressed interest in Petitioner's resume and Petitioner was interviewed once. Further, the record shows Petitioner otherwise cooperated through-out placement services. Petitioner last participated in vocational services on 6/1/16. Based on the record as a whole, the Arbitrator concludes that Respondent shall pay Petitioner maintenance benefits of **$781.89/week** for **135-6/7th** weeks, commencing

10/25/13 through **6/1/16**, as provided in Section 8(a) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **10/25/13** through **6/1/16**, and shall pay the remainder of the award, if any, in weekly payments. Respondent shall be given a credit of **$130,575.63** for maintenance benefits that have been paid. Ax3.

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

1. ***Date of accident September 23, 2008, claim number 10 WC 25058***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. As stated above the only specialist opinion of records was provided by Dr. Barbara Heller who diagnosed a left sacroiliac joint strain. Petitioner underwent 5 months of physical therapy, a cortisone injection prior to a release to full duty work. Petitioner complained that he still notices low back pain with extended sitting and standing. The Arbitrator finds this testimony credible and corroborated by Petitioner's later treatment records for his other claims, which noted some back pain. Based on the above, the Arbitrator finds that Petitioner sustained a left sacroiliac joint strain as a result of his 9/23/08 accident, which required the treatment described above. Therefore, Respondent shall pay Petitioner permanent partial disability benefits of **$664.72/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.

2. ***Date of accident August 31, 2009, claim number 10 WC 25059***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found Petitioner's cervical and head injuries causally related to his 8/31/09 work accident, the Arbitrator finds Petitioner's condition has reached a state of permanency. As noted previously, the Arbitrator adopts Petitioner's treatment records and the opinions of Dr. Cherchi, who diagnosed post-concussion syndrome, vertigo, disequilibrium and cervicalgia. The Arbitrator also adopts the opinions of Dr. Slack in determining the nature and extent of Petitioner's injuries. Drs. Cherchi and Slack otherwise released Petitioner to full duty work but Dr. Cherchi cautioned Petitioner should avoid situations that could result in unanticipated loss of equilibrium. At trial, Petitioner testified he continued to experience pain with side-to-side motion of his head and that background movement sometimes cause imbalance. Petitioner did not testify whether his work for Respondent subjected him to unanticipated loss of equilibrium. For the reasons stated above, the Arbitrator finds the opinions of Dr. Cherchi and Dr. Slack more persuasive than Dr. Lazar. In consideration of the above and based on the record as a whole, the Arbitrator finds that Respondent shall pay Petitioner permanent partial disability benefits of **$664.72/week** for **37.50 weeks**, because the injuries sustained caused the **7.5%** loss of the person as a whole, as provided in **Section 8(d)2** of the Act.

3. ***Date of accident April 5, 2010, claim number 25060***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found Petitioner's right foot injuries causally related to his 4/5/10 work accident, the Arbitrator finds Petitioner's condition reached a state of permanency on 5/2/11, the date in which Dr. Lee released Petitioner to work with restrictions.

Dr. Lee diagnosed status post right foot crush injury with injuries to the right mid foot, first and second and TMT joints. He opined Petitioner's condition was causally related to his work accident. Dr. Kodros diagnosed status post crush type injury to the dorsal aspect of the right forefoot and midfoot. He also noted fractures of the first and second metatarsals per MRI. Dr. Kodros stated Petitioner could function within the

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restrictions of Dr. Lee's 5/2/11 medical note. For the reasons stated above, the Arbitrator finds the opinions of Dr. Lee and Dr. Kodros more persuasive than the opinion of Dr. Horak.

Petitioner asks the Arbitrator to conclude he is permanently and totally disabled. An employee is totally and permanently disabled when he is unable to make some contribution to industry sufficient to justify the payment of wages. *A.M.T.C. of Illinois v. Indus. Comm'n*, 77 Ill. 2d 482, 487, 397 N.E.2d 804 (1979). If, as in this case, a claimant's disability is of such a nature that he is not obviously unemployable or 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 an "odd-lot" category; that being an individual who, although not altogether incapacitated, is so handicapped that he is not regularly employable in any well-known branch of the labor market. *Valley Mold & Iron Co. v. Indus. Comm'n*, 84 Ill. 2d 538, 546-47, 419 N.E.2d 1159 (1981). A claimant ordinarily satisfies his burden in one of two ways: (1) by showing diligent but unsuccessful attempts to find work; or (2) by showing that, because of his age, skills, training and work history, he will not be regularly employed in a well-known branch of the labor market. *Westin Hotel v. Indus. Comm'n*, 372 Ill. App. 3d 527, 544, 865 N.E.2d 342 (2007). Once a claimant establishes that he falls within an "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.

After careful deliberation, the Arbitrator concludes that Petitioner has failed to prove he is permanently and totally disabled under either theory. First, Petitioner has not shown he has been determined medically totally disabled per any medical record. Second, Petitioner has failed to show that he is so handicapped that he is not regularly employable in any well-known branch of the labor market. In support thereof, the Arbitrator first notes for nearly two years after being released by Dr. Lee, Petitioner failed to engage in any diligent job search efforts. Petitioner offered no explanation at trial. Second, while it is true that over 600 applications were submitted, most were submitted by Brown rather than Petitioner. In addition, Brown rather than Petitioner followed up on a majority of job leads. Petitioner provided few job leads on his own, followed up minimally on potential employment opportunities and went to few job fairs. In this way, Petitioner fails to meet the first prong of the "odd-lot" proof required – diligent but unsuccessful attempts to find work. Regarding the second prong of the "odd-lot" test, Petitioner has failed to show that due to his age, skills, training and/or work history, he will not be regularly employed. Here, Respondent presented a labor market survey demonstrating that Petitioner's qualifications made him eligible to potentially find employment within a range of positions related to Petitioner's specialty. Petitioner's skills and education showed that he has a high school education, an automotive certification and over 30 years of experience in the automotive industry. Of the applications submitted, on many occasions potential employers expressed interest in Petitioner based on qualifications listed in his resume. In the Arbitrator's view, the job searches performed mostly by Brown demonstrate the existence of a stable labor market; all job leads and applications were in Petitioner's industry. To the extent Petitioner did not secure employment, Petitioner has not proven it was due to his age, skills or training and/or work history. On one occasion, Petitioner was nearly offered a position but told the potential employer he would not be able to perform part of the essential job function. On another occasion, an employer related to Brown that they called Petitioner and Petitioner later told Brown he received no such call.

In reviewing Mr. Patsavis' vocational report, the Arbitrator assigns less weight as Petitioner demonstrated transferable skills that, during his time with Brown, led to several employers expressing interest based on those skills and that led to several interviews. Patsavis noted Petitioner's gap in employment but the

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Arbitrator only found one instance out of over 600 applications that an employer expressed or remarked concern regarding same.

In rejecting Petitioner's contention that he is permanently and totally disabled, the Arbitrator concludes that the evidence most demonstrates that Petitioner has suffered a loss of trade. See, *Hubl v. Cert. Installations*, 06 WC 386, 12 IWCC 0176 (Feb. 16, 2012). Here, Petitioner was released with restrictions in 2011 and ultimately did not return to his previous employment with Respondent as a lead mechanic. In consideration of the above and based on the record as a whole, the Arbitrator finds that Respondent shall pay Petitioner permanent partial disability benefits of **$669.64/week** for **200 weeks**, because the injuries sustained caused the **40%** loss of the person as a whole, as provided in **Section 8(d)2** of the Act.

Signature of Arbitrator

8-17-16
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Thomas Santangelo,
Petitioner,
vs.

17IWCC0780

NO: 10 WC 25059

Pepsi Beverages Co.,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 25, 2016 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $25,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DEC 4 - 2017

DATED:
KWL/vf
O-10/24/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0780

SANTANGELO, THOMAS
Employee/Petitioner

Case# **10WC025059**

10WC025060
10WC025058

PEPSI BEVERAGES CO
Employer/Respondent

On 8/25/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0328 LEWIS & DAVIDSON
RICHARD SCHOLLENBERGER
ONE N FRANKLIN ST SUITE 1850
CHICAGO, IL 60606

2337 INMAN & FITZGIBBONS LTD
G STEVEN MURDOCK
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

17IWCC0780

THOMAS SANTANGELO,
Employee/Petitioner

v.

PEPSI BEVERAGES, CO.,
Employer/Respondent.

Case # 10 WC 25059

Consolidated cases: 10 WC 25060
10 WC 25058

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **6/9/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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FINDINGS

On **8/31/09**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$60,987.68**; the average weekly wage was **$1,172.84**.

On the date of accident, Petitioner was **57** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$0.00**. Respondent is entitled to a credit of **$0.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$6,371.29**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of for medical benefits that have been paid against this award and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$664.72/week** for **37.50 weeks**, because the injuries sustained caused the **7.5%** loss of the person as a whole, as provided in **Section 8(d)2** of the Act.

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

8-17-16
Date

AUG 25 2016

17IWCC0780

FINDINGS OF FACT

A. Date of accident September 23, 2008 claim number 10 WC 25058

Thomas Santangelo ("Petitioner) and Pepsi Beverage Co. ("Respondent") stipulated to an accident of 9/23/08, arising out of an in the course of his employment with Respondent. Ax1. At trial, the parties disputed the issues of causal connection and nature and extent. *Id.* On this date, Petitioner testified that he was removing a heavy frame from a fork lift. The piece began to fall. Petitioner held the frame to prevent it from falling and twisted his low back. After the accident, he felt an onset of low back pain.

Petitioner was seen the same day at Respondent's direction at Concentra Medical Center by Dr. Peter Sorokin and would continue to treat here through 2/20/09. Px1:2-105. Diagnosis was lumbosacral strain and lumbar pain. Petitioner was prescribed medications, light duty and therapy. Therapy for his low back commenced at Concentra on 9/25/08. Thereafter, Petitioner came under the care of Dr. Dan Paloyan at Concentra, who monitored Petitioner's condition while in therapy. Dr. Paloyan diagnosed lumbar strain. On 10/2/08, Petitioner saw Dr. Kathuria, who diagnosed lumbar strain and recommended continued light duty and therapies. Px1:17.

On 10/14/08, Dr. Payolan noted Petitioner had improved symptoms but low back pain was about the same with continued pain down both legs. Petitioner's medical history was positive for prior low back pain 10-20 years earlier requiring therapy. The doctor diagnosed lumbar strain and lumbar radiculopathy. The plan was for an MRI of the lumbar spine. *Id.* at 27. Petitioner was released to light duty and to continued therapies. MRI of the lumbar spine showed minimal disc bulging and early degeneration at L5-S1 and early degenerative changes in the facet joints. Dr. Payolan then referred Petitioner to Dr. Barbara Heller. *Id.* at 40.

On 11/7/08, Petitioner first saw Dr. Heller. Px1:43-44. She noted Petitioner injured his back when he tried to prevent a 160-pound back rest from falling. Petitioner related back pain radiating to the posterior thigh, calf and upper back. He had no numbness or tingling. On exam, lumbar flexion and extension were mildly decreased by left sided low back pain. She noted pain emanated from the left sacral sulcus and positive Patrick's on the left. She noted that lumbar flexion and extension was mildly reduced by left-sided low back pain emanating from the left sacral sulcus. She interpreted the MRI to show mild disc desiccation at L5-S1. Diagnosis was left sacroiliac (SI) joint strain. An injection was recommended. Petitioner was given light duty. Petitioner returned to Dr. Heller and reported relief with the SI joint injection. Dr. Heller recommended regular duty and continued therapy through the end of 2008.

On 1/2/09, Petitioner returned to Dr. Heller. Px1:63. Petitioner's low back symptoms were improved with residual discomfort but had secondary upper back and neck myofascial pain. Assessment was improving SI joint strain and persistent secondary myofascial pain. Additional therapy and full duty was prescribed.

On 1/30/09, Petitioner returned to Dr. Heller. *Id.* at 83. Dr. Heller noted improvement with conservative care and ongoing stiffness. Petitioner completed his physical therapy on 2/19/09. On 2/20/09, Dr. Heller released Petitioner from care, placed him at maximum medical improvement and released him to regular work duties. Px1:105. Petitioner no longer has any low back pain but would continue home exercise. On exam, lumbar flexion and extension were full without discomfort, range of motion was full, Patrick's was negative bilaterally, strength, sensation and reflexes were normal and gait was without deficit. Assessment was resolved SI joint strain.

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By stipulation Petitioner lost no time from work as a result of this accident. Petitioner testified that as a result of this accident, he continues to suffer low back pain with bending and extended periods of sitting, standing and walking.

B. Date of accident August 31, 2009 claim number 10 WC 25059

The parties stipulated to an accident of 8/31/09, arising out of an in the course of Petitioner's employment with Respondent. Ax2. At trial, the parties disputed the issues of casual connection, medical bills, and nature and extent of the injury. *Id.* Petitioner testified that on this date he struck his head on a metal beam, fell to the ground and may have lost consciousness. He saw the onsite nurse, where he rested then returned to work. When he attempted to return to work, he felt dizzy and left for the day. Petitioner testified he took personal time off without improvement of symptoms.

On 9/18/09, Respondent sent Petitioner to Concentra Medical Center for treatment by Dr. Rolando Garces. Px1:106. It was noted Petitioner did not lose consciousness but was dazed for 15 seconds. Petitioner complained of lower neck pain into the left shoulder, without radiation. Symptoms were exacerbated with neck movement and there was associated stiffness and dizziness. The plan was for cervical spine x-rays, physical therapy and regular duty. Dr. Garces assessed cervical strain.

On 9/22/09, Petitioner followed up at Concentra with Dr. Paloyan. Px1:109. Petitioner reported continued moderate pain in the left side of the neck down to the left shoulder area, aggravated by movement, continued dizziness and blurred vision. He denied radicular symptoms, paresthesias, numbness or weakness. Dr. Paloyan diagnosed cervical strain and possible concussion syndrome. He recommended an MRI of the cervical spine, continued physical therapy and a CT scan if head symptoms continued. That same date, Petitioner began physical therapy for a diagnosis of cervical strain, which would continue through 12/4/09. Px1:111-167. Petitioner reported hitting the left side of his head, decreased range of motion, pain in the left side of the neck and occasional dizziness. The therapist noted that "examination is consistent with the medical diagnosis." Further, the therapist noted that impairments were preventing Petitioner from performing standard activities of daily living and work activities and that therapy was indicated to address same.

On 9/25/09, Dr. Paloyan noted Petitioner remained unchanged and the doctor again recommended an MRI of the cervical spine. Exam showed moderate tenderness to palpation at C5-6, positive Spurling's, pain on extension and lateral flexion and reduced range of motion. Diagnosis was cervical strain, possible post-concussion syndrome and cervical radiculopathy. Petitioner continued with therapy.

On 10/7/09, Petitioner returned to Dr. Paloyan. Petitioner was minimally improved with continued moderate pain on the left side of the neck but with no radicular component. MRI of the cervical spine was negative for herniation and impingement. Petitioner continued with mild dizziness. On 10/12/09, Petitioner returned to Dr. Paloyan stating his pain was slightly improved with physical therapy. He continued with moderate stiffness, aggravated by movement with pain localized to the left side of the neck. Assessment was cervical strain. Dr. Paloyan continued therapy and referred Petitioner to a neurosurgeon.

That same date, Petitioner was seen by neurosurgeon, Dr. Leonard Cerullo. Px1:139. Petitioner described ongoing pain aggravated by hip motion especially left lateral bending and left rotation. He also complained of intermittent left interscapular pain radiating to the left shoulder. He reported constant dizziness

exacerbated by movement and exercise, which Dr. Cerullo stated was true vertigo. Petitioner reported word-finding difficulties and feeling "out of it." Dr. Cerullo suspected concussion, post-traumatic syndrome including post-traumatic vertigo. The plan was for therapy and an MRI of the brain. Therapists again noted Petitioner's condition related to the presenting diagnosis. *Id.* at 146. On 11/4/09, Dr. Cerullo diagnosed post-concussion syndrome with vertigo. He again recommended a brain MRI, possible neurotologic consultation, continued therapy and home exercise.

On 11/11/09, Dr. Cerullo concluded Petitioner's brain MRI was normal. The doctor prescribed medication for unresolved vertigo and recommended continued physical therapy. Petitioner's last physical therapy visit at Concentra was on 12/4/09. At that time, Petitioner's lifting ability was 25 pounds and that he had not met his lifting goal of 50 pounds. Further treatment was held pending medical consultation.

On 12/3/09, Petitioner received a neurotology consult by Dr. Richard Wiet at Rush University Medical Center. Px2. Petitioner provided a history of striking his head on a beam, followed by neck stiffness and unusual visual symptoms. He described that when he looks at an object the background objects move and he experiences imbalance. Petitioner stated that on occasion the symptoms caused him to vomit. He also described occasional slurred speech, memory problems, constant pain in the back of his head and intermittent pain in the left ear. Dr. Wiet recommended an MRI of the internal auditory canals, a contrast MRI of the brain, an audiogram, a VGN, a posturography and rotational chair testing. Contrast MRI of the brain showed nonspecific punctate area of T2 signal change in the left frontal subcortical white matter. Approximately seven months later, on 7/12/10, Petitioner returned to Dr. Wiet and was largely unchanged. The doctor recommended the same tests and flexible laryngoscopy.

On 9/20/10, Petitioner saw Dr. Marcello Cherchi for otoneurology consult at the referral of Dr. Wiet. Px3. Petitioner related he hit his head at work and went down for about 10 minutes. Symptoms included blurred vision, poor concentration, memory loss, fatigue and neck pain with radiation to the left upper extremity. Dr. Cherchi reviewed prior audiogram and noted normal bilateral hearing in low and mid frequencies. In high frequencies, there was asymmetrical hearing loss, right greater than left. Normal canal volume and ear pressure was noted. The doctor noted that prior videonystagmography (VNG) was found to be normal but Dr. Cherchi noted 18% left unilateral caloric weakness. Concomitant with exam, the doctor conducted several tests. A distortion product optoacoustic emissions (DPOAE) test showed some high frequency hearing loss bilaterally, right greater than left, consistent with prior audiogram. Vestibular evoked myogenic potential (VEMP) tests showed 10% left sided weakness within the 35% upper limit of asymmetry. On 9/20/10, Dr. Cherchi performed a rotary chair test, which was normal. He also performed an electrocochleography (ECoG), which showed inconsistent results. Impression was head trauma, followed by exacerbation of pre-existing disequilibrium and by cognitive symptoms of impaired concentration, impaired memory, and fatigue, all in the context of an unremarkable physical examination and otovestibular testing. He suspected and diagnosed post-concussive syndrome as well as vertigo, disequilibrium and cervicalgia. Px3:2,7, 51. Consideration was given for cervical spine MRI, neuropsychological evaluation, therapy for gait, balance and neck and rehab for post-concussive syndrome.

On 11/22/10, Petitioner started therapy for vertigo/disequilibrium at Elite Physical Therapy. Px4. Petitioner reported persistent cervical pain referring to the left upper extremity, constant vertigo with imbalance and visual deficits and impaired short term memory. On 11/29/10, Dr. Cherchi recommended Petitioner avoid tasks and situations in which unanticipated loss of equilibrium would endanger him or others. Px3:62. On

2/16/11, Dr. Cherchi opined that his diagnosis of Petitioner is more likely than not related to the work accident. Px3:63-64.

On 11/24/10, Petitioner was seen by Dr. Richard Lazar at the request of Respondent. Rx6. After a review of history and records, Dr. Lazar documented current complaints of short-term memory loss, visual difficulties, dizziness, left sided neck pain, numbness, and loss of motion. He described his vision issues as normal central fixation with movement of the background field. Dr. Lazar stated that the treatment rendered to date had been reasonable and appropriate. Dr. Lazar stated that the only injury Petitioner sustained in the accident was scalp abrasions and a brief cerebral concussion of the most insignificant magnitude. He opined that Petitioner's current complaints were not related to the accident but caused by intense anxiety and personality traits. He recommended full duty work and no further treatment.

On 6/15/11, Petitioner was evaluated by Dr. Charles Slack at his attorney's request. Px6. Petitioner described his accident of 8/31/09, ongoing complaints of dizziness, vision difficulties, difficulty balancing, pain with sideways head motion, occasional numbness in the left upper arm, and low back stiffness. On examination, Dr. Slack found pain with lumbar flexion and markedly limited cervical rotation and tilt. Dr. Slack diagnosed cervical myofascial pain secondary to neck and head injury with what appears to have been diagnosed as post concussive syndrome. He stated the cervical pain was due to work accident. Regarding work, Dr. Slack stated the cervical symptoms would be problematic for return to work as a mechanic and deferred his opinion regarding work restriction for the post-concussive syndrome to Petitioner's neurologists.

Petitioner testified that he continues to experience neck pain and loss of cervical motion since the date of accident. He also testified that he continues to notice the movement of background objects and resulting dizziness.

C. Date of accident April 5, 2010 claim number 10 WC 25060

The parties stipulated to an accident of 4/5/10, arising out of an in the course of Petitioner's employment with Respondent. Ax3. At trial, the parties disputed the issues of casual connection, temporary total disability, maintenance and nature and extent of the injury. *Id.* On this date, Petitioner's right foot got stuck under a forklift and he lost his balance falling backward. He testified he felt an onset of pain on the top of his right foot.

On 4/6/10, Petitioner was sent by Respondent to Concentra and seen by Dr. Paloyan and would continue to treat there through 9/15/10. Px1:168-286. Dr. Paloyan noted Petitioner's accident and major crush injury with resulting searing pain. Dr. Paloyan found tenderness to palpation of the right foot with minimal swelling and erythema. Right foot x-rays at that time showed no fractures. He ordered physical therapy and work restrictions including 80% sitting. Assessment was right foot contusion. Petitioner returned on 4/8/10 and plans and recommendations were unchanged.

On 4/19/10, Petitioner returned to Dr. Paloyan stating he had been working within the restrictions and that his right foot remained moderately sore and was aggravated by movement. Petitioner was tender to palpation over the dorsal aspect of the 2nd metatarsal. The doctor assessed contusion with possible sprain. Dr. Paloyan again recommended therapy and work restrictions to 70% sitting. On 4/29/10, Petitioner described the same complaints and Dr. Paloyan changed his restrictions to 25% sitting. During this time, Petitioner continued to work within his duty restrictions.

On 5/11/10, Dr. Paloyan noted continued moderate tenderness to palpation on the dorsal aspect over the 2nd metatarsal. Petitioner reported he was on regular duty without any problems or pain. Px1:209. Exam was unchanged. The doctor assessed contusion with possible ligament or occult bone injury. Petitioner was released to modified duty with 25% sitting. X-rays were again negative. An MRI was ordered and showed suspected stress type fractures within the base of the 1st metatarsal with bone marrow edema. Bone marrow edema was identified in the 2nd metatarsal. Dr. Paloyan reviewed the MRI and diagnosed possible stress fractures to the right 1st and 2nd metatarsals. The doctor ordered an immediate orthopaedic consult. On 5/20, Petitioner was released to return to work with sitting 100% of the time.

On 5/26/10, Petitioner was seen at Concentra by orthopaedic surgeon, Dr. Christos Giannoulias. The doctor diagnosed 1st and 2nd metatarsal fractures. He ordered a cast shoe and 100% sitting work. Petitioner testified that as of this date work was no longer proved by Respondent.

On 6/23/10, Dr. Giannoulias ordered supervised physical therapy and continued sedentary duty. Assessment was metatarsal fracture. New x-rays failed to identify fracture. Petitioner began therapies for the right foot at Concentra through 7/19/10. Px1:242-257.

On 7/21/10, Petitioner returned to Dr. Giannoulias and reported 50-60% improvement but complained on neck and back pain. Exam of the foot showed stiffness with dorsiflexion of the great toe and mild tenderness of the 1st and 2nd ray. Dr. Giannoulias recommended continued therapy including therapy for the neck and back. Petitioner was released to modified duty with sitting 90% of the time. Therapy for the foot continued. Petitioner reported continued difficulty with weight bearing and that work could not be accommodated.

On 8/18/10, Dr. Giannoulias noted Petitioner had not started the recommended neck and back treatment. He also noted right foot problems including difficulty with plantar flexion and tenderness over the midfoot. Petitioner complained of pain and stiffness over the dorsum of the foot. Dr. Giannoulias recommended a consult with Dr. Simon Lee and possible cortisone injection. The doctor noted Petitioner appeared to have a healed fracture and that Petitioner had some degenerative changes in the midfoot which may be causing the pain he has. Assessment was midfoot pain and metatarsal fracture. Restrictions continued.

On 9/13/10, Dr. Simon Lee first saw Petitioner as a Section 12 doctor for Respondent. Px5:9-10. The doctor wrote that Petitioner's right foot was run over at work in May 2010. The doctor noted Petitioner's prior medical history and noted review of symptoms were non-contributory. Petitioner's right foot complaints at that time were significant pain and dysfunction of the right foot especially with prolonged weight bearing or ambulatory activity or flexion or extension of the foot. Exam of the right showed decreased medial longitudinal arch pronation of the hind-foot and full dorsiflexion, plantar flexion, range of motion of the ankle. Dr. Lee found significant pain with attempts at dorsiflexion, plantar flexion, or supination and pronation of the mid-foot. A majority of pain and discomfort was localized and specific to the medial mid-foot within the region of the TMT joints over the mid-foot, 1st and 3rd. X-rays showed concern for calcification within the base of the first and second TMT joint with possible minimal incongruity between the bases. Diagnosis was status-post right foot crush injury with possible Lisfranc injury or post-traumatic arthropathy. Dr. Lee also noted a component of neuritis, possibly related to the crush injury but he was unsure whether this was related to a deep peroneal nerve injury or superficial peroneal nerve as it was difficult to differentiate between traumatic arthropathy and injury to the TMT joint line without further study. On 9/15/10, Dr. Giannoulias released Petitioner to Dr. Lee. Px1:281.

On 9/28/10, Dr. Lee issued an addendum opinion after reviewing the May 2010 right foot/ankle MRI report and films. Px5. The doctor concluded it was consistent with edema and swelling within the base of the 1st and 2nd metatarsal consistent with crush injury, contusion and Lisfranc type injury. The doctor found the report consistent with symptoms and radiographs. Recommendations were unchanged and the doctor added recommendation for a cortisone injection.

On 12/14/10, Dr. Lee noted Petitioner's symptoms were unchanged and he continued to complain of pain with weight-bearing over the dorsal mid-arch of his foot and generalized sensitivity that radiated to the toes. Px5. He was not in active treatment and was not working. Exam was unchanged and the doctor noted pain with stressing, inversion, eversion, supination, pronation and direct palpation. He had positive Tinel's radiating to the digits. A cortisone injection was administered into the first and second TMT and inter-cuneiform joint line. Sit down sedentary work was continued.

On 1/24/11, Petitioner returned to Dr. Lee stating that initially he had no improvement after the injections but several days later notice 70% improvement. Px5, Rx1. Subsequently the pain returned while pushing off with his foot from a sitting to standing position. Petitioner continued with at least a first TMT instability. Dr. Lee stated that as a result of the continued significant functional limitations and pain, he recommended a custom orthotic with a turned toe plate for further stiffening and a CT scan. Petitioner remained on light duty. CT showed mild degenerative changes within the mid foot region and insertional posterior tibial tendonitis. Dr. Lee continued to recommend a custom orthotic. On 3/2/11, Petitioner's work restrictions were continued by Dr. Lee.

On 3/29/11, Petitioner was evaluated by Dr. Horak at the request of Respondent. Rx2. The doctor noted Petitioner presented with a frustrated victimized attitude. He noted Dr. Lee incorrectly noted a crush injury and stated the injury was in fact a plantar flexory injury. He noted Petitioner had an exaggerated response to light touch. Tinel's was non-specifically positive on all tested sites of the right lower extremity. Range of motion was normal and produced non-specific pain on testing. Dr. Horak diagnosed bilateral diffuse psoriatic/osteoarthritis of the TMT and ST joints, left worse than right. The doctor concluded Petitioner's right foot condition was unrelated to the accident of 4/5/10 and no work restrictions were indicated.

On 5/2/11, Petitioner returned to Dr. Lee. Px5. He had been using his orthotic for one month. Petitioner continued with post-traumatic degenerative changes through the midfoot and Lisfranc areas. Diagnosis was status post right foot crush injury with injuries to the right mid foot, first and second and Lisfranc TMT joints. The doctor opined directly causation between the condition and the work accident. Petitioner did not wish to pursue additional treatment and continued with some lower functional limitations and disability. Dr. Lee released Petitioner from care with restrictions of no lifting, carrying, pushing, pulling greater than 25 pounds, limited bending, stooping, squatting activity, and alternating sitting and standing 30 minutes per hour, ground level work only, limited ladder and stair climbing.

On 3/27/13, Petitioner was then evaluated by Dr. Kodros at the request of Respondent. Rx3. The doctor took Petitioner's accident history and reviewed records. Petitioner's chief complaint was balance issues. X-rays taken at exam failed to show any previous fractures. The doctor noted there was no evidence of a prior Lisfranc injury. He noted ongoing residual symptoms likely related to the soft tissue component of Petitioner's injury and the doctor offered that he had no ready explanation for Petitioner's ongoing residual right foot complaints.

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The doctor performed an exam and his impression was status post crush type injury to the dorsal aspect of the right forefoot and midfoot. He opined that the condition was causally related to the April 2010 accident. Dr. Kodros recommended use of stiff shoes with inserts and recommended against further injections, supervised therapy and surgery. With respect to activity, Dr. Kodros stated Petitioner can function within the restrictions of Dr. Lee's 5/2/11 note.

On 9/19/13, Sandra Brown ("Brown") of Brown Rehab Review performed a labor market survey without contact with Petitioner. Rx4. She contacted 8 potential employers and concluded Petitioner had an earning capacity of $68,740.00 and that the salary range for the jobs located was $26,807.00 to $68,740 with an average salary of $47,4773.50. On 10/7/13, Brown developed a vocational rehabilitation plan consisting of job seeking skills training, a documented job search, job development log sheets, following up on job leads, meeting with Brown, interviewing, establishing a resume, maintaining telephone contact with potential employers and accepting valid job offers.

Petitioner met with Brown from 11/2/13 through 4/10/16 for vocational evaluation and placement services with. Rx4. Petitioner stated he had sedentary restrictions and that due to union affiliations he could no longer work in the automotive industry. Ms. Horn noted both Dr. Horak's and Dr. Lee's return to work restrictions. She noted Petitioner had a high school education, auto industry certification and worked as a mechanic for the last 30 years, considered to be heavy. She concluded that based on transferrable skills, Petitioner could diagnose, read job orders and would still be capable of handling certain positions in his field which are still within his current physical demands. Based on this and a recent labor market survey, she concluded there was a good possibility Petitioner could find employment in his current field, physical demand level and skill level. She recommended job placement within his current field of expertise.

Starting 10/25/13, Petitioner and Brown met on a weekly basis for job placement. Rx4. Petitioner was given job seeking skills training and Brown submitted resumes for employment starting December 2013. In March 2014, Brown broadened the job search to include other employment opportunities and advised Petitioner about presentation, attire and preparation. Brown generated vocational progress reports showing that over 600 applications/resumes were submitted. During this time, Petitioner submitted some job leads, attending some job fairs and had several telephone or in-person interviews. Brown advised Petitioner about his role in the search process and asked him to provide leads. She also recommended he take free computer classes offered at the local library to aid in his job search efforts. Petitioner received some phone calls expressing interest and underwent some interviews. Brown generated a rehabilitation closure report and concluded that based on Petitioner's recent labor market survey and transferrable skills analysis, there was a good possibility he could establish gainful employment within his current expertise, physical demand level and skill level. Rx5. Petitioner last saw Brown on 6/1/16.

On 8/31/15, Petitioner was evaluated by his own vocational expert, David Patsavis. Px7. He confirmed that Petitioner graduated high school in 1971 and was then currently 63 years old. He noted that from 1980 to 2011 Petitioner worked for Pepsi as a lead mechanic. Mr. Patsavis concluded that given the fact that Petitioner has not worked during the past 5 years and has limited transferable skills, as well as unsuccessful Job Placement Activities for the past two years, it was his opinion that Petitioner would be an odd lot or permanently and totally disabled. He concluded that a viable and stable labor market does not exist for Petitioner.

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Petitioner testified that he continues to have pain in his right foot with extended standing and walking. He also testified that he continues to require a shoe orthotic.

CONCLUSIONS OF LAW

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

1. Date of accident September 23, 2008, claim number 10 WC 25058

The unrebutted evidence is that on 9/23/08, Petitioner caught a heavy frame falling from a fork lift and felt a sudden onset of low back pain. He was evaluated the same day at Respondent's direction by Dr. Sorokin at Concentra Medical Center who diagnosed a lumbosacral strain and lumbar pain. He continued to treat by way of conservative care in the form of physical therapy, medications, MRI and an injection. On 2/20/09, Dr. Heller released Petitioner from care at MMI to continue his regular work duties. The Arbitrator finds Petitioner's medical records for this accident consistent with one another and all repeatedly reference his work accident as the precipitating cause or factor. Petitioner's history of prior low back pain was far removed from the date of his accident and the Arbitrator finds Petitioner was in a state of good health relative to his low back immediately before this work accident. Respondent has presented no evidence to the contrary. Based on Petitioner's credible testimony and medical records and under a chain of events theory, the Arbitrator concludes that Petitioner's low back/lumbar spine condition is causally related to his work accident of 9/23/08 in case number 10 WC 25058.

2. Date of accident August 31, 2009, claim number 10 WC 25059

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The unrebutted evidence is that on 8/31/09, Petitioner struck his head on a metal beam causing him for either briefly lose consciousness or was dazed for 15 to 20 seconds. The parties did not dispute accident. Petitioner began complaining of cervical/neck pain into the left upper extremity area. Petitioner also began complaining of dizziness, blurred vision and stiffness. Concentra doctors diagnosed cervical strain with possible concussion syndrome. Therapists opined Petitioner's examinations were consistent with the stated diagnosis. Petitioner eventually came under the care of Dr. Cerullo, who suspected concussion, post-concussion syndrome and post-traumatic vertigo. As Petitioner continued to treat, his complaints were that of slurred speech, nausea, blurred vision, memory problems, poor concentration, fatigue and pain. Petitioner then came under the care of Dr. Cherchi, who suspected and diagnosed post-concussive syndrome, vertigo, disequilibrium and cervicalgia. The doctor believed Petitioner's diagnoses were most likely related to his work accident.

Petitioner offered the opinion of Petitioner's physician, Dr. Slack. Dr. Slack diagnosed cervical myofascial pain secondary to the neck and head injury of 8/31/09, with what appears to have been diagnosed as post concussive syndrome. He stated the cervical pain was due to the job injury. Respondent offered the opinion of Dr. Richard Lazar who stated that the only injury Petitioner sustained in the accident was scalp abrasions and a brief cerebral concussion of the most insignificant magnitude. He opined that Petitioner's current complaints were not related to the accident but caused by intense anxiety and personality traits.

In weighing the competing medical opinions, the Arbitrator concludes that Petitioner's current condition of ill-being is causally related to his undisputed work accident based on the credible medical opinions of Drs. Cerullo, Wiet, Cherchi and Slack. The Arbitrator, in adopting these opinions, finds these opinions more

credible and entitled to more weight than the opinions of Dr. Lazar. Petitioner treated extensively with his providers, who conducted a thoughtful and thorough work up of Petitioner's complaints and symptoms; doctors ruled out herniation, impingement and brain injury. They all similarly concluded Petitioner was likely suffering from vertigo and post-concussion syndrome. Post-concussion syndrome was suspected as early as Petitioner's treatment with Concentra as noted in his records. Therapists also believed Petitioner's presentation was consistent with his doctor's diagnoses. Dr. Cherchi reviewed a batter of examinations and concluded Petitioner was suffering from post-concussion syndrome, vertigo and disequilibrium, all likely the result of his work accident. Dr. Lazar, on the other hand, agreed that Petitioner suffered a concussion but declined to find that Petitioner also suffered from post-concussion syndrome. The Arbitrator finds that Petitioner's medical treatment record supports the opposite conclusion. To the extent Dr. Lazar concluded Petitioner's complaints were caused by anxiety and personality traits, the Arbitrator is not persuaded by these opinions as they are neither supported by any medical or psychological record(s) and, as a neurologist, the doctor failed to state how he reached these conclusions on exam and from a neurological point of view. For example, the doctor found no amnesia but failed to persuasively address this statement against Petitioner's documented complaints of memory loss. In another example, the doctor cited lexical processing errors but Petitioner described no word recognition problem. Regarding vertigo, the doctor noted an absence of objective and subjective vertigo but Petitioner gave specific examples of perceived subjective vertigo. Further, Dr. Lazar's opinion ignores VNG/caloric test results.

Based on the temporal course of and onset of symptoms, the circumstances surrounding the onset of symptoms, the character of symptoms, as well as Petitioner's credible testimony and medical record, the Arbitrator concludes Petitioner's current condition of ill-being as it relates to his cervical injury, post-concussion syndrome, vertigo and disequilibrium are causally related to his work accident 8/31/09.

3. Date of accident April 5, 2010, claim number 10 WC 25060

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The unrebutted evidence is that on 4/5/10, Petitioner's right foot was caught under a forklift when he lost his balance and fell backward experiencing immediate pain on the top of his right foot. The parties did not dispute accident at trial. Petitioner again sought treatment with Dr. Paloyan at Concentra who, after MRI, diagnosed possible stress fractures to the right first and second metatarsals and ordered an orthopaedic consult.

Dr. Christos Giannoulias performed the consult and also diagnosed first and second metatarsal fractures. Petitioner was referred to Dr. Simon Lee, who found the MRI was consistent with edema and swelling within the base of the first and second metatarsal consistent with a crush injury, contusion and possible Lisfranc type injury. Dr. Lee opined the MRI was consistent with Petitioner's reported symptoms and radiographs. Petitioner underwent a cortisone injection to the TMT area, was placed in a custom orthotic and CT revealed mild degenerative changes within the mid foot region and insertional posterior tibial tendonitis. In his final visit, Dr. Lee diagnosed post-traumatic degenerative changes through the midfoot and Lisfranc areas. Dr. Lee confirmed his prior diagnosis of status post right foot crush injury with injuries to the right mid foot, first and second and TMT joints. The doctor opined Petitioner's condition was causally related to his 4/5/10 work accident.

Respondent offered the opinions of Drs. Horak and Kodros. Dr. Horak disagreed with Dr. Lee stating that Petitioner suffered from bilateral diffuse psoriatic/osteoarthritis of the TMT and ST joints with left worse than right. He stated Petitioner's right foot condition was unrelated to the accident of 4/5/10. Dr. Kodros diagnosed status-post crush type injury to the dorsal aspect of the right forefoot and midfoot. He reported

associated fractures of the first and second metatarsals by MRI. He stated some of Petitioner's residual complains may be related to a soft tissue component of the injury. He opined that the condition was causally related to the April 2010 accident.

In weighing the opinions, the Arbitrator finds and concludes that the medical opinions of Drs. Giannoulias and Lee are entitled to greater weight when compared to Dr. Horak. Of note, Dr. Lee was initially Respondent's examining doctor and causally related Petitioner's condition to the accident. Similarly, Dr. Kodros found a causal component between Petitioner's condition and the work accident, although he felt residual complaints were more associated with soft tissue injury. In rejecting Dr. Horak's opinion, the Arbitrator notes that Petitioner's right foot injuries and symptoms, whether degenerative as suggested by Dr. Horak, Petitioner was pain and symptom free prior to the date of his accident. Following the accident, Petitioner's immediate onset of symptoms were found consistent with MRI findings and treated accordingly. Accordingly, the Arbitrator finds that Petitioner right foot injuries are causally connected to the accident of 4/5/10.

ISSUE (J) Were the medical services that were provided to Petitioner reasonable and necessary?

1. Date of accident August 31, 2009, claim number 10 WC 25059

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Petitioner only alleged outstanding medical bills in case number 10 WC 25059. Ax2. Having found in favor of Petitioner on the issue of causal connection, the Arbitrator finds Petitioner's medical treatment for his post-concussion syndrome, cervical injury, vertigo and disequilibrium was reasonable and necessary to cure and otherwise relieve Petitioner from his injuries. In so concluding, the Arbitrator finds Petitioner's course of treatment was reasonable and necessary as shown by numerous referrals to specialists in order to specifically address and treat his post-concussion syndrome, vertigo, disequilibrium and cervical injury. Petitioner's medical records demonstrate a medical necessity for these various referrals, testing and treatment. The Arbitrator's conclusion is also supported by Respondent's doctor, Dr. Lazar, who opined that Petitioner's treatment was reasonable and appropriate.

Petitioner submitted a Rush University Medical Group bill for the 7/12/10 visit with Dr. Wiet in the amount of $122.00. Px2:11. Petitioner also submitted the Rush University Medical Center bill for the 9/6/10 audiology testing done by Dr. Wiet at Rush University in the amounts of $2,796.25. Px2:12. Petitioner also submitted the Chicago Dizziness and Hearing bill for an office visit and tests on 9/20/10 and 10/28/10 in the amount of $720.00. Petitioner also submitted the Elite Physical Therapy bill for rehabilitation services ordered by Dr. Wiet from 11/22/10-12/7/10 in the total amount of $2,733.04. The Arbitrator finds the bills contain all necessary data for processing of payment and all bills correspond to dates of service for medical services the Arbitrator has concluded to be reasonable and necessary. No contrary evidence by way of utilization review was presented on the reasonableness or necessity or the amounts charged/billed.

Accordingly, the Arbitrator concludes that Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$6,371.29**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of for medical benefits that have been paid against this award 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.

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ISSUE (K) What temporary benefits are in dispute?

1. Date of accident April 5, 2010, claim number 10 WC 25060

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. At trial, Petitioner only claimed entitlement to temporary benefits for date of accident 4/5/10 in case number 10 WC 25060. Ax3. Specifically, Petitioner claimed entitlement to temporary total disability (TTD) from 5/6/10 through 5/2/11 or 51-5/7th weeks. Respondent asserted Petitioner was only entitled to TTD through 4/14/11. Petitioner also claimed entitlement to maintenance benefits from 5/3/11 through 8/31/15 or 226 weeks. Respondent asserted Petitioner was only entitled to maintenance from 4/1/13 through the present time.

a. Temporary Total Disability Benefits

Medical evidence showed Petitioner was either placed off of work or on light duty restriction from 5/6/10 (date of accident) through 5/2/11, the last date in which Petitioner sought treatment with Dr. Lee. Petitioner testified that he began losing time on 5/26/10, the date on which Respondent no longer offered him work within the restrictions given by his treating doctors for this injury. Respondent asserts Petitioner is only entitled to TTD on through 4/14/11 but provides to evidence why TTD should only be paid through this date, as there is no date of service, no Section 12 exam occurring on this date. Ax3. The Arbitrator finds that Petitioner reached maximum medical improvement MMI for his right foot on 5/2/11, his late date of medical treatment with Dr. Lee and that thereafter; Petitioner's condition reached its state of permanency. The Arbitrator declines to adopt Dr. Horak's opinion that Petitioner has no restriction. Respondent shall pay Petitioner temporary total disability benefits of **$781.89/week** for **48-6/7th** weeks, commencing **5/26/10** through **5/2/11**, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **5/26/10** through **5/2/11**, and shall pay the remainder of the award, if any, in weekly payments. Respondent shall be given a credit of **$38,200.91** for temporary total disability benefits that have been paid. Ax3.

b. Maintenance Benefits

On 5/2/11, Dr. Lee released Petitioner to restrictions of no lifting, carrying, pushing or pulling greater than 25 pounds, limited bending, stooping, squatting activity and alternating sitting and standing 30 minutes per hour, ground level work only and limited ladder and stair climbing. These restrictions were subsequently endorsed by Dr. Kodros, Respondent's examining doctor. Again, the Arbitrator adopts these restrictions as Petitioner's permanent restriction and finds that Petitioner reached MMI on 5/2/11. Petitioner seeks maintenance benefits from 5/3/11 through 8/31/15. However, the Arbitrator notes that between Petitioner's release by Dr. Lee on 5/2/11and the start of vocational placement services on 11/2/13, there appears to have been no placement services implemented, no vocational rehabilitation plan and/or no job search. No explanation for this gap was provided at trial. The Arbitrator declines to award maintenance benefits for this time period.

The evidence further established that Petitioner began vocational rehabilitation services with Brown Rehab through Respondent in November 2013 through April 2016. During this time, over 600 resume/applications were submitted. Petitioner testified did what he was told. The vocational records show that several potential employers expressed interest in Petitioner's resume and Petitioner was interviewed once. Further, the record shows Petitioner otherwise cooperated through-out placement services. Petitioner last participated in vocational services on 6/1/16. Based on the record as a whole, the Arbitrator concludes that Respondent shall pay Petitioner maintenance benefits of **$781.89/week** for **135-6/7th** weeks, commencing

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10/25/13 through **6/1/16**, as provided in Section 8(a) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **10/25/13** through **6/1/16**, and shall pay the remainder of the award, if any, in weekly payments. Respondent shall be given a credit of **$30,575.63** for maintenance benefits that have been paid. Ax3.

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

1. ***Date of accident September 23, 2008, claim number 10 WC 25058***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. As stated above the only specialist opinion of records was provided by Dr. Barbara Heller who diagnosed a left sacroiliac joint strain. Petitioner underwent 5 months of physical therapy, a cortisone injection prior to a release to full duty work. Petitioner complained that he still notices low back pain with extended sitting and standing. The Arbitrator finds this testimony credible and corroborated by Petitioner's later treatment records for his other claims, which noted some back pain. Based on the above, the Arbitrator finds that Petitioner sustained a left sacroiliac joint strain as a result of his 9/23/08 accident, which required the treatment described above. Therefore, Respondent shall pay Petitioner permanent partial disability benefits of **$664.72/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.

2. ***Date of accident August 31, 2009, claim number 10 WC 25059***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found Petitioner's cervical and head injuries causally related to his 8/31/09 work accident, the Arbitrator finds Petitioner's condition has reached a state of permanency. As noted previously, the Arbitrator adopts Petitioner's treatment records and the opinions of Dr. Cherchi, who diagnosed post-concussion syndrome, vertigo, disequilibrium and cervicalgia. The Arbitrator also adopts the opinions of Dr. Slack in determining the nature and extent of Petitioner's injuries. Drs. Cherchi and Slack otherwise released Petitioner to full duty work but Dr. Cherchi cautioned Petitioner should avoid situations that could result in unanticipated loss of equilibrium. At trial, Petitioner testified he continued to experience pain with side-to-side motion of his head and that background movement sometimes cause imbalance. Petitioner did not testify whether his work for Respondent subjected him to unanticipated loss of equilibrium. For the reasons stated above, the Arbitrator finds the opinions of Dr. Cherchi and Dr. Slack more persuasive than Dr. Lazar. In consideration of the above and based on the record as a whole, the Arbitrator finds that Respondent shall pay Petitioner permanent partial disability benefits of **$664.72/week** for **37.50 weeks**, because the injuries sustained caused the **7.5%** loss of the person as a whole, as provided in **Section 8(d)2** of the Act.

3. ***Date of accident April 5, 2010, claim number 25060***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found Petitioner's right foot injuries causally related to his 4/5/10 work accident, the Arbitrator finds Petitioner's condition reached a state of permanency on 5/2/11, the date in which Dr. Lee released Petitioner to work with restrictions.

Dr. Lee diagnosed status post right foot crush injury with injuries to the right mid foot, first and second and TMT joints. He opined Petitioner's condition was causally related to his work accident. Dr. Kodros diagnosed status post crush type injury to the dorsal aspect of the right forefoot and midfoot. He also noted fractures of the first and second metatarsals per MRI. Dr. Kodros stated Petitioner could function within the

restrictions of Dr. Lee's 5/2/11 medical note. For the reasons stated above, the Arbitrator finds the opinions of Dr. Lee and Dr. Kodros more persuasive than the opinion of Dr. Horak.

Petitioner asks the Arbitrator to conclude he is permanently and totally disabled. An employee is totally and permanently disabled when he is unable to make some contribution to industry sufficient to justify the payment of wages. *A.M.T.C. of Illinois v. Indus. Comm'n*, 77 Ill. 2d 482, 487, 397 N.E.2d 804 (1979). If, as in this case, a claimant's disability is of such a nature that he is not obviously unemployable or 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 an "odd-lot" category; that being an individual who, although not altogether incapacitated, is so handicapped that he is not regularly employable in any well-known branch of the labor market. *Valley Mold & Iron Co. v. Indus. Comm'n*, 84 Ill. 2d 538, 546-47, 419 N.E.2d 1159 (1981). A claimant ordinarily satisfies his burden in one of two ways: (1) by showing diligent but unsuccessful attempts to find work; or (2) by showing that, because of his age, skills, training and work history, he will not be regularly employed in a well-known branch of the labor market. *Westin Hotel v. Indus. Comm'n*, 372 Ill. App. 3d 527, 544, 865 N.E.2d 342 (2007). Once a claimant establishes that he falls within an "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.

After careful deliberation, the Arbitrator concludes that Petitioner has failed to prove he is permanently and totally disabled under either theory. First, Petitioner has not shown he has been determined medically totally disabled per any medical record. Second, Petitioner has failed to show that he is so handicapped that he is not regularly employable in any well-known branch of the labor market. In support thereof, the Arbitrator first notes for nearly two years after being released by Dr. Lee, Petitioner failed to engage in any diligent job search efforts. Petitioner offered no explanation at trial. Second, while it is true that over 600 applications were submitted, most were submitted by Brown rather than Petitioner. In addition, Brown rather than Petitioner followed up on a majority of job leads. Petitioner provided few job leads on his own, followed up minimally on potential employment opportunities and went to few job fairs. In this way, Petitioner fails to meet the first prong of the "odd-lot" proof required – diligent but unsuccessful attempts to find work. Regarding the second prong of the "odd-lot" test, Petitioner has failed to show that due to his age, skills, training and/or work history, he will not be regularly employed. Here, Respondent presented a labor market survey demonstrating that Petitioner's qualifications made him eligible to potentially find employment within a range of positions related to Petitioner's specialty. Petitioner's skills and education showed that he has a high school education, an automotive certification and over 30 years of experience in the automotive industry. Of the applications submitted, on many occasions potential employers expressed interest in Petitioner based on qualifications listed in his resume. In the Arbitrator's view, the job searches performed mostly by Brown demonstrate the existence of a stable labor market; all job leads and applications were in Petitioner's industry. To the extent Petitioner did not secure employment, Petitioner has not proven it was due to his age, skills or training and/or work history. On one occasion, Petitioner was nearly offered a position but told the potential employer he would not be able to perform part of the essential job function. On another occasion, an employer related to Brown that they called Petitioner and Petitioner later told Brown he received no such call.

In reviewing Mr. Patsavis' vocational report, the Arbitrator assigns less weight as Petitioner demonstrated transferable skills that, during his time with Brown, led to several employers expressing interest based on those skills and that led to several interviews. Patsavis noted Petitioner's gap in employment but the

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Arbitrator only found one instance out of over 600 applications that an employer expressed or remarked concern regarding same.

In rejecting Petitioner's contention that he is permanently and totally disabled, the Arbitrator concludes that the evidence most demonstrates that Petitioner has suffered a loss of trade. See, *Hubl v. Cert. Installations*, 06 WC 386, 12 IWCC 0176 (Feb. 16, 2012). Here, Petitioner was released with restrictions in 2011 and ultimately did not return to his previous employment with Respondent as a lead mechanic. In consideration of the above and based on the record as a whole, the Arbitrator finds that Respondent shall pay Petitioner permanent partial disability benefits of **$669.64/week** for **200 weeks**, because the injuries sustained caused the **40%** loss of the person as a whole, as provided in **Section 8(d)2** of the Act.

Signature of Arbitrator

8-17-16
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Thomas Santangelo,
Petitioner,
vs.

17IWCC0781
NO: 10 WC 25058

Pepsi Beverages Co.,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 25, 2016 is hereby affirmed and adopted.

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

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 $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: DEC 4 - 2017
KWL/vf
O-10/24/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0781

SANTANGELO, THOMAS
Employee/Petitioner

Case# **10WC025058**

10WC025059
10WC025060

PEPSI BEVERAGES CO
Employer/Respondent

On 8/25/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0328 LEWIS & DAVIDSON
RICHARD SCHOLLENBERGER
ONE N FRANKLIN ST SUITE 1850
CHICAGO, IL 60606

2337 INMAN & FITZGIBBONS LTD
G STEVEN MURDOCK
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

17IWCC0781

THOMAS SANTANGELO,
Employee/Petitioner

v.

PEPSI BEVERAGES, CO.,
Employer/Respondent.

Case # 10 WC 25058

Consolidated cases: 10 WC 25059
10 WC 25060

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **6/9/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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FINDINGS

On **9/23/08**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$60,987.68**; the average weekly wage was **$1,172.84**.

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

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

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

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$0.00**. Respondent is entitled to a credit of **$0.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$664.72/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

8-17-16
Date

AUG 25 2016

FINDINGS OF FACT

A. Date of accident September 23, 2008 claim number 10 WC 25058

Thomas Santangelo ("Petitioner) and Pepsi Beverage Co. ("Respondent") stipulated to an accident of 9/23/08, arising out of an in the course of his employment with Respondent. Ax1. At trial, the parties disputed the issues of causal connection and nature and extent. *Id.* On this date, Petitioner testified that he was removing a heavy frame from a fork lift. The piece began to fall. Petitioner held the frame to prevent it from falling and twisted his low back. After the accident, he felt an onset of low back pain.

Petitioner was seen the same day at Respondent's direction at Concentra Medical Center by Dr. Peter Sorokin and would continue to treat here through 2/20/09. Px1:2-105. Diagnosis was lumbosacral strain and lumbar pain. Petitioner was prescribed medications, light duty and therapy. Therapy for his low back commenced at Concentra on 9/25/08. Thereafter, Petitioner came under the care of Dr. Dan Paloyan at Concentra, who monitored Petitioner's condition while in therapy. Dr. Paloyan diagnosed lumbar strain. On 10/2/08, Petitioner saw Dr. Kathuria, who diagnosed lumbar strain and recommended continued light duty and therapies. Px1:17.

On 10/14/08, Dr. Payolan noted Petitioner had improved symptoms but low back pain was about the same with continued pain down both legs. Petitioner's medical history was positive for prior low back pain 10-20 years earlier requiring therapy. The doctor diagnosed lumbar strain and lumbar radiculopathy. The plan was for an MRI of the lumbar spine. *Id.* at 27. Petitioner was released to light duty and to continued therapies. MRI of the lumbar spine showed minimal disc bulging and early degeneration at L5-S1 and early degenerative changes in the facet joints. Dr. Payolan then referred Petitioner to Dr. Barbara Heller. *Id.* at 40.

On 11/7/08, Petitioner first saw Dr. Heller. Px1:43-44. She noted Petitioner injured his back when he tried to prevent a 160-pound back rest from falling. Petitioner related back pain radiating to the posterior thigh, calf and upper back. He had no numbness or tingling. On exam, lumbar flexion and extension were mildly decreased by left sided low back pain. She noted pain emanated from the left sacral sulcus and positive Patrick's on the left. She noted that lumbar flexion and extension was mildly reduced by left-sided low back pain emanating from the left sacral sulcus. She interpreted the MRI to show mild disc desiccation at L5-S1. Diagnosis was left sacroiliac (SI) joint strain. An injection was recommended. Petitioner was given light duty. Petitioner returned to Dr. Heller and reported relief with the SI joint injection. Dr. Heller recommended regular duty and continued therapy through the end of 2008.

On 1/2/09, Petitioner returned to Dr. Heller. Px1:63. Petitioner's low back symptoms were improved with residual discomfort but had secondary upper back and neck myofascial pain. Assessment was improving SI joint strain and persistent secondary myofascial pain. Additional therapy and full duty was prescribed.

On 1/30/09, Petitioner returned to Dr. Heller. *Id.* at 83. Dr. Heller noted improvement with conservative care and ongoing stiffness. Petitioner completed his physical therapy on 2/19/09. On 2/20/09, Dr. Heller released Petitioner from care, placed him at maximum medical improvement and released him to regular work duties. Px1:105. Petitioner no longer has any low back pain but would continue home exercise. On exam, lumbar flexion and extension were full without discomfort, range of motion was full, Patrick's was negative bilaterally, strength, sensation and reflexes were normal and gait was without deficit. Assessment was resolved SI joint strain.

17IWCC0781

By stipulation Petitioner lost no time from work as a result of this accident. Petitioner testified that as a result of this accident, he continues to suffer low back pain with bending and extended periods of sitting, standing and walking.

B. Date of accident August 31, 2009 claim number 10 WC 25059

The parties stipulated to an accident of 8/31/09, arising out of an in the course of Petitioner's employment with Respondent. Ax2. At trial, the parties disputed the issues of casual connection, medical bills, and nature and extent of the injury. *Id.* Petitioner testified that on this date he struck his head on a metal beam, fell to the ground and may have lost consciousness. He saw the onsite nurse, where he rested then returned to work. When he attempted to return to work, he felt dizzy and left for the day. Petitioner testified he took personal time off without improvement of symptoms.

On 9/18/09, Respondent sent Petitioner to Concentra Medical Center for treatment by Dr. Rolando Garces. Px1:106. It was noted Petitioner did not lose consciousness but was dazed for 15 seconds. Petitioner complained of lower neck pain into the left shoulder, without radiation. Symptoms were exacerbated with neck movement and there was associated stiffness and dizziness. The plan was for cervical spine x-rays, physical therapy and regular duty. Dr. Garces assessed cervical strain.

On 9/22/09, Petitioner followed up at Concentra with Dr. Paloyan. Px1:109. Petitioner reported continued moderate pain in the left side of the neck down to the left shoulder area, aggravated by movement, continued dizziness and blurred vision. He denied radicular symptoms, paresthesias, numbness or weakness. Dr. Paloyan diagnosed cervical strain and possible concussion syndrome. He recommended an MRI of the cervical spine, continued physical therapy and a CT scan if head symptoms continued. That same date, Petitioner began physical therapy for a diagnosis of cervical strain, which would continue through 12/4/09. Px1:111-167. Petitioner reported hitting the left side of his head, decreased range of motion, pain in the left side of the neck and occasional dizziness. The therapist noted that "examination is consistent with the medical diagnosis." Further, the therapist noted that impairments were preventing Petitioner from performing standard activities of daily living and work activities and that therapy was indicated to address same.

On 9/25/09, Dr. Paloyan noted Petitioner remained unchanged and the doctor again recommended an MRI of the cervical spine. Exam showed moderate tenderness to palpation at C5-6, positive Spurling's, pain on extension and lateral flexion and reduced range of motion. Diagnosis was cervical strain, possible post-concussion syndrome and cervical radiculopathy. Petitioner continued with therapy.

On 10/7/09, Petitioner returned to Dr. Paloyan. Petitioner was minimally improved with continued moderate pain on the left side of the neck but with no radicular component. MRI of the cervical spine was negative for herniation and impingement. Petitioner continued with mild dizziness. On 10/12/09, Petitioner returned to Dr. Paloyan stating his pain was slightly improved with physical therapy. He continued with moderate stiffness, aggravated by movement with pain localized to the left side of the neck. Assessment was cervical strain. Dr. Paloyan continued therapy and referred Petitioner to a neurosurgeon.

That same date, Petitioner was seen by neurosurgeon, Dr. Leonard Cerullo. Px1:139. Petitioner described ongoing pain aggravated by hip motion especially left lateral bending and left rotation. He also complained of intermittent left interscapular pain radiating to the left shoulder. He reported constant dizziness exacerbated by movement and exercise, which Dr. Cerullo stated was true vertigo. Petitioner reported word-finding difficulties and feeling "out of it." Dr. Cerullo suspected concussion, post-traumatic syndrome including post-traumatic vertigo. The plan was for therapy and an MRI of the brain. Therapists again noted

Petitioner's condition related to the presenting diagnosis. *Id.* at 146. On 11/4/09, Dr. Cerullo diagnosed post-concussion syndrome with vertigo. He again recommended a brain MRI, possible neurotologic consultation, continued therapy and home exercise.

On 11/11/09, Dr. Cerullo concluded Petitioner's brain MRI was normal. The doctor prescribed medication for unresolved vertigo and recommended continued physical therapy. Petitioner's last physical therapy visit at Concentra was on 12/4/09. At that time, Petitioner's lifting ability was 25 pounds and that he had not met his lifting goal of 50 pounds. Further treatment was held pending medical consultation.

On 12/3/09, Petitioner received a neurotology consult by Dr. Richard Wiet at Rush University Medical Center. Px2. Petitioner provided a history of striking his head on a beam, followed by neck stiffness and unusual visual symptoms. He described that when he looks at an object the background objects move and he experiences imbalance. Petitioner stated that on occasion the symptoms caused him to vomit. He also described occasional slurred speech, memory problems, constant pain in the back of his head and intermittent pain in the left ear. Dr. Wiet recommended an MRI of the internal auditory canals, a contrast MRI of the brain, an audiogram, a VGN, a posturography and rotational chair testing. Contrast MRI of the brain showed nonspecific punctate area of T2 signal change in the left frontal subcortical white matter. Approximately seven months later, on 7/12/10, Petitioner returned to Dr. Wiet and was largely unchanged. The doctor recommended the same tests and flexible laryngoscopy.

On 9/20/10, Petitioner saw Dr. Marcello Cherchi for otoneurology consult at the referral of Dr. Wiet. Px3. Petitioner related he hit his head at work and went down for about 10 minutes. Symptoms included blurred vision, poor concentration, memory loss, fatigue and neck pain with radiation to the left upper extremity. Dr. Cherchi reviewed prior audiogram and noted normal bilateral hearing in low and mid frequencies. In high frequencies, there was asymmetrical hearing loss, right greater than left. Normal canal volume and ear pressure was noted. The doctor noted that prior videonystagmography (VNG) was found to be normal but Dr. Cherchi noted 18% left unilateral caloric weakness. Concomitant with exam, the doctor conducted several tests. A distortion product optoacoustic emissions (DPOAE) test showed some high frequency hearing loss bilaterally, right greater than left, consistent with prior audiogram. Vestibular evoked myogenic potential (VEMP) tests showed 10% left sided weakness within the 35% upper limit of asymmetry. On 9/20/10, Dr. Cherchi performed a rotary chair test, which was normal. He also performed an electrocochleography (ECoG), which showed inconsistent results. Impression was head trauma, followed by exacerbation of pre-existing disequilibrium and by cognitive symptoms of impaired concentration, impaired memory, and fatigue, all in the context of an unremarkable physical examination and otovestibular testing. He suspected and diagnosed post-concussive syndrome as well as vertigo, disequilibrium and cervicalgia. Px3:2,7, 51. Consideration was given for cervical spine MRI, neuropsychological evaluation, therapy for gait, balance and neck and rehab for post-concussive syndrome.

On 11/22/10, Petitioner started therapy for vertigo/disequilibrium at Elite Physical Therapy. Px4. Petitioner reported persistent cervical pain referring to the left upper extremity, constant vertigo with imbalance and visual deficits and impaired short term memory. On 11/29/10, Dr. Cherchi recommended Petitioner avoid tasks and situations in which unanticipated loss of equilibrium would endanger him or others. Px3:62. On 2/16/11, Dr. Cherchi opined that his diagnosis of Petitioner is more likely than not related to the work accident. Px3:63-64.

On 11/24/10, Petitioner was seen by Dr. Richard Lazar at the request of Respondent. Rx6. After a review of history and records, Dr. Lazar documented current complaints of short-term memory loss, visual

difficulties, dizziness, left sided neck pain, numbness, and loss of motion. He described his vision issues as normal central fixation with movement of the background field. Dr. Lazar stated that the treatment rendered to date had been reasonable and appropriate. Dr. Lazar stated that the only injury Petitioner sustained in the accident was scalp abrasions and a brief cerebral concussion of the most insignificant magnitude. He opined that Petitioner's current complaints were not related to the accident but caused by intense anxiety and personality traits. He recommended full duty work and no further treatment.

On 6/15/11, Petitioner was evaluated by Dr. Charles Slack at his attorney's request. Px6. Petitioner described his accident of 8/31/09, ongoing complaints of dizziness, vision difficulties, difficulty balancing, pain with sideways head motion, occasional numbness in the left upper arm, and low back stiffness. On examination, Dr. Slack found pain with lumbar flexion and markedly limited cervical rotation and tilt. Dr. Slack diagnosed cervical myofascial pain secondary to neck and head injury with what appears to have been diagnosed as post concussive syndrome. He stated the cervical pain was due to work accident. Regarding work, Dr. Slack stated the cervical symptoms would be problematic for return to work as a mechanic and deferred his opinion regarding work restriction for the post-concussive syndrome to Petitioner's neurologists.

Petitioner testified that he continues to experience neck pain and loss of cervical motion since the date of accident. He also testified that he continues to notice the movement of background objects and resulting dizziness.

C. Date of accident April 5, 2010 claim number 10 WC 25060

The parties stipulated to an accident of 4/5/10, arising out of an in the course of Petitioner's employment with Respondent. Ax3. At trial, the parties disputed the issues of casual connection, temporary total disability, maintenance and nature and extent of the injury. *Id.* On this date, Petitioner's right foot got stuck under a forklift and he lost his balance falling backward. He testified he felt an onset of pain on the top of his right foot.

On 4/6/10, Petitioner was sent by Respondent to Concentra and seen by Dr. Paloyan and would continue to treat there through 9/15/10. Px1:168-286. Dr. Paloyan noted Petitioner's accident and major crush injury with resulting searing pain. Dr. Paloyan found tenderness to palpation of the right foot with minimal swelling and erythema. Right foot x-rays at that time showed no fractures. He ordered physical therapy and work restrictions including 80% sitting. Assessment was right foot contusion. Petitioner returned on 4/8/10 and plans and recommendations were unchanged.

On 4/19/10, Petitioner returned to Dr. Paloyan stating he had been working within the restrictions and that his right foot remained moderately sore and was aggravated by movement. Petitioner was tender to palpation over the dorsal aspect of the 2nd metatarsal. The doctor assessed contusion with possible sprain. Dr. Paloyan again recommended therapy and work restrictions to 70% sitting. On 4/29/10, Petitioner described the same complaints and Dr. Paloyan changed his restrictions to 25% sitting. During this time, Petitioner continued to work within his duty restrictions.

On 5/11/10, Dr. Paloyan noted continued moderate tenderness to palpation on the dorsal aspect over the 2nd metatarsal. Petitioner reported he was on regular duty without any problems or pain. Px1:209. Exam was unchanged. The doctor assessed contusion with possible ligament or occult bone injury. Petitioner was released to modified duty with 25% sitting. X-rays were again negative. An MRI was ordered and showed suspected stress type fractures within the base of the 1st metatarsal with bone marrow edema. Bone marrow edema was identified in the 2nd metatarsal. Dr. Paloyan reviewed the MRI and diagnosed possible stress fractures to the

right 1st and 2nd metatarsals. The doctor ordered an immediate orthopaedic consult. On 5/20, Petitioner was released to return to work with sitting 100% of the time.

On 5/26/10, Petitioner was seen at Concentra by orthopaedic surgeon, Dr. Christos Giannoulias. The doctor diagnosed 1st and 2nd metatarsal fractures. He ordered a cast shoe and 100% sitting work. Petitioner testified that as of this date work was no longer proved by Respondent.

On 6/23/10, Dr. Giannoulias ordered supervised physical therapy and continued sedentary duty. Assessment was metatarsal fracture. New x-rays failed to identify fracture. Petitioner began therapies for the right foot at Concentra through 7/19/10. Px1:242-257.

On 7/21/10, Petitioner returned to Dr. Giannoulias and reported 50-60% improvement but complained on neck and back pain. Exam of the foot showed stiffness with dorsiflexion of the great toe and mild tenderness of the 1st and 2nd ray. Dr. Giannoulias recommended continued therapy including therapy for the neck and back. Petitioner was released to modified duty with sitting 90% of the time. Therapy for the foot continued. Petitioner reported continued difficulty with weight bearing and that work could not be accommodated.

On 8/18/10, Dr. Giannoulias noted Petitioner had not started the recommended neck and back treatment. He also noted right foot problems including difficulty with plantar flexion and tenderness over the midfoot. Petitioner complained of pain and stiffness over the dorsum of the foot. Dr. Giannoulias recommended a consult with Dr. Simon Lee and possible cortisone injection. The doctor noted Petitioner appeared to have a healed fracture and that Petitioner had some degenerative changes in the midfoot which may be causing the pain he has. Assessment was midfoot pain and metatarsal fracture. Restrictions continued.

On 9/13/10, Dr. Simon Lee first saw Petitioner as a Section 12 doctor for Respondent. Px5:9-10. The doctor wrote that Petitioner's right foot was run over at work in May 2010. The doctor noted Petitioner's prior medical history and noted review of symptoms were non-contributory. Petitioner's right foot complaints at that time were significant pain and dysfunction of the right foot especially with prolonged weight bearing or ambulatory activity or flexion or extension of the foot. Exam of the right showed decreased medial longitudinal arch pronation of the hind-foot and full dorsiflexion, plantar flexion, range of motion of the ankle. Dr. Lee found significant pain with attempts at dorsiflexion, plantar flexion, or supination and pronation of the mid-foot. A majority of pain and discomfort was localized and specific to the medial mid-foot within the region of the TMT joints over the mid-foot, 1st and 3rd. X-rays showed concern for calcification within the base of the first and second TMT joint with possible minimal incongruity between the bases. Diagnosis was status-post right foot crush injury with possible Lisfranc injury or post-traumatic arthropathy. Dr. Lee also noted a component of neuritis, possibly related to the crush injury but he was unsure whether this was related to a deep peroneal nerve injury or superficial peroneal nerve as it was difficult to differentiate between traumatic arthropathy and injury to the TMT joint line without further study. On 9/15/10, Dr. Giannoulias released Petitioner to Dr. Lee. Px1:281.

On 9/28/10, Dr. Lee issued an addendum opinion after reviewing the May 2010 right foot/ankle MRI report and films. Px5. The doctor concluded it was consistent with edema and swelling within the base of the 1st and 2nd metatarsal consistent with crush injury, contusion and Lisfranc type injury. The doctor found the report consistent with symptoms and radiographs. Recommendations were unchanged and the doctor added recommendation for a cortisone injection.

On 12/14/10, Dr. Lee noted Petitioner's symptoms were unchanged and he continued to complain of pain with weight-bearing over the dorsal mid-arch of his foot and generalized sensitivity that radiated to the toes. Px5. He was not in active treatment and was not working. Exam was unchanged and the doctor noted pain with stressing, inversion, eversion, supination, pronation and direct palpation. He had positive Tinel's radiating to the digits. A cortisone injection was administered into the first and second TMT and inter-cuneiform joint line. Sit down sedentary work was continued.

On 1/24/11, Petitioner returned to Dr. Lee stating that initially he had no improvement after the injections but several days later notice 70% improvement. Px5, Rx1. Subsequently the pain returned while pushing off with his foot from a sitting to standing position. Petitioner continued with at least a first TMT instability. Dr. Lee stated that as a result of the continued significant functional limitations and pain, he recommended a custom orthotic with a turned toe plate for further stiffening and a CT scan. Petitioner remained on light duty. CT showed mild degenerative changes within the mid foot region and insertional posterior tibial tendonitis. Dr. Lee continued to recommend a custom orthotic. On 3/2/11, Petitioner's work restrictions were continued by Dr. Lee.

On 3/29/11, Petitioner was evaluated by Dr. Horak at the request of Respondent. Rx2. The doctor noted Petitioner presented with a frustrated victimized attitude. He noted Dr. Lee incorrectly noted a crush injury and stated the injury was in fact a plantar flexory injury. He noted Petitioner had an exaggerated response to light touch. Tinel's was non-specifically positive on all tested sites of the right lower extremity. Range of motion was normal and produced non-specific pain on testing. Dr. Horak diagnosed bilateral diffuse psoriatic/osteoarthritis of the TMT and ST joints, left worse than right. The doctor concluded Petitioner's right foot condition was unrelated to the accident of 4/5/10 and no work restrictions were indicated.

On 5/2/11, Petitioner returned to Dr. Lee. Px5. He had been using his orthotic for one month. Petitioner continued with post-traumatic degenerative changes through the midfoot and Lisfranc areas. Diagnosis was status post right foot crush injury with injuries to the right mid foot, first and second and Lisfranc TMT joints. The doctor opined directly causation between the condition and the work accident. Petitioner did not wish to pursue additional treatment and continued with some lower functional limitations and disability. Dr. Lee released Petitioner from care with restrictions of no lifting, carrying, pushing, pulling greater than 25 pounds, limited bending, stooping, squatting activity, and alternating sitting and standing 30 minutes per hour, ground level work only, limited ladder and stair climbing.

On 3/27/13, Petitioner was then evaluated by Dr. Kodros at the request of Respondent. Rx3. The doctor took Petitioner's accident history and reviewed records. Petitioner's chief complaint was balance issues. X-rays taken at exam failed to show any previous fractures. The doctor noted there was no evidence of a prior Lisfranc injury. He noted ongoing residual symptoms likely related to the soft tissue component of Petitioner's injury and the doctor offered that he had no ready explanation for Petitioner's ongoing residual right foot complaints. The doctor performed an exam and his impression was status post crush type injury to the dorsal aspect of the right forefoot and midfoot. He opined that the condition was causally related to the April 2010 accident. Dr. Kodros recommended use of stiff shoes with inserts and recommended against further injections, supervised therapy and surgery. With respect to activity, Dr. Kodros stated Petitioner can function within the restrictions of Dr. Lee's 5/2/11 note.

On 9/19/13, Sandra Brown ("Brown") of Brown Rehab Review performed a labor market survey without contact with Petitioner. Rx4. She contacted 8 potential employers and concluded Petitioner had an earning capacity of $68,740.00 and that the salary range for the jobs located was $26,807.00 to $68,740 with an average

salary of $47,4773.50. On 10/7/13, Brown developed a vocational rehabilitation plan consisting of job seeking skills training, a documented job search, job development log sheets, following up on job leads, meeting with Brown, interviewing, establishing a resume, maintaining telephone contact with potential employers and accepting valid job offers.

Petitioner met with Brown from 11/2/13 through 4/10/16 for vocational evaluation and placement services with. Rx4. Petitioner stated he had sedentary restrictions and that due to union affiliations he could no longer work in the automotive industry. Ms. Horn noted both Dr. Horak's and Dr. Lee's return to work restrictions. She noted Petitioner had a high school education, auto industry certification and worked as a mechanic for the last 30 years, considered to be heavy. She concluded that based on transferrable skills, Petitioner could diagnose, read job orders and would still be capable of handling certain positions in his field which are still within his current physical demands. Based on this and a recent labor market survey, she concluded there was a good possibility Petitioner could find employment in his current field, physical demand level and skill level. She recommended job placement within his current field of expertise.

Starting 10/25/13, Petitioner and Brown met on a weekly basis for job placement. Rx4. Petitioner was given job seeking skills training and Brown submitted resumes for employment starting December 2013. In March 2014, Brown broadened the job search to include other employment opportunities and advised Petitioner about presentation, attire and preparation. Brown generated vocational progress reports showing that over 600 applications/resumes were submitted. During this time, Petitioner submitted some job leads, attending some job fairs and had several telephone or in-person interviews. Brown advised Petitioner about his role in the search process and asked him to provide leads. She also recommended he take free computer classes offered at the local library to aid in his job search efforts. Petitioner received some phone calls expressing interest and underwent some interviews. Brown generated a rehabilitation closure report and concluded that based on Petitioner's recent labor market survey and transferrable skills analysis, there was a good possibility he could establish gainful employment within his current expertise, physical demand level and skill level. Rx5. Petitioner last saw Brown on 6/1/16.

On 8/31/15, Petitioner was evaluated by his own vocational expert, David Patsavis. Px7. He confirmed that Petitioner graduated high school in 1971 and was then currently 63 years old. He noted that from 1980 to 2011 Petitioner worked for Pepsi as a lead mechanic. Mr. Patsavis concluded that given the fact that Petitioner has not worked during the past 5 years and has limited transferable skills, as well as unsuccessful Job Placement Activities for the past two years, it was his opinion that Petitioner would be an odd lot or permanently and totally disabled. He concluded that a viable and stable labor market does not exist for Petitioner.

Petitioner testified that he continues to have pain in his right foot with extended standing and walking. He also testified that he continues to require a shoe orthotic.

CONCLUSIONS OF LAW

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

1. Date of accident September 23, 2008, claim number 10 WC 25058

The unrebutted evidence is that on 9/23/08, Petitioner caught a heavy frame falling from a fork lift and felt a sudden onset of low back pain. He was evaluated the same day at Respondent's direction by Dr. Sorokin at Concentra Medical Center who diagnosed a lumbosacral strain and lumbar pain. He continued to treat by

way of conservative care in the form of physical therapy, medications, MRI and an injection. On 2/20/09, Dr. Heller released Petitioner from care at MMI to continue his regular work duties. The Arbitrator finds Petitioner's medical records for this accident consistent with one another and all repeatedly reference his work accident as the precipitating cause or factor. Petitioner's history of prior low back pain was far removed from the date of his accident and the Arbitrator finds Petitioner was in a state of good health relative to his low back immediately before this work accident. Respondent has presented no evidence to the contrary. Based on Petitioner's credible testimony and medical records and under a chain of events theory, the Arbitrator concludes that Petitioner's low back/lumbar spine condition is causally related to his work accident of 9/23/08 in case number 10 WC 25058.

2. ***Date of accident August 31, 2009, claim number 10 WC 25059***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The unrebutted evidence is that on 8/31/09, Petitioner struck his head on a metal beam causing him for either briefly lose consciousness or was dazed for 15 to 20 seconds. The parties did not dispute accident. Petitioner began complaining of cervical/neck pain into the left upper extremity area. Petitioner also began complaining of dizziness, blurred vision and stiffness. Concentra doctors diagnosed cervical strain with possible concussion syndrome. Therapists opined Petitioner's examinations were consistent with the stated diagnosis. Petitioner eventually came under the care of Dr. Cerullo, who suspected concussion, post-concussion syndrome and post-traumatic vertigo. As Petitioner continued to treat, his complaints were that of slurred speech, nausea, blurred vision, memory problems, poor concentration, fatigue and pain. Petitioner then came under the care of Dr. Cherchi, who suspected and diagnosed post-concussive syndrome, vertigo, disequilibrium and cervicalgia. The doctor believed Petitioner's diagnoses were most likely related to his work accident.

Petitioner offered the opinion of Petitioner's physician, Dr. Slack. Dr. Slack diagnosed cervical myofascial pain secondary to the neck and head injury of 8/31/09, with what appears to have been diagnosed as post concussive syndrome. He stated the cervical pain was due to the job injury. Respondent offered the opinion of Dr. Richard Lazar who stated that the only injury Petitioner sustained in the accident was scalp abrasions and a brief cerebral concussion of the most insignificant magnitude. He opined that Petitioner's current complaints were not related to the accident but caused by intense anxiety and personality traits.

In weighing the competing medical opinions, the Arbitrator concludes that Petitioner's current condition of ill-being is causally related to his undisputed work accident based on the credible medical opinions of Drs. Cerullo, Wiet, Cherchi and Slack. The Arbitrator, in adopting these opinions, finds these opinions more credible and entitled to more weight than the opinions of Dr. Lazar. Petitioner treated extensively with his providers, who conducted a thoughtful and thorough work up of Petitioner's complaints and symptoms; doctors ruled out herniation, impingement and brain injury. They all similarly concluded Petitioner was likely suffering from vertigo and post-concussion syndrome. Post-concussion syndrome was suspected as early as Petitioner's treatment with Concentra as noted in his records. Therapists also believed Petitioner's presentation was consistent with his doctor's diagnoses. Dr. Cherchi reviewed a batter of examinations and concluded Petitioner was suffering from post-concussion syndrome, vertigo and disequilibrium, all likely the result of his work accident. Dr. Lazar, on the other hand, agreed that Petitioner suffered a concussion but declined to find that Petitioner also suffered from post-concussion syndrome. The Arbitrator finds that Petitioner's medical treatment record supports the opposite conclusion. To the extent Dr. Lazar concluded Petitioner's complaints were caused by anxiety and personality traits, the Arbitrator is not persuaded by these opinions as they are neither supported by any medical or psychological record(s) and, as a neurologist, the doctor failed to state how he reached these conclusions on exam and from a neurological point of view. For example, the doctor found no amnesia but failed to persuasively address this statement against Petitioner's documented complaints of memory

loss. In another example, the doctor cited lexical processing errors but Petitioner described no word recognition problem. Regarding vertigo, the doctor noted an absence of objective and subjective vertigo but Petitioner gave specific examples of perceived subjective vertigo. Further, Dr. Lazar's opinion ignores VNG/caloric test results.

Based on the temporal course of and onset of symptoms, the circumstances surrounding the onset of symptoms, the character of symptoms, as well as Petitioner's credible testimony and medical record, the Arbitrator concludes Petitioner's current condition of ill-being as it relates to his cervical injury, post-concussion syndrome, vertigo and disequilibrium are causally related to his work accident 8/31/09.

3. Date of accident April 5, 2010, claim number 10 WC 25060

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The unrebutted evidence is that on 4/5/10, Petitioner's right foot was caught under a forklift when he lost his balance and fell backward experiencing immediate pain on the top of his right foot. The parties did not dispute accident at trial. Petitioner again sought treatment with Dr. Paloyan at Concentra who, after MRI, diagnosed possible stress fractures to the right first and second metatarsals and ordered an orthopaedic consult.

Dr. Christos Giannoulias performed the consult and also diagnosed first and second metatarsal fractures. Petitioner was referred to Dr. Simon Lee, who found the MRI was consistent with edema and swelling within the base of the first and second metatarsal consistent with a crush injury, contusion and possible Lisfranc type injury. Dr. Lee opined the MRI was consistent with Petitioner's reported symptoms and radiographs. Petitioner underwent a cortisone injection to the TMT area, was placed in a custom orthotic and CT revealed mild degenerative changes within the mid foot region and insertional posterior tibial tendonitis. In his final visit, Dr. Lee diagnosed post-traumatic degenerative changes through the midfoot and Lisfranc areas. Dr. Lee confirmed his prior diagnosis of status post right foot crush injury with injuries to the right mid foot, first and second and TMT joints. The doctor opined Petitioner's condition was causally related to his 4/5/10 work accident.

Respondent offered the opinions of Drs. Horak and Kodros. Dr. Horak disagreed with Dr. Lee stating that Petitioner suffered from bilateral diffuse psoriatic/osteoarthritis of the TMT and ST joints with left worse than right. He stated Petitioner's right foot condition was unrelated to the accident of 4/5/10. Dr. Kodros diagnosed status-post crush type injury to the dorsal aspect of the right forefoot and midfoot. He reported associated fractures of the first and second metatarsals by MRI. He stated some of Petitioner's residual complains may be related to a soft tissue component of the injury. He opined that the condition was causally related to the April 2010 accident.

In weighing the opinions, the Arbitrator finds and concludes that the medical opinions of Drs. Giannoulias and Lee are entitled to greater weight when compared to Dr. Horak. Of note, Dr. Lee was initially Respondent's examining doctor and causally related Petitioner's condition to the accident. Similarly, Dr. Kodros found a causal component between Petitioner's condition and the work accident, although he felt residual complaints were more associated with soft tissue injury. In rejecting Dr. Horak's opinion, the Arbitrator notes that Petitioner's right foot injuries and symptoms, whether degenerative as suggested by Dr. Horak, Petitioner was pain and symptom free prior to the date of his accident. Following the accident, Petitioner's immediate onset of symptoms were found consistent with MRI findings and treated accordingly. Accordingly, the Arbitrator finds that Petitioner right foot injuries are causally connected to the accident of 4/5/10.

ISSUE (J) Were the medical services that were provided to Petitioner reasonable and necessary?

1. Date of accident August 31, 2009, claim number 10 WC 25059

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Petitioner only alleged outstanding medical bills in case number 10 WC 25059. Ax2. Having found in favor of Petitioner on the issue of causal connection, the Arbitrator finds Petitioner's medical treatment for his post-concussion syndrome, cervical injury, vertigo and disequilibrium was reasonable and necessary to cure and otherwise relieve Petitioner from his injuries. In so concluding, the Arbitrator finds Petitioner's course of treatment was reasonable and necessary as shown by numerous referrals to specialists in order to specifically address and treat his post-concussion syndrome, vertigo, disequilibrium and cervical injury. Petitioner's medical records demonstrate a medical necessity for these various referrals, testing and treatment. The Arbitrator's conclusion is also supported by Respondent's doctor, Dr. Lazar, who opined that Petitioner's treatment was reasonable and appropriate.

Petitioner submitted a Rush University Medical Group bill for the 7/12/10 visit with Dr. Wiet in the amount of $122.00. Px2:11. Petitioner also submitted the Rush University Medical Center bill for the 9/6/10 audiology testing done by Dr. Wiet at Rush University in the amounts of $2,796.25. Px2:12. Petitioner also submitted the Chicago Dizziness and Hearing bill for an office visit and tests on 9/20/10 and 10/28/10 in the amount of $720.00. Petitioner also submitted the Elite Physical Therapy bill for rehabilitation services ordered by Dr. Wiet from 11/22/10-12/7/10 in the total amount of $2,733.04. The Arbitrator finds the bills contain all necessary data for processing of payment and all bills correspond to dates of service for medical services the Arbitrator has concluded to be reasonable and necessary. No contrary evidence by way of utilization review was presented on the reasonableness or necessity or the amounts charged/billed.

Accordingly, the Arbitrator concludes that Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$6,371.29**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of for medical benefits that have been paid against this award 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?

1. Date of accident April 5, 2010, claim number 10 WC 25060

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. At trial, Petitioner only claimed entitlement to temporary benefits for date of accident 4/5/10 in case number 10 WC 25060. Ax3. Specifically, Petitioner claimed entitlement to temporary total disability (TTD) from 5/6/10 through 5/2/11 or 51-5/7th weeks. Respondent asserted Petitioner was only entitled to TTD through 4/14/11. Petitioner also claimed entitlement to maintenance benefits from 5/3/11 through 8/31/15 or 226 weeks. Respondent asserted Petitioner was only entitled to maintenance from 4/1/13 through the present time.

a. Temporary Total Disability Benefits

Medical evidence showed Petitioner was either placed off of work or on light duty restriction from 5/6/10 (date of accident) through 5/2/11, the last date in which Petitioner sought treatment with Dr. Lee. Petitioner testified that he began losing time on 5/26/10, the date on which Respondent no longer offered him work within the restrictions given by his treating doctors for this injury. Respondent asserts Petitioner is only entitled to TTD on through 4/14/11 but provides to evidence why TTD should only be paid through this date, as

there is no date of service, no Section 12 exam occurring on this date. Ax3. The Arbitrator finds that Petitioner reached maximum medical improvement MMI for his right foot on 5/2/11, his late date of medical treatment with Dr. Lee and that thereafter; Petitioner's condition reached its state of permanency. The Arbitrator declines to adopt Dr. Horak's opinion that Petitioner has no restriction. Respondent shall pay Petitioner temporary total disability benefits of **$781.89/week** for **48-6/7th** weeks, commencing **5/26/10** through **5/2/11**, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **5/26/10** through **5/2/11**, and shall pay the remainder of the award, if any, in weekly payments. Respondent shall be given a credit of **$38,200.91** for temporary total disability benefits that have been paid. Ax3.

b. Maintenance Benefits

On 5/2/11, Dr. Lee released Petitioner to restrictions of no lifting, carrying, pushing or pulling greater than 25 pounds, limited bending, stooping, squatting activity and alternating sitting and standing 30 minutes per hour, ground level work only and limited ladder and stair climbing. These restrictions were subsequently endorsed by Dr. Kodros, Respondent's examining doctor. Again, the Arbitrator adopts these restrictions as Petitioner's permanent restriction and finds that Petitioner reached MMI on 5/2/11. Petitioner seeks maintenance benefits from 5/3/11 through 8/31/15. However, the Arbitrator notes that between Petitioner's release by Dr. Lee on 5/2/11and the start of vocational placement services on 11/2/13, there appears to have been no placement services implemented, no vocational rehabilitation plan and/or no job search. No explanation for this gap was provided at trial. The Arbitrator declines to award maintenance benefits for this time period.

The evidence further established that Petitioner began vocational rehabilitation services with Brown Rehab through Respondent in November 2013 through April 2016. During this time, over 600 resume/applications were submitted. Petitioner testified did what he was told. The vocational records show that several potential employers expressed interest in Petitioner's resume and Petitioner was interviewed once. Further, the record shows Petitioner otherwise cooperated through-out placement services. Petitioner last participated in vocational services on 6/1/16. Based on the record as a whole, the Arbitrator concludes that Respondent shall pay Petitioner maintenance benefits of **$781.89/week** for **135-6/7th** weeks, commencing **10/25/13** through **6/1/16**, as provided in Section 8(a) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **10/25/13** through **6/1/16**, and shall pay the remainder of the award, if any, in weekly payments. Respondent shall be given a credit of **$30,575.63** for maintenance benefits that have been paid. Ax3.

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

1. Date of accident September 23, 2008, claim number 10 WC 25058

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. As stated above the only specialist opinion of records was provided by Dr. Barbara Heller who diagnosed a left sacroiliac joint strain. Petitioner underwent 5 months of physical therapy, a cortisone injection prior to a release to full duty work. Petitioner complained that he still notices low back pain with extended sitting and standing. The Arbitrator finds this testimony credible and corroborated by Petitioner's later treatment records for his other claims, which noted some back pain. Based on the above, the Arbitrator finds that Petitioner sustained a left sacroiliac joint strain as a result of his 9/23/08 accident, which required the treatment described above. Therefore, Respondent shall pay Petitioner permanent partial disability benefits of **$664.72/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.

2. Date of accident August 31, 2009, claim number 10 WC 25059

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found Petitioner's cervical and head injuries causally related to his 8/31/09 work accident, the Arbitrator finds Petitioner's condition has reached a state of permanency. As noted previously, the Arbitrator adopts Petitioner's treatment records and the opinions of Dr. Cherchi, who diagnosed post-concussion syndrome, vertigo, disequilibrium and cervicalgia. The Arbitrator also adopts the opinions of Dr. Slack in determining the nature and extent of Petitioner's injuries. Drs. Cherchi and Slack otherwise released Petitioner to full duty work but Dr. Cherchi cautioned Petitioner should avoid situations that could result in unanticipated loss of equilibrium. At trial, Petitioner testified he continued to experience pain with side-to-side motion of his head and that background movement sometimes cause imbalance. Petitioner did not testify whether his work for Respondent subjected him to unanticipated loss of equilibrium. For the reasons stated above, the Arbitrator finds the opinions of Dr. Cherchi and Dr. Slack more persuasive than Dr. Lazar. In consideration of the above and based on the record as a whole, the Arbitrator finds that Respondent shall pay Petitioner permanent partial disability benefits of **$664.72/week** for **37.50 weeks**, because the injuries sustained caused the **7.5%** loss of the person as a whole, as provided in **Section 8(d)2** of the Act.

3. Date of accident April 5, 2010, claim number 25060

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found Petitioner's right foot injuries causally related to his 4/5/10 work accident, the Arbitrator finds Petitioner's condition reached a state of permanency on 5/2/11, the date in which Dr. Lee released Petitioner to work with restrictions.

Dr. Lee diagnosed status post right foot crush injury with injuries to the right mid foot, first and second and TMT joints. He opined Petitioner's condition was causally related to his work accident. Dr. Kodros diagnosed status post crush type injury to the dorsal aspect of the right forefoot and midfoot. He also noted fractures of the first and second metatarsals per MRI. Dr. Kodros stated Petitioner could function within the restrictions of Dr. Lee's 5/2/11 medical note. For the reasons stated above, the Arbitrator finds the opinions of Dr. Lee and Dr. Kodros more persuasive than the opinion of Dr. Horak.

Petitioner asks the Arbitrator to conclude he is permanently and totally disabled. An employee is totally and permanently disabled when he is unable to make some contribution to industry sufficient to justify the payment of wages. *A.M.T.C. of Illinois v. Indus. Comm'n*, 77 Ill. 2d 482, 487, 397 N.E.2d 804 (1979). If, as in this case, a claimant's disability is of such a nature that he is not obviously unemployable or 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 an "odd-lot" category; that being an individual who, although not altogether incapacitated, is so handicapped that he is not regularly employable in any well-known branch of the labor market. *Valley Mold & Iron Co. v. Indus. Comm'n*, 84 Ill. 2d 538, 546-47, 419 N.E.2d 1159 (1981). A claimant ordinarily satisfies his burden in one of two ways: (1) by showing diligent but unsuccessful attempts to find work; or (2) by showing that, because of his age, skills, training and work history, he will not be regularly employed in a well-known branch of the labor market. *Westin Hotel v. Indus. Comm'n*, 372 Ill. App. 3d 527, 544, 865 N.E.2d 342 (2007). Once a claimant establishes that he falls within an "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.

After careful deliberation, the Arbitrator concludes that Petitioner has failed to prove he is permanently and totally disabled under either theory. First, Petitioner has not shown he has been determined medically totally disabled per any medical record. Second, Petitioner has failed to show that he is so handicapped that he

is not regularly employable in any well-known branch of the labor market. In support thereof, the Arbitrator first notes for nearly two years after being released by Dr. Lee, Petitioner failed to engage in any diligent job search efforts. Petitioner offered no explanation at trial. Second, while it is true that over 600 applications were submitted, most were submitted by Brown rather than Petitioner. In addition, Brown rather than Petitioner followed up on a majority of job leads. Petitioner provided few job leads on his own, followed up minimally on potential employment opportunities and went to few job fairs. In this way, Petitioner fails to meet the first prong of the "odd-lot" proof required – diligent but unsuccessful attempts to find work. Regarding the second prong of the "odd-lot" test, Petitioner has failed to show that due to his age, skills, training and/or work history, he will not be regularly employed. Here, Respondent presented a labor market survey demonstrating that Petitioner's qualifications made him eligible to potentially find employment within a range of positions related to Petitioner's specialty. Petitioner's skills and education showed that he has a high school education, an automotive certification and over 30 years of experience in the automotive industry. Of the applications submitted, on many occasions potential employers expressed interest in Petitioner based on qualifications listed in his resume. In the Arbitrator's view, the job searches performed mostly by Brown demonstrate the existence of a stable labor market; all job leads and applications were in Petitioner's industry. To the extent Petitioner did not secure employment, Petitioner has not proven it was due to his age, skills or training and/or work history. On one occasion, Petitioner was nearly offered a position but told the potential employer he would not be able to perform part of the essential job function. On another occasion, an employer related to Brown that they called Petitioner and Petitioner later told Brown he received no such call.

In reviewing Mr. Patsavis' vocational report, the Arbitrator assigns less weight as Petitioner demonstrated transferable skills that, during his time with Brown, led to several employers expressing interest based on those skills and that led to several interviews. Patsavis noted Petitioner's gap in employment but the Arbitrator only found one instance out of over 600 applications that an employer expressed or remarked concern regarding same.

In rejecting Petitioner's contention that he is permanently and totally disabled, the Arbitrator concludes that the evidence most demonstrates that Petitioner has suffered a loss of trade. See, *Hubl v. Cert. Installations*, 06 WC 386, 12 IWCC 0176 (Feb. 16, 2012). Here, Petitioner was released with restrictions in 2011 and ultimately did not return to his previous employment with Respondent as a lead mechanic. In consideration of the above and based on the record as a whole, the Arbitrator finds that Respondent shall pay Petitioner permanent partial disability benefits of **$669.64/week** for **200 weeks**, because the injuries sustained caused the **40%** loss of the person as a whole, as provided in **Section 8(d)2** of the Act.

Signature of Arbitrator

8-17-16
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DARNELL KEEL,

Petitioner,

17IWCC0782

vs. NO: 14 WC 30108

CITY OF HARVEY,

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 medical expenses 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.

On August 19, 2014, Petitioner, a detective with the City of Harvey Police Department, sustained a gunshot wound to his right arm while assisting a fellow officer respond to a 911 call. He subsequently treated at Advocate Christ Medical Center where he was diagnosed with a fractured ulna. The following day, on August 20, 2014, Dr. Michael Weisburger performed an open reduction and internal fixation to treat the fractured fibula. Petitioner was discharged the day after the surgery on August 21, 2014.

Post-discharge, Petitioner continued to treat with Dr. Weisburger at Midwest Orthopaedic Consultants, S.C. After five months of medical treatment and occupational therapy, also undertaken at Midwest Orthopaedic Consultants, Petitioner was released to return to work without restrictions effective January 23, 2015.

The Commission takes notice that the progress note written by Dr. Weisburger on January 22, 2015, that released Petitioner back to work without restrictions contained the

notation that Petitioner was healed enough to go back to full activities. Despite what is interpreted by the Commission as incomplete healing, that same note declared Petitioner to be at maximum medical improvement.

Though Petitioner discontinued treatment with Dr. Weisburger, Petitioner, testifying before Arbitrator Simpson, indicated that he experiences occasional pain in his right arm, that the upper portion of his right arm is numb, that his right arm occasionally tingles, and to being unable to lift more than fifty (50) pounds with his right arm. He also testified to still being unable to close his small finger and now holding his service weapon in his left hand though his right hand is his dominant hand. These residual complaints indicate, as Dr. Weisburger implied in his January 22, 2015, progress note, that Petitioner still, as of the date of the arbitration hearing was still had deficiencies attributable to his being shot on August 19, 2014.

The Decision of the Arbitrator discussed Petitioner's testimony concerning diminished right arm strength, continuing pain in Petitioner's right arm, and Petitioner's having to use his service weapon in his left hand rather than in his dominant right hand due to his inability to full contract the small finger in his right hand. The Decision of the Arbitrator, however, failed to discuss the numbness and the tingling Petitioner continued to experience. For that reason, the Commission finds Petitioner to be worse off than as found in the Decision of the Arbitrator. The Commission believes Petitioner to have lost 30% of his right arm due to the injury he sustained on August 19, 2014.

As this injury occurred after September 1, 2011, Section 8.1b(b) of the Act requires that five (5) factors be considered when determining the nature and extent of an injured worker's permanent disability. These factors are: 1) Any expressed AMA impairment rating; 2) the injured worker's occupation; 3) the age of the injured worker at the time of the injury; 4) the injured worker's future earning capacity; and 5) evidence of any disability corroborated by the treating medical records. The Commission notes the Decision of the Arbitrator contains the statutorily-mandated application of the five (5) factors and concurs with said application.

The Commission, after reviewing the evidence, affirms and adopts all aspects of the Decision of the Arbitrator except with respect to the degree Petitioner has been permanently disabled.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $735.37 per week for a period of 75.9 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 30% loss of use of the right arm.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Advocate Medical Group the sum of $142.00 pursuant to the Medical Fee Schedule or previous agreement, whichever is less, pursuant to Section 8(a) and Section 8.2 of the Act.56

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

17IWCC0782

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 $56,100.00. 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: DEC 4 - 2017
KWL/mav
O: 10/24/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0782

KEEL, DARNELL
Employee/Petitioner

Case# **14WC030108**

CITY OF HARVEY
Employer/Respondent

On 9/7/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0320 LANNON LANNON & BARR LTD
MICHAEL S ROLENC
200 N LASALLE ST SUITE 2820
CHICAGO, IL 60601

1295 SMITH AMUNDSEN LLC
GAIL A GALANTE
3815 E MAIN ST SUITE A-1
ST CHARLES, IL 60174

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 17IWCC0782

Darnell Keel
Employee/Petitioner

v.

City of Harvey
Employer/Respondent

Case # 14 WC 30108

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago** , on **July 11, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0782

FINDINGS

On **August 19, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$64,051.00**; the average weekly wage was **$1,231.75**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **1** dependent children.

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

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

ORDER

Respondent shall pay the Advocate Medical Group bill in the amount of $142.00 directly to the provider pursuant to the Medical Fee Schedule or previous agreement, whichever is less, pursuant to Section 8a and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $735.37/week for 50.6 weeks because the injuries sustained caused 20% loss of use of the right arm, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from **3/16/2015** through **7/11/2016**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Deborah L. Simpson

Signature of Arbitrator

September 7, 2016
Date

SEP - 7 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Darnell Keel,	)	
	)	
Petitioner,	)	17IWCC0782
	)	
vs.	)	**No. 14 WC 30108**
	)	
City of Harvey,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on August 19, 2014, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. On that date the Petitioner sustained an accidental injury that arose out of and in the course of the employment. They further agree that the Petitioner gave the Respondent notice of the accident within the time limits stated in the Act. In the year preceding the injury the Petitioner earned $64,051.00 and his average weekly wage calculated pursuant to Section 10 of the Act was $1,231.75

At issue in this hearing is as follows: (1) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (2) Is the Respondent liable for the outstanding medical bills for Advocate Medical in the amount of $142.00; and (3) the nature and extent of the injury.

STATEMENT OF FACTS

On August 19, 2014, the Petitioner was employed by the Respondent as a Detective, assigned to the Sexual Offender Unit. He had been employed by the Respondent for 18 years at that time and is currently employed by the Respondent in the same capacity, as a Detective. According to the Petitioner his duties include monitoring the activities of sexual offenders to make sure they are complying with the terms of their release; he meets with them in the field and in the office; he also responds to dispatch calls for backup assistance.

Petitioner testified he was out in the field when a call went our seeking officer assistance. Petitioner testified that he was in the area working on an unrelated matter and he responded to the call for assistance in Harvey.

Petitioner testified that he and a uniformed officer knocked on the front door of the residence but no one answered. There was an individual working on a vehicle in the backyard

and Petitioner went to speak with him. Petitioner asked individual in the back if he called 911. The person responded that he said he did not call 911, nor did he live there. He advised the officers that it was his nephew's house.

Petitioner and the uniformed officer went to the back door and knocked on it. According to the Petitioner, the door slowly opened and the individual inside the house told Petitioner that he did not call the police. The person then closed the door. Petitioner testified that, as he turned around to leave, the door opened and someone "came flying out yelling 'they got my kids as hostages in the house.'" Right after that, somebody inside the house started shooting at the Petitioner and the other police officer.

The Petitioner testified that he got shot in his right arm. He sought cover and shortly thereafter, an ambulance came and took him to Christ Hospital.

Petitioner testified he was admitted to Christ Hospital where he underwent surgery to his right arm by Dr. Michael Weisburger. The surgery consisted of a right ulnar open reduction and internal fixation with screws and plate. The diagnosis was a right proximal ulnar fracture as result of being shot in the arm. Petitioner remained hospitalized until August 21, 2014 (PX. 1)

Following his discharge from Christ Hospital, Petitioner followed up with Dr. Weisburger for his post-op care. His first visit was on September 4, 2014 at which time Dr. Weisburger removed the splint from his arm. He also authorized Petitioner off work (PX. 2).

The Petitioner had a follow-up visit on October 9, 2014 at which time he was prescribed occupational therapy and released to return to work with restrictions.

From October 24 to December 8, 2014, he received occupational therapy. (PX. 1)

On November 6, 2014, Petitioner was seen by Dr. Weisburger and reported that he was doing well. His work restrictions were continued at that time. (PX. 2)

On December 11, 2014, Dr. Weisburger examined Petitioner and told him to discontinue using the brace. Dr. Weisburger recommended a bone stimulator for quicker healing of the fracture. (PX. 2) The Petitioner testified that he did use the bone stimulator.

On January 19, 2015, Petitioner was examined by Dr. William Vitello at the request of the Respondent pursuant to Section 12 of the Act. The diagnosis was healing right ulnar fracture secondary to gunshot wound. Dr. Vitello opined that Petitioner was not yet at MMI and needed some continued strengthening exercises followed by a CT scan. (RX 1)

On January 22, 2015, Petitioner was examined by Dr. Weisburger who noted Petitioner was doing very well. Petitioner was released by Dr. Weisburger to return to work full duty with no restrictions. (PX. 2)

Petitioner testified that, per departmental regulations, police officers and detectives who were involved in a shooting were required to see a psychologist before they could return to active duty. Petitioner testified that he saw a psychologist, Dr. Tim McManus, on February 23, 2015. The mental status examination was normal; Petitioner did not appear to be experiencing any psychological problems. At that visit, the Petitioner reported to Dr. McManus that, he had

returned to the gym and was pleased he could perform bench presses and curls. Dr. McManus recommended that Petitioner re-qualify on the shooting range before returning to work. On March 5, Dr. McManus released Petitioner to work his regular job effective March 10. On March 13, 2015, Dr. McManus released him to work full duty without restrictions effective March 16. He received no further treatment from Dr. McManus. (PX. 3)

On March 30, 2016, Petitioner was re-examined by Dr. Vitello at the request of the Respondent. The purpose of this examination was for an impairment rating. Petitioner was working full duty, the physical examination showed intact ulnar nerve function. There was a deficit in right little finger range of motion consistent with incompetent or dysfunctional flexor digitorum profundus tendon. Left grip strength was 35 pounds; right grip strength was 32 pounds. The x-ray showed a healed right forearm ulnar shaft fracture. Dr. Vitello provided an AMA impairment rating of 3% upper extremity impairment for the right forearm fracture. For the right little finger, the impairment was 6% of the hand, which equals 5% upper extremity impairment or 3% whole person impairment. The right forearm impairment and the small finger impairment were combined together utilizing the Combined Values Chart equaling 5% whole person impairment. (RX. 2)

Petitioner testified that he returned to work for the Respondent as a detective in the sex crimes unit. He testified that he does not have the same strength in his right arm as he did before the shooting. He also has pain in the right arm and has difficulty making a fist because his little finger will not close all the way into the palm.

The Petitioner testified that he is ambidextrous, right and left handed. In March 2015, he re-qualified for shooting with his left hand. Before 2014, he used his right hand to shoot; since the accident, he uses his left hand to shoot. Petitioner testified that his right arm would hurt when he attempted to squeeze the trigger. He still does bench presses and curls. He notices right arm pain and numbness; he cannot lift over 60 pounds; he cannot make a complete grip with his right hand; his right little finger does not completely close.

He continues to work as a Detective, Sexual Offenders Unit, without restrictions. Since returning to work, Petitioner has assisted officers in other calls. Petitioner testified he did not injure his right arm prior to the shooting or after it.

CONCLUSIONS OF LAW

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

In determining the level of permanent partial disability, for injuries that occur on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future

earning capacity; (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. (820 ILCS 305/8.1b)

In support of the Arbitrator's decision with regard to whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Petitioner testified he responded to a call to assist an officer responding to a 911 call. As he and the officer were leaving the back door someone came running out and gunfire erupted from inside the house. The Petitioner was shot in the right arm on at the time. Petitioner was taken by ambulance to Christ Hospital where he underwent surgery to repair the comminuted ulna in his right arm. The Petitioner denied sustaining any other injury to his right arm either before or after the shooting on August 19, 2014.

This testimony is supported by the medical records of Petitioner's treating physician, Dr. Weisburger and the reports of the Section 12 examiner Dr. Vitello who examined Petitioner at the request of the Respondent on January 19, 2015. Dr. Vitello opined that Petitioner had a healing right ulnar fracture secondary to gunshot wound sustained in the course of his work duties on August 19, 2014.

The Arbitrator, therefore, concludes that Petitioner's current condition of ill-being is causally connected to the accident of August 19, 2014.

In support of the Arbitrator's decision with regard to whether the Respondent is liable for the unpaid medical bills for Advocate Medical in the amount of $142.00, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Petitioner submitted an outstanding medical bill for Advocate Medical Group in the amount of $142.00 for treatment by Dr. Jeanne Barley at Christ Hospital on 8/21/2014. The Petitioner did not submit medical records to substantiate the treatment. The Petitioner was treated at Christ Hospital after the injury and had the surgery there. No evidence was offered establishing that the Petitioner received treatment for any other injury or illness during the time period he was hospitalized for treatment for the gunshot wound. The Arbitrator finds that the 8/21/14 medical bill is reasonable and related to the injury. The Petitioner did not submit the fee schedule for the bill. The Arbitrator awards payment of the bill to the provider pursuant to the fee schedule or previous agreement, whichever is less, as provided in the Act.

In support of the Arbitrator's decision with regard to what the nature and extent of the Petitioner's injury is, the Arbitrator makes the following conclusions of law:

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

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

AMA Impairment Rating: On March 30, 2015, at the request of the Respondent, Dr. Vitello, re-examined the Petitioner in order to prepare an impairment rating. The Petitioner was working full duty at that time. The Petitioner had re-qualified at the shooting range and had been determined to have no psychological issues as result of the shooting by a psychologist who examined the Petitioner as part of the department regulations for officers who have been involved in shootings. The physical examination conducted by Dr. Vitello at the time, showed intact ulnar nerve function. There was a deficit in right little finger range of motion consistent with incompetent or dysfunctional flexor digitorum profundus tendon. Petitioner's left grip strength was 35 pounds; right grip strength was 32 pounds. An x-ray showed a healed right forearm ulnar shaft fracture. Dr. Vitello provided an AMA impairment rating of 3% upper extremity impairment for the right forearm fracture. For the right little finger, the impairment was 6% of the hand, which equals 5% upper extremity impairment or 3% whole person impairment. The right forearm impairment and the small finger impairment were combined together utilizing the Combined Values Chart equaling 5% whole person impairment. The Arbitrator gives significant weight to this factor.

2. ***Occupation of the injured employee***: Petitioner was employed by Respondent as a Detective in the Sexual Offenders unit of the police department. At the conclusion of his medical treatment and physical therapy, the Petitioner returned to this position, full duty with no restrictions. Petitioner testified that he continues to work for the Respondent in his capacity as a Detective at the time of the hearing. The Arbitrator gives significant weight to this factor as well.

3. ***Age of the employee at the time of the injury***: Petitioner was 46 years old at the time of his accident. There is no evidence that Petitioner's age impacted his injury or created any permanent disability. The Arbitrator gives little weight to this factor.

4. ***Employee's future earning capacity***: Petitioner testified that he continues to work for the Respondent in his capacity as a Detective for the Police Department. The Petitioner did not testify to any diminution of his earnings since this accident. No evidence was presented that the Petitioner's wages were decreased, his hours were decreased or that the injury has any effect on future promotions. There is no evidence of disability due to this factor. The Arbitrator gives some weight to this factor.

5. ***Evidence of disability corroborated by the treating medical records***:

On August 19, 2014, the Petitioner sustained a comminuted ulnar shaft fracture which required that he undergo surgery to repair the damage in the form of an open reduction internal fixation. Petitioner underwent a course of physical therapy as well. The hardware remains in place. On January 22, 2015, the Petitioner was discharged from treatment by his surgeon Dr. Weisburger; he had no pain or tenderness; strength and sensation were normal; he was released to work without restrictions; he has received no further treatment.

Petitioner testified that currently he does not have the same strength in his right arm as he did prior to the shooting. He also has pain in his right arm and is unable to bring his right little finger completely into the palm. Petitioner testified that he is ambidextrous, and that he now uses his left hand for shooting because of the pain in his right hand when he would squeeze the trigger.

In his report of January 29, 2015, Dr. Vitello noted that Petitioner's subjective complaints were consistent with weakness and inability to make a complete grip with his right small finger and for noted loss of FDP (flexor digitorum profundus) function. In his report and AMA rating from March of 2015, Dr. Vitello noted intact ulnar nerve function; a deficit in right little finger range of motion consistent with incompetent or dysfunctional flexor digitorum profundus tendon; Petitioner's left grip strength was 35 pounds; right grip strength was 32 pounds; and that an x-ray showed a healed right forearm ulnar shaft fracture.

Given the nature of the injury the Petitioner suffered to his right arm following the August 19, 2014, incident, he is entitled to have and receive from the Respondent compensation for **20%** loss of use of the right arm, or **50.6** weeks at a weekly PPD rate of **$735.37** / per week.

ORDER OF THE ARBITRATOR

Petitioner is found to have suffered a permanent injury pursuant to Section 8(e) (10) of the Act. Respondent shall pay Petitioner permanent partial disability benefits of **735.37**/week for **50.6** weeks, because the injuries sustained caused the **50.6%** loss of the right arm, as provided in Section 8(e)(10) of the Act.

Deborah L. Simpson

Signature of Arbitrator

September 7, 2016
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF MCCLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lynn Yonker,

Petitioner,

vs. NO: 15 WC 10544

State Farm,

17IWCC0783

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice provided to all parties, the Commission, after considering the issues of accident, causal relationship, temporary total disability benefits, medical expenses, and permanent disability and being advised of the facts and the law, affirms the Decision of the Arbitrator, which is attached hereto and made a part hereof with supplemental reasoning as noted below. To that end, the Commission strikes paragraphs one and two on page seven of the Arbitrator's decision.

Findings of Fact

At the October 24, 2016 arbitration hearing, Petitioner testified she has been employed with Respondent for 19 years. T. 8-9. Her work location is One State Farm Plaza and has been so for the last two and a half years. T. 9. For the past year and a half, she worked as a compliance regulator analyst. T. 10.

Petitioner testified as to her specific recollections regarding March 6, 2015 stating, "That was the day that I fell. I parked in the parking lot. I was going across the crosswalk. I noticed on the sidewalk ahead of me some ice spots. As I was walking, the next thing I know I fell. A gentleman helped me up. When I left work to go to the doctor is when I looked at – you know,

he assumed I had fallen on the ice, because he commented about the ice that day. I said: I don't know. I didn't inspect – I just wanted to get up and get in the building. When I left, I did look at the crosswalk and noticed that there was a raised lip that goes across the crosswalk. I don't know if that's what I fell on." T. 12-13.

On March 6, 2015, Petitioner parked in the State Farm employee parking lot. T. 13. Various parking lots exist, and Petitioner alternated parking lots depending on her arrival time but all of which were designated employee lots. *Id.* Petitioner testified there are several entrances to the building some of which are strictly employee entrances. T. 14. Petitioner typically utilized the same entrance which was six feet from her department. T. 15. The entrance was closed to the public as an employee badge was necessary to gain entry. *Id.*

Petitioner testified on the morning of March 6, 2015 it was very cold. T. 16. Petitioner testified that morning she noticed black ice patches meaning ice which was smooth and difficult to discern. T. 17. Petitioner walked towards the entrance carrying her purse and State Farm laptop bag. *Id.* Petitioner was asked if she had any opinion about what caused her fall. T. 19. Petitioner testified, "I don't know how I fell, but when I was falling the pull of my bag – I think I would have been able to catch myself had I not had that on my arm." *Id.* The fall happened in a split second. *Id.* Petitioner landed on her left hand on the ground. T. 19-20. A gentleman was walking on the sidewalk, put down his coffee, and came over to help Petitioner. T. 20. At the time, the gentleman mentioned the ice previously caused him to slip, and he asked Petitioner if she was okay. T. 21.

On cross-examination, Petitioner was asked and answered the following: "Q…As we sit here today, you don't really know what caused you to fall, is that correct? A. Correct. Q. But you think there might have been black ice that lead to your fall, is that correct? A. Yes." T. 31. Petitioner testified she observed ice on the sidewalk towards where she was walking. *Id.*

Ms. Kelli Lucas was called to testify on behalf of Respondent. Ms. Lucas testified she is employed with Sedgwick and had been so for the last five years. T. 36. She is an assistant team leader and the adjustor on the case. *Id.* Ms. Lucas testified she spoke to Petitioner on three occasions. T. 37. On the first occasion, Ms. Lucas contacted Petitioner to obtain a recorded statement to verify the details of the accident. T. 37, 39. When Ms. Lucas obtained her statement, Petitioner did not provide a history of slipping and falling on ice. T. 39. Ms. Lucas stated Petitioner reported: "She indicated to me that she believed she tripped over a gap or a small dip in the concrete." T. 40. On the second occasion, Ms. Lucas called and informed Petitioner of the denial of the matter, and Petitioner made no mention of slipping and falling on ice. T. 40-41. On the third occasion, Petitioner called Ms. Lucas inquiring as to why the denial of the claim. T. 41. In that third conversation, Ms. Lucas explained to Petitioner the basis for the claim denial, which was that she was at no greater risk than the general public, and there was no documented hazard present. T. 42. Ms. Lucas testified Petitioner asked whether the weather conditions on March 6, 2015 were investigated, and Ms. Lucas testified she advised Petitioner no

as the claimed mechanism of injury was tripping. Petitioner subsequently advised she might have slipped on ice. T. 43.

Petitioner was recalled in rebuttal and testified she recognized Ms. Lucas as the adjustor on her claim. T. 47. Petitioner agreed she had three separate conversations with Ms. Lucas. *Id.* The first conversation she had with Ms. Lucas was a recorded statement. *Id.* Petitioner testified Ms. Lucas' assessment of the second conversation was accurate, and Petitioner's claim was denied during that conversation. T. 48. During the third conversation, Petitioner reiterated that she believed in the initial call (recorded statement) she stated she did not know exactly how she fell. T. 49. Petitioner testified she explained to Ms. Lucas the conditions. Petitioner believed she discussed with Ms. Lucas the existence of ice in the area during their initial conversation. T. 50.

On cross-examination, Respondent's attorney reiterated Petitioner's testimony as to the cause of her fall. Petitioner was asked and answered: "Q. So whether there was ice on the pavement or around the building, you don't know if you slipped on ice; is that correct? A. Correct." *Id.* Petitioner testified when she was on the ground after falling, she did not look for any ice on any area where she had fallen; she just wanted to get up and get into the building. T. 51-52.

Conclusions of Law

On the threshold issue of accident, the Commission affirms the Arbitrator's finding Petitioner failed to prove she sustained an accidental injury arising out of her employment on March 6, 2015. The Commission affirms the Arbitrator's finding that all the remaining issues are moot.

To obtain benefits under the Act, an employee must prove her injury arose out of and occurred during the course of her employment. "In the course of" speaks to time, place, and circumstances of the injury. Petitioner was in the course of her employment when her fall occurred as she was on the Respondent's premises en route to her office. See *e.g. Caterpillar Tractor Company v. The Industrial Commission*, 129 Ill. 2d 52, 57, 541 N.E.2d 665 (1989) ("This Court has recognized that accidental injuries sustained on an employer's premises within a reasonable time before and after work are generally deemed to arise in the course of the employment"). "Arising out of" speaks to risk- is the risk encountered by the employee a risk incidental to the employment as not all injures suffered while at work are compensable. See *e.g. Brady v. Louis Ruffolo & Sons Construction Company*, 143 Ill. 2d 542, 552, 578 N.E.2d 921 (1991) ("This court has previously declined to adopt the positional risk doctrine, believing that the doctrine would not be consistent with the requirements expressed by the legislature in the Act").

Regarding falls, "a claimant must present evidence supporting a reasonable inference that the fall stemmed from an employment-related risk. After all, the 'arising out of' requirement

contemplates 'a causal connection between the accidental injury and some risk incidental to or connected with the activity an employee must do to fulfill [her] duties.' *Stapleton, 282 Ill. App. 3d at 15.* Awarding compensation for a purely unexplained fall would eviscerate this requirement." *Builders Square v. The Industrial Commission*, 339 Ill. App. 3d 1006, 1010, 791 N.E.2d 1308 (2003).

Petitioner testified repeatedly on both direct and cross-examination she did not know why she fell. In her recorded statement, Petitioner indicated she tripped, possibly on a raised piece of concrete in the crosswalk, but was not certain as to why she fell. Therefore, it is incumbent on Petitioner to set forth sufficient evidence from which it can be inferred her fall was work-related. Petitioner failed to do so.

Petitioner offered two potential theories as to the cause of her fall: 1) ice, and 2) raised lip of concrete. As for the ice, Petitioner testified she did not look at the time of her fall to determine if ice was present. More importantly, when providing her recorded statement three days after she fell, she specifically denied falling on ice instead indicating she tripped. Petitioner testified she observed ice at the time of her fall, but such ice was on the sidewalk not the location of her fall. "[C]ircumstantial evidence can only support an inference which is reasonable and probable, not merely possible. [citations omitted]. Where the evidence allows for the inference of the nonexistence of a fact to be just as probable as the existence, the conclusion that the fact exists is a matter of speculation, surmise, and conjecture, and the inference cannot reasonably be drawn." *First Cash Financial Services v. The Industrial Commission*, 367 Ill. App. 3d 102, 106, 853 N.E.2d 799 (2006). To find Petitioner fell on ice would be speculation and not a reasonable inference.

As for the raised lip of concrete, Petitioner failed to present any evidence such concrete was a hazardous condition. The sum total of Petitioner's testimony regarding the concrete is "there was a raise lip that goes across the crosswalk." T. 12-13. Petitioner presented no evidence suggesting that the crosswalk was more hazardous or different than any other crosswalk. There is simply no evidence the crosswalk and the lip of concrete was defective or hazardous. Further, Petitioner appeared to abandon this theory at trial instead testifying she believed ice caused her fall. It is just as likely Petitioner tripped, and to find otherwise would be mere speculation.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's November 28, 2016 decision is affirmed for the reasons stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that since Petitioner failed to prove she sustained accidental injuries arising out of her employment on March 6, 2015, her claim for compensation and medical expenses is hereby denied.

17IWCC0783

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: DEC 4 - 2017
LEC/maw
o10/04/17
43

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

YONKER, LYNN
Employee/Petitioner

Case# **15WC010544**

STATE FARM
Employer/Respondent

17IWCC0783

On 11/28/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
SEAN D OSWALD
3100 N KNOXVILLE AVE
PEORIA, IL 61603

1109 GAROFALO SCHREIBER STORM
DANIEL L GRANT
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

17IWCC0783

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

LYNN YONKER,
Employee/Petitioner

v.

STATE FARM,
Employer/Respondent

Case # **15** WC **10544**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Bloomington**, on **10/24/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [ ] 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 **3/6/15**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$68,405.48**; the average weekly wage was **$1,315.49**.

On the date of accident, Petitioner was **43** 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 **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$00.00**.

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

ORDER

Petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury that arose out of and in the course of her employment by respondent on 3/6/15. Petitioner's claim for compensation is denied.

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

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

Maureen D. Pulia
Signature of Arbitrator

11/14/16
Date

NOV 2 8 2016

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 43 year old Business Analyst, alleges she sustained an accidental injury to her left arm when she slipped and fell on ice while walking into respondent's building on 3/6/15.

Petitioner was working at 1 State Farm Plaza on 3/6/15. She testified that there are more than one employee parking lots, which the public can also park in. She also testified that there are visitor parking lots where employees cannot park. On 3/6/15 petitioner parked in an employee parking lot. Petitioner testified that she has parked in other employee parking lots around the facility. She stated that although she can enter the building using various doors, 90% of the time, depending on what time she gets there, she enters through the same door she did on 3/6/15. Petitioner testified that the door she enters 90% of the time can only be opened with an employee badge. The public cannot enter this door. This entrance is about 6 feet from her department.

After petitioner parked in the employee lot she walked across the crosswalk. She testified that she saw ice spots on sidewalk ahead of her. As she was walking to the employee entrance she fell. Petitioner testified that the cross walk had a raised lip. She then testified that she was not sure what she fell on. Petitioner testified that the crosswalk was the most direct route from the employee parking lot to the entrance.

Petitioner testified that on 3/6/15 the weather was very cold and she saw black ice patches as she was walking to the entrance. At the time of the fall petitioner was carrying her purse, and her respondent issued laptop. She was carrying both of these items on her left shoulder. As she fell, she lunged forward and the pull of the bag prevented her from catching herself and she fell on her left hand on the ground.

Petitioner testified that she was helped up by another employee. She did not recognize him or know who he was. However, she testified he was one of respondent's employees because he had a State Farm ID on.

When petitioner got inside respondent's building she went to her desk and started to work. She reported a lot of pain in her left arm. About 15 minutes later she reported the incident to her manager, Judy Hiltbrand. She then went back and started typing with her right hand. Later on, Hiltbrand came back and took petitioner to respondent's medical department. Ice was placed on her left elbow that was starting to swell. Petitioner also testified that her wrist hurt. After about 30 minutes petitioner returned to her desk and began working again with her right hand.

A while later Hiltbrand returned to see how petitioner was doing. She offered to take petitioner to Urgent Care, but petitioner decided to go elsewhere.

On 3/6/15 petitioner presented to St. Joseph Medical Center. She reported a fall. She complained of injury to her left elbow, forearm and wrist. X-rays of the left elbow revealed left radial head fracture, no elbow dislocation, and unremarkable left wrist. Petitioner then presented to OSF. She gave a history of a fall 1-3 hours ago while walking. She reported that the point of impact was her left wrist, but the pain was in her left elbow. Petitioner reported that she fell in the parking lot at work. She was diagnosed with a left elbow fracture and was given an orthopedic referral.

Later that day petitioner presented to Dr. Lawrence Li, an orthopedic specialist. Petitioner gave a history of crossing the crosswalk in front of her office building and falling. She noted that she tried to catch herself with her left arm. She complained of severe pain in her left elbow. Dr. Li diagnosed a left elbow nondisplaced radial head fracture. He placed her in a cast. He prescribed occupational therapy. Petitioner could not handle the cast, and it was removed on 3/10/15. She was given a removable long arm splint. Petitioner was also given Game Ready Vasopneumatic compression therapy that decreased her swelling significantly.

On 3/12/15 petitioner returned to work for respondent. She testified that she continued to work but could not move her left arm in certain positions. Petitioner continued to ice.

On 3/27/15 additional xrays were taken that showed her fracture was in excellent alignment. On 3/30/15 petitioner underwent an initial evaluation with Occupational Therapy. She gave a history of crossing the crosswalk in front of her office building and falling. She stated that she tried to catch herself with her left arm. Petitioner underwent occupational therapy three times a week for 12 weeks. During this period she also followed up with Dr. Li approximately once a month through 7/24/15.

On 7/23/15 petitioner reported to the occupational therapist that she had noticed improved range of motion and some decreased pain. She stated that she was able to put on her headset at work without assistance. She had ongoing difficulty with combined motions of elbow flexion and supination or elbow flexion and pronation for extended periods of time, but it was improving. She reported some level of pain at all times.

Petitioner last followed-up with Dr. Li on 7/24/15. Petitioner reported that she was progressing and her range of motion was improved. She reported pain over the triceps. An examination revealed slightly limited range of motion. X-rays revealed excellent alignment and moderate healing. Dr. Li dispensed a 2 month supply of Mobic and Rabeprazole with an NSAID. Petitioner was given a home exercise program and use of a JAS Brace. Petitioner was released on an as needed basis.

Following this release petitioner testified that she continued to use ice and do her home exercises for several months. While recovering before 7/24/15 she stated that everything, including washing her

hair, cooking, and cleaning took longer. She stated that her boys helped her with certain chores and activities.

Currently, petitioner reported that she is 90% of normal with respect to her left arm. She still reports the inability to lift certain weights and perform certain exercises. She also testified that she cannot move furniture.

On 3/9/15 petitioner provided a recorded statement to Kelli Lucas, Adjustor with Sedgwick, respondent's comp carrier. Petitioner gave the following responses to Lucas with respect to the incident on 3/6/15.

> Lucas: And where did it happen?
> Petitioner: Umm, I was going across [RD] crosswalk at work and there's like a, a raised piece. And I must've just, like caught it right [laughs].
> Lucas: OK.OK. So you were on the crosswalk at work. Is this inside? Outside?
> Petitioner: Yeah. Outside. Like, you, we, I was, out, out of the parking lot. And then I was goin' across the crosswalk to get on the sidewalk that's next to…
> Lucas: …what exactly happened.
> Petitioner: Um, like, it's, there's, like, a, I don't know if it's due to, like, you know, the cold and the hot and whatever, but there's, like, a raised piece. And I think I must've just, like I said, hit it right as I was walking. And I just tripped, and I had, I broke my purse. ….
> Lucas: …second. OK. Um, so you said there's a raised piece. A raised piece of what?
> Petitioner: Um, concrete.
> Lucas: OK.OK. So there's a raised piece of concrete on this crosswalk that you're walking …
> Petitioner: Yes.
> Lucas: OK, And then you said you must have hit it. Do you remember actually hitting it? Or are you …
> Petitioner: … I tripped. Like, I felt my, seems like my toe got caught. Like, you know what I'm saying? You just, I was just walking, and it was like all of a sudden I just tripped on, I mean that's why, I felt like I had knocked into something. When I left, um, I looked as I was goin', you know, back across the crosswalk, and I saw, you know, the raised piece. So I thought, 'Oh. That's probably, you, know, what I tripped on.
> Lucas: OK. How high up is this, like, how much of a difference is this raised piece?
> Petitioner: Oh, gosh, I'm not really, I mean, maybe a couple inches. I'm not good with [laughs] ….
> Lucas: OK. So there were three people around you, but you don't …
> Petitioner: …were up on the sidewalk. And I was comin' across the walk, you know, across the crosswalk. But they were walking, like, to the, the one guy, he came running over. He was like, 'Oh my God, Are you OK?'. And was he was like, "I fell last Friday on the ice." So I'm like, I said, 'I didn't hit ice.' I said, 'I, you know, I think I tripped on s-, you know, it was just kind of a …

On cross examination, petitioner admitted that she does not know what caused her to fall on 3/6/15. She testified that she thought it might be black ice because she saw black ice ahead of her. She testified that she saw patches of ice on the sidewalk next to the building.

Kelli Lucas, Adjustor of petitioner's cases, was called as a witness on behalf of respondent. Lucas testified that she spoke with petitioner three times after the accident. The first time was on 3/9/15 when she took a

recorded statement from petitioner. She testified that at that time petitioner did not report slipping and falling on ice. She testified that petitioner told her she slipped over a gap or small dip in the concrete.

Lucas testified that she spoke with petitioner about two weeks later. At that time she told petitioner that her claim had been investigated and was being denied. Lucas testified that during this conversation petitioner did not report any slip and fall on 3/6/15.

Two days later petitioner called Lucas to discuss further the reason why her claim was being denied. Petitioner testified that Lucas told her there was no documented hazard and therefore she was not at any greater risk than the general public. Petitioner testified that she told Lucas that there may have been ice. She also testified that she asked the adjustor if she knew what the weather was on 3/9/15 and she said no. She also testified that Lucas told her that if she stated she tripped over something, weather would not be an issue.

Petitioner, on rebuttal, testified that during third conversation with Lucas she discussed the ice, and this was not the first time she mentioned it to her. She stated that she would need to see the records statement to know what her exact words were during the initial conversation.

On rebuttal cross examination, petitioner testified that she still believes she does not know what caused her to fall. She testified that she does not know if she slipped on ice. She testified that she did not look for ice where she fell after she got up.

On rebuttal redirect, petitioner testified that she had fallen on ice before and was not familiar with the sensation of falling on ice.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

Petitioner claims she was a greater risk than the general public when she fell on her way into work on 3/6/15. In support of this claim petitioner pointed out that she parked in an employee designated parking lot, and entered a door that could only be accessed with a respondent ID badge. Petitioner testified that although this is not the only door she can enter, this is the door she used to enter the building 90% of the time. She testified that this entrance is 6 feet from her department. Petitioner testified that the crosswalk is the most direct route from the employee parking lot to the entrance she used 90% of the time.

Petitioner testified that as she was walking across the crosswalk she saw black ice spots on the sidewalk ahead of her, and noticed a raised lip on the crosswalk. Petitioner testified that she was carrying her purse and respondent issued laptop when she fell. She also testified on direct examination that was not sure what she fell on.

Petitioner claims she was at a greater risk than the general public because she parked in an employee parking lot and entered through an "employee only" entrance. However, petitioner was able to park in any of the employee parking lots and use any entrance to enter the building. She testified that the only area she could not park in was the visitors parking on the south side of the building. Petitioner also testified that the general public can park in the employee parking lots. Petitioner testified that she used this entrance because it was the closest to her department where she worked.

Since petitioner testified that the general public can park in the employee lots, the arbitrator does not find by parking in that lot petitioner was at any greater risk than the general public. Additionally, although petitioner chose to enter through the "employee entrance" by her department, she was not required to enter in through that entrance.

In addition to the fact that petitioner was not required to park in that employee lot and enter through that employee door, the petitioner admitted at trial, on direct examination, cross examination, and rebuttal examination that she does not know what caused her to fall on 3/6/15. She speculated that she may have tripped over a lip in the crosswalk, and also that she may have slipped on some black ice, but could not state with any certainty what caused her to fall.

Even when petitioner's recorded statement was taken on 3/9/15, she testified that there was this raised piece on the crosswalk and she caught it. She stated that she tripped over the raised piece of concrete as she was walking. She stated that she knocked into something while she was walking and tripped. She stated that after falling she looked back and saw a raised piece that she thought was probably what she tripped on. She stated the piece was raised a couple inches. Later in her recorded statement petitioner testified that she told the gentleman who helped her up that she did not hit ice.

Petitioner did not offer evidence to support her claim that there was a raised piece on the crosswalk. Additionally, the arbitrator finds it significant that petitioner could not state with any certainty what caused her to fall while she was walking across the crosswalk on 3/6/15. She repeatedly admitted that she did not know if she slipped on ice, or tripped over the raised concrete, or if her fall was caused by something else. As such, the arbitrator cannot find the petitioner sustained a compensable fall, since it is unknown what caused the petitioner to fall.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury that arose out of and in the course of her employment by respondent on 3/6/15. The arbitrator bases this finding primarily on the fact that

petitioner herself testified that she does not know what caused her to fall on 3/6/15. Although she told Lucas on 3/9/15 during her recorded statement that she tripped on a raised piece on the crosswalk, and did not slip on ice, at trial she testified to the possibility of slipping on ice. However, when pressed on the cause of her slip or fall petitioner admitted that she does not know what caused her to fall. Given this, the arbitrator finds the petitioner's fall is not compensable.

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 has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury that arose out of and in the course of her employment by respondent on 3/6/15, the arbitrator finds these remaining issues moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Annalee J. Berninger,
Petitioner,

vs.

NO: 16WC 22448

State of Illinois, Taylorville Correctional Center,
Respondent.

17IWCC0784

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 26, 2017, is hereby affirmed and adopted.

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

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

No bond or summons required for State of Illinois cases.

DATED: DEC 7 - 2017
o120517
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BERNINGER, ANNALEE J
Employee/Petitioner

Case# **16WC022448**

ST OF IL TAYLORVILLE CORRECTIONAL CENTER
Employer/Respondent

17IWCC0784

On 6/26/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

0514 ASSISTANT ATTORNEY GENERAL
GLISSON, RICHARD C
500 S SECOND ST
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0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
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1350 CENTRAL MANAGEMENT SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JUN 26 2017

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

17IWCC0784

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Annalee J. Berninger,
Employee/Petitioner

v.

State of Illinois, Taylorville Correctional Center,
Employer/Respondent

Case # 16 WC 22448

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 Douglas McCarthy, Arbitrator of the Commission, in the city of **Springfield**, on April 26, 2017. By stipulation, the parties agree:

On the date of accident, June 9, 2016, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $74,651.72, and the average weekly wage was $1,435.61.

At the time of injury, Petitioner was 55 years of age, ***married*** with **0** dependent children.

Necessary medical services will be paid by Respondent.

Respondent shall be given a credit in medical bills for which credit is allowed under §8J of the Act.

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

ORDER

Respondent shall pay Petitioner the sum of $755.22/week for a further period of 43 weeks, as provided in Section **8(e)12** of the Act, because the injuries sustained caused **20% loss of use of the left leg.**

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

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

D. Dylan McEarty

Signature of Arbitrator

6/19/2017
Date

ICArbDecN&E p.2

JUN 26 2017

Petitioner has been a Correctional Officer with the Illinois Department of Corrections for 20 years and 4 ½ months with the last 4 years at Taylorville Correctional Center.

On June 9, 2016, Petitioner went through a door at the Center, when an inmate that was engaged in a custodial maintenance class, backed into the Petitioner really hard causing the Petitioner to sustain an injury to her left knee.

Petitioner initially treated with her family physician that referred her to Dr. Youssef El-Bitar an orthopedic surgeon with Southern Illinois University School of Medicine.

An M.R.I. of the left knee was done on June 28, 2016. The impression of the radiologist was:

1. Mild chondromalacia of the patella.
2. ACL, PCL and menisci are without a tear. Degenerative signal posterior horn medial meniscus.
3. Moderate effusion.

On August 18, 2016, Dr. El-Bitar performed a left knee arthoscopy; debridement of medial meniscus tear; debridement of lateral meniscus tear; and a debridement of chondromalacia of medial femoral condyle and patella.

What is the Nature and Extent of Petitioner's Injury?

Petitioner followed up post-operatively on September 16, 2016. Dr. El-Bitar noted the patient has been doing well after surgery, with significant reduction in her pain as well as improvement in her range of motion and function. She still has swelling in her left knee with some improvement compared to last clinic visit. The patient denies any fever or chills, denies any wound drainage, denies erythema or warmth in the left knee. The patient is doing physical therapy for range of motion and strengthening.

On October 14, 2016, Dr. El-Bitar noted the patient has been progressing slowly recently with some pain posteriorly. She reports complete resolution of the medial knee pain but has some pain mostly posteriorly and occasionally anteriorly. She is working with physical therapy on range of motion as well as strengthening. The swelling has decreased significantly compared to last clinic visit.

On November 11, 2016, Dr. El-Bitar noted the patient has progressed slowly over the past several weeks. She was doing physical therapy with strengthening and range of motion to the left knee. The patient reports occasional pain and popping anteriorly, especially when squatting and going up and down the stairs. The patient reports

complete resolution of the medial knee pain and the posterior knee pain as well. The patient reports significant improvement in the swelling compared to prior visits.

Petitioner underwent physical therapy for her knee. The therapist noted on December 2, 2016:

> Patient had improved knee flexion AROM today. She tolerated strengthening without increase in pain . . . Able to return to physical actions and tasks related to leisure activity without complaint.

On December 5, 2016, the therapist noted patient denies having any pain after treatment.

> On December 7, 2016, the Petitioner reported to the therapist:
>
> That she is feeling really good today and denies having any knee pain before and after treatment.
>
> On December 9, 2016 Petitioner:
>
> Again denied having any knee pain before and after today's treatment. She states that she is ready to be done and return to work. The therapist indicated patient has met all goals as stated in her initial evaluation and will continue to progress at home with more strengthening exercises. Discharge per goals met.
>
> Therapist Drew Casner wrote Dr. El-Bitar on December 9, 2016,
>
> "Annalee has now completed 37 total visits in our Physical Therapy clinic. She has progressed well in these last few weeks. She reports that her knee is not hurting as much anymore and rates her pain a 0/10 on average at start of treatments. She states that the only thing that makes her knee hurt is climbing stairs but she is able to perform them. Her AROM is as follows: 0 degrees extension and 134 degrees flexion. Her MMS is 5/5 throughout left knee and hip. She is now able to perform a full squat to lift 50 lbs x 2 reps without difficulty. Annalee has now met all goals as stated in her initial evaluation and states that she is ready to return to work. She will be discharged from PT at this time and thank you for the referral of this patient."

On December 9, 2016 Petitioner had her last visit with Dr. El-Bitar who noted:

> The patient has progressed well with physical therapy with improved strength and range of motion to the left knee. The patient is happy so far with her progress. The patient still struggles a bit with stairs and kneeling, but overall she is happy with the results. The patient feels she is ready to go back to work.

Dr. El-Bitar's plan on that date was as follows:

- The patient has progressed well over the past month with physical therapy with improvement in range of motion and strength in addition to marked improvement in the pain and reduction the swelling of the left knee.
- The patient can go back to work without restrictions starting Tuesday, December 13.
- Topical ice and heat as needed for pain, over-the-counter oral pain medications as needed for pain.
- The patient's questions were answered at today's visit.
- The patient was instructed to call the office if any new concerns or significant worsening occurs.
- Follow-up in clinic as needed.

Petitioner has worked without restrictions in her normal capacity as a Correctional Officer since that time. Petitioner has not returned to Dr. El-Bitar with any complaints since that time. Petitioner is not on any prescribed medication for her knee at the time of hearing.

Pursuant to §8.1b in determining PPD the Arbitrator notes there was no reported level of impairment presented by a licensed physician.

As to the occupation of the Petitioner as a Correctional Officer, Petitioner testified sometimes she is a writ officer, tower officer, housing officer or the reception officer. As a tower officer she has to walk up and down 52 stairs. As a housing officer Petitioner is required to do three shakedowns a day and check inmates' units, bank, and property. This requires you to squat and kneel down to check their property boxes. As a reception officer you bring visitors into the prison by checking them into the computer, taking them into the shake down room to store their keys etc. and then have them go

into a metal detector. Petitioner testified she has to carry a firearm, 12 rounds of ammunition and mace which she estimated weighs an extra 8-10 pounds. She believed on average she would spend approximately six hours a day standing and/or walking.

Petitioner testified since she has returned to work her knee gets tired quickly and she puts ice on it after work and takes an Ibuprophen. In addition she testified she has a sharp pain and swelling. Further she testified she has three opportunities to qualify for weapons testing. She attempted to qualify with weapons but was unable to pass. As a result, she cannot work towers or do writs. Petitioner attributed her failure to pass because of her difficulty kneeling or squatting.

Petitioner, however, was returned to full duty work without any restrictions by her treating surgeon. In addition, she has not been back to see her treating physician nor were any medical records put in after her last visit to her surgeon noting any ongoing issues with her knee. Further, Petitioner testified she has two more opportunities to qualify with the weapons before she has to take a week long training class in Springfield.

The Petitioner's occupation includes her work in the towers and writs and both require her to pass a weapons test. She testified credibly that she failed the test due to problems with her left knee but is able to attempt to pass the test on two more occasions. If she fails, she would be able to take a training course in order to improve her chances. Thus, her occupation requires her to use her knee in a physical manner, and the Arbitrator gives significant weight to this factor.

With regard to Petitioner's age, the third factor, the Arbitrator finds Petitioner was 55 years of age and has twenty plus years in at the Department of Corrections. Petitioner is nearing retirement age and does not have to deal with this condition as long as a younger Petitioner so weighs this factor in favor of the Respondent.

With regard to the fourth factor, Petitioner's future earning capacity, Petitioner testified if she fails to qualify after three attempts it might affect her future earning capacity. At the time of trial, however, she had only attempted to qualify one time. It would be speculative on the part of the Arbitrator to assume she will not qualify in the future since she had qualified for the last twenty years. Further, Petitioner is receiving the same pay as she was receiving before she was injured, absent overtime, which she will start getting when she qualifies. Therefore, the Arbitrator affords this moderate weight.

As previously noted, with regard to evidence of disability as corroborated by the treating medical records, all the records towards the end of patient's care indicated she was essentially pain free without any ongoing issues other than the stairs or kneeling, but overall was happy with the results and ready to go back to work. She did have

positive findings of mild tenderness over the anterior lateral area of the knee and a positive patellar grind test. The Arbitrator further notes that her injury involved unstable complex tears of both the medial and lateral menisci. Dr. El Bitar removed a significant portion of each meniscus in surgery. (PX 2) She was able to return to work without restrictions This factor weighs moderately in the Petitioner's favor..

Based on all of the above, the Arbitrator concludes Petitioner has sustained 20% loss of use of Petitioner's left leg.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KATHLEEN HAWKES,

Petitioner,

vs. NO: 15 WC 9688

STATE OF ILLINOIS DEPARTMENT OF REVENUE,

17IWCC0785

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, and permanent partial disability (PPD), and being advised of the facts and applicable law, modifies in part and affirms in part the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission hereby modifies the Arbitrator's Decision relative only to the nature and extent of Petitioner's post-concussion syndrome. The Arbitrator awarded Petitioner 10% loss of use of the body as a whole pursuant to Section 8(d)2 of the Act. The Commission instead finds the Petitioner to be permanently partially disabled to the extent of 7.5% loss of use of the body, and otherwise affirms and adopts the remainder of the Arbitrator's Decision.

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties.

17IWCC0785

The Arbitrator considered the five factors in Section 8.1(b) of the Act to determine the nature and extent of Petitioner's condition. Although no single enumerated factor shall be the sole determinant of disability, the Commission disagrees with the weight the Arbitrator placed on certain factors, and finds that the PPD award should be reduced to 7.5% loss of use of the body as a whole.

In consideration of the five factors listed under Section 8.1(b) of the Act, the Commission finds:

(i) Impairment Rating: No weight should be given to this factor as neither party offered any evidence or opinion relative to impairment.

(ii) Occupation of Injured Employee: Following the December 31, 2014 work-related accident, Petitioner returned without restriction to her same duties as an account technician for Respondent; her job duties included processing renewals of professional licenses, reinstatements, and duplicates for licensees. (T.12; RX1). The Commission disagrees with the Arbitrator and finds that no weight should be given to this factor.

(iii) Petitioner's Age: Petitioner was 65 years old on the accident date. The Arbitrator noted that "Petitioner may be considered of relatively advanced age." However, Petitioner testified that she planned to continue working until she was 75 years old so she could earn her pension. (T.35). Noting that Petitioner may have to contend with her disability for an extended period of time, the Arbitrator afforded some weight to this factor.

(iv) Petitioner's Future Earning Capacity: There is no evidence in the record as to reduced earning capacity. The Commission disagrees with the Arbitrator and finds that no weight should be given to this factor.

(v) Evidence of Disability: Petitioner's primary diagnosis was post-concussion syndrome, and her main complaint involved her memory. (PX4). Petitioner had also complained of neck pain, but as of the date of arbitration Petitioner testified that she did not have any continuing problems with her neck that related to the December 31, 2014 accident. (T.23; T.31; PX5). However, Petitioner still had difficulty with her memory, as well as an occasional bout of tinnitus. Her ability to recall affected her work in terms of remembering certain requirements for license renewals. (T.32-33).

Petitioner had consulted with Dr. Christine Paradee and underwent a neuropsychological evaluation on May 28, 2015. The test indicated that Petitioner was intact cognitively, except for her ability to copy and recall. Dr. Paradee concluded that this was the expected course of recovery following Petitioner's injury and that Petitioner should not fear permanent brain injury. (PX6).

Based on the totality of the evidence, the Commission finds an award of 7.5% loss of use of the body as a whole more appropriate.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed January 19, 2017, is hereby modified as stated above, and the remainder shall be affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical expenses as identified in Petitioner's Exhibit 8, and as provided in Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall receive credit for all medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act, and shall further 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.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's claim for temporary total disability benefits is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $432.00 per week for a period of 37.5 weeks, as provided in Section 8(d)2 of the Act, for the reason that the injuries sustained caused 7.5% loss of use of the body as a whole.

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

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

DATED: DEC 7 - 2017

MJB/pm
O: 11-21-17
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HAWKES, KATHLEEN
Employee/Petitioner

Case# **15WC009688**

ILLINOIS DEPARTMENT OF REVENUE
Employer/Respondent

17IWCC0785

On 1/19/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1590 SGRO HANRAHAN DURR RABIN ET AL
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0499 CMS RISK MANAGEMENT
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PO BOX 19208
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4138 ASSISTANT ATTORNEY GENERAL
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ATTORNEY GENERAL
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CHICAGO, IL 60601-3227

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

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

JAN 19 2017

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

17IWCC0785

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

Kathleen Hawkes
Employee/Petitioner

v.

Illinois Department of Revenue
Employer/Respondent

Case # **15** WC **09688**

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield**, on **November 18, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 31, 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 **$37,488.00**; the average weekly wage was **$720.00**.

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

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

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

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **4.8 days of sick leave benefits** paid to Petitioner for which credit is allowed under Section 8(j) of the Act.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$432.00/week** for a total of **50 weeks** because the injuries sustained cause the **10% loss of a person as a whole**, as provided in Section 8(d)2 of the Act.

Petitioner's claim for temporary total disability benefits is denied.

Petitioner is awarded the **medical bills set forth in PX 8** pursuant to the Medical Fee Schedule and Section 8(a) and 8.2 of the Illinois Workers' Compensation Act. Respondent's dispute regarding the bills was based upon liability. Respondent shall receive credit for all medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act and shall further 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 compensation that has accrued between **December 31, 2014** and **November 18, 2016** and shall pay the remainder of the award, if any, in weekly installments.

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

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

Signature of Arbitrator

January 13, 2017
Date

JAN 19 2017

KATHLEEN HAWKES v. ILLINOIS DEPARTMENT OF REVENUE, 15 WC 9688

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner was seen at the emergency room at Memorial Medical Center on December 31, 2014 According to page 5 of the ER documents, Petitioner leaned forward while in a sitting position and hit her head on the corner of a metal shelving unit while at work. She had about a one cm. laceration to the top of her head. (PX 3, p. 5/47) According to pages 6 and 7 of the ER documents, Petitioner complained of losing her balance and hitting her head on metal resulting in a scalp laceration. The bleeding was under control and a cervical collar was in place. (PX 3, pp. 6-7/47) A more detailed history is found on page 8 of the ER records:

> The onset was 4 hours ago. The occurrence was single episode. Slipped. Lost balance. The location where the incident occurred was at work. Location: head. The character of symptoms is bleeding, no pain, no swelling, not tingling and not loss of mobility. (PX 3, p. 8/47)

Petitioner reported that her right lower extremity was generally weak when trying to change positions due to her polio but the incident occurred so rapidly that "she just wanted to get checked out." Petitioner had fallen forward into a shelf. (PX 3, p. 8/47) Petitioner underwent a CT of her head which showed no acute intracranial abnormality. (PX 3, pp. 11, 21-22/47) A cervical spine CT showed no acute osseous abnormality of the cervical spine. (PX 3, pp. 12, 21/47) Petitioner was diagnosed with a head injury and laceration and told to follow up with Jennifer Richards within 1 - 2 days. (PX 3, p. 14/47) The integumentary assessment, shown as page 45 of 47 in Petitioner's Exhibit #3 notes that "Patient states leaned forward while in sitting position and hit head on corner of metal shelving while at work." Petitioner's head laceration was stapled shut to control the bleeding and Petitioner was discharged with a Philadelphia Collar. (PX 3)

Petitioner contacted the tele-nurse at Springfield Clinic on the day following the accident, January 1, 2015. Petitioner reported that she had hit her head at work on an over-head bookshelf the day before which required three staples. Petitioner denied any loss of consciousness or dizziness or lightheadedness but felt very tired and was sleeping a lot. Petitioner also reported an inability to concentrate. Petitioner was re-assured and told to call back if her symptoms worsened. (PX 4)

Petitioner completed a Notice of Injury form on January 2, 2015 stating that she had injured herself on December 31, 2014 when she was getting out of her chair and hit her head on a sharp corner of a metal shelf when she was "pitched forward." She reported sustaining a scalp laceration and concussion. (RX 1) Respondent reported the injury that same day. The Employer's First Report of Injury indicated Petitioner was getting out of her chair and when she stood up she went forward and hit her head on a metal corner on a shelf above her desk. (RX 1)

Petitioner contacted the tele-nurse at Springfield Clinic on January 4, 2015, reporting complaints of ringing in her ears. She described is as a high pitched sound and that it originally began the day before but had subsided only to return that morning. Petitioner acknowledged having ringing in the ears in the past and that it subsided after an "adjustment" with her chiropractor. Petitioner was calling because she'd been diagnosed with a concussion on new Year's Eve after she was at work and her chair "pitched forward" and she hit her head on the corner of a metal shelf. She was calling as she wondered if the ringing in her ears could be related to her

concussion. Petitioner was advised that ringing could be a symptom of a concussion but it wasn't an "emergent symptom." She was encouraged to discuss it with her doctor when she met with him on the 5th. (PX 4)

Petitioner was seen at the Springfield Clinic on January 5, 2015, when she saw the physician's assistant for her primary care physician for staple removal. She described herself as "woozy" and excessively tired. Her gross and fine motor skills were described as intact. Ms. Newell noted that Petitioner was not experiencing any significant balance problems outside of her usual post-polio difficulties. Dr. Richards was consulted and advised Petitioner's symptoms were typical post-concussion symptoms. She was told to stay home from work for two more days and rest and hydrate. (PX 4)

In addition to visiting her primary care physician's office, Petitioner visited with Loren Richie, D.C. for chiropractic treatment to her neck, as is more fully shown by Petitioner's Exhibit #5. Petitioner's Exhibit #5 indicates that Petitioner saw Dr. Richie on January 5, 2015, reporting she tripped and fell at work a few days earlier injuring her neck. She had been experiencing persistent pain since then, including aching and stiffness aggravated by looking up and bending. (PX 5)

A Supervisor's Report of Injury/Illness was completed by Marcy Kreorer on January 9, 2015. Petitioner's supervisor confirmed that the accident occurred on December 31, 2014 and that she received notice that same day. Petitioner reportedly did not remember the accident but the supervisor stated she "got up from her chair and fell forward hitting her head on [an] overhead shelf of cubicle." Petitioner was given a different chair after the accident. There were no witnesses. (RX 1)

On February 2, 2015 Petitioner signed her Application for Adjustment of Claim herein alleging an injury on December 31, 2104 when she "fell into [a] metal shelf." (PX 1)

Petitioner returned to Dr. Richards' office on February 16, 2015, reporting memory loss which Dr. Richards described as post-concussive. She was described as "better" but not where she needed to be. Petitioner told the doctor that she was working on December 31, 2104 straightening up her desk and had three piles on her desk. "She turned toward with her records in her hand, went to get up out of [the] chair and [the] next thing she knew she had hit her head on the sharp metal corner of the shelf over her desk." Petitioner told the doctor her chair had not been acting "right" the week before and she felt it was somewhat unstable "but not sure if this contributed to her hitting her head." She immediately sat back down and put her hand on her head but noticed blood dripping off her head and called for a co-worker. There was lots of bleeding and she went to the emergency room after co-workers urged her to do so. Petitioner reported some improvement in the last week with her memory but she was just forgetting things more easily – "mostly nouns, but was quite dramatic right after the head injury" and couldn't make sense of things that day when trying to read. Petitioner had staples removed after and had worked and driven right after the accident. Petitioner reported that she used to just power through things but was having trouble with word finding and some slower cognition. She felt she was better on the 15th. Petitioner also reported some ringing in her hears. Dr. Richards felt all of her symptoms were consistent with a concussion. (PX 4)

Petitioner returned to see Dr. Richards on March 24, 2015 and reported that she had sleep loss, but it was improving. Petitioner's ear ringing was ongoing. She described to Dr. Richards that she was unable to concentrate and related an episode of watching the television weather several times by replaying it because she could not seem to absorb it. On examination the doctor noted she had a few episodes of very minor word finding difficulty that day. Dr. Richards was concerned and opined that Petitioner might have suffered a post-traumatic brain injury. Dr. Richards did not believe Petitioner was yet at maximum medical improvement. She felt there might be some utility to a neuropsych evaluation. Dr. Richards also noted that Petitioner had been undergoing some increased stress in the last few days due to family illness (her brother had early onset coronary

disease) and was so exhausted from it that she had slept well in the last two weeks. Dr. Richards referred Petitioner for a cardiac evaluation and noted Petitioner should return for follow-up. (PX 3)

Petitioner returned to see Dr. Richards on April 3, 2015 reporting that she was still having problems with her memory. Petitioner did not feel like herself at all and had received comments from family and friends about this. Petitioner continued to report memory problems so Dr. Richards referred her to a neuro-psychologist. (PX 3)

Petitioner returned to see Dr. Richie on May 13, 2015 regarding neck complaints which she reported as being present since her accident on December 31, 2014. Cervical chiropractic treatment was provided. (PX 5)

The neuro-psychological referral was to Dr. Christine Paradee and the examination occurred on May 28, 2015 (PX 6) Petitioner testified that the examination required a full day. Petitioner provided Dr. Paradee with a history of getting out of her chair in December of 2014 when she fell forward and hit her head on a metal shelf. Since her injury she had noted problems with her memory as she would repeat herself, forget conversation, and get lost in her thoughts, especially when reading. Petitioner was having trouble concentrating but it was getting harder for her to learn new things at work. Her cognitive problems, however, had been gradually improving since the time of her injury. Petitioner denied any difficulty with her basic activities of daily living, including cooking or driving. She could handle her own finances as well as those of a nonprofit organization. Petitioner's medical history was significant for tinnitus and post-polio syndrome. Dr. Paradee's summary of tests and impressions led her to conclude that Petitioner's neuropsychological evaluation revealed overall intellectual functioning falling in the average range with indices of perceptual reasoning and speed of thought processing also in the average range. Her verbal comprehension and working memory abilities fell in the above-average range. Dr. Paradee noted, "These results are somewhat below predictions based upon a word reading task which placed her overall in the superior range." Her memory abilities were unimpaired. She had no difficulty learning and recalling verbal information, no difficulty with memory for visual information with the exception of her ability to reproduce a complex abstract figure she previously copied. Petitioner displayed no deficits in language functioning or executive abilities. Her lack of energy was felt to be consistent with her own self-report of sleep problems, worsened since her injury. Petitioner acknowledged that her cognitive symptoms had been gradually improving since her injury. She was assured she need not fear permanent brain injury despite experiencing, at the very least, a concussion. (PX 6)

Petitioner followed up with Dr. Richie on September 28, 2015 regarding neck symptoms and chiropractic treatment was provided. She made no mention of the December 31, 2014 accident. (PX 5) She returned to see Dr. Richie on October 2, 2015 and received further treatment. Again, there was no mention of the symptoms being associated with her December 31, 2014 accident. (PX 5)

On November 21, 2015 Petitioner presented to Dr. Richie regarding symptoms rated a "4/10" which she associated with her December 31, 2014 accident. Treatment was provided. (PX 5)

Petitioner returned to Dr. Richards on July 28, 2016. She continued to report memory issues and vertigo. Petitioner reported that standing in one place for more than ten minutes wasn't always possible. Additionally, when more fatigued, she would notice weakness from her post-polio syndrome. Petitioner reported issues walking to get the mail or for more than five minutes on occasion. Petitioner further reported clear drainage from her right ear after the head injury and her memory was somewhat better. Petitioner also reported sinus problems since the head injury. Finally, Petitioner noted she could no longer go on a merry go round with her grandson as she would get vertigo. Dr. Richards' diagnoses were ear problems and a closed head injury. Dr. Richards imposed standing and sitting restrictions "for life" due to Petitioner's post-polio syndrome. (PX 4)

Petitioner's case proceeded to hearing on November 18, 2016. While the issues in dispute were accident, temporary total disability, medical services, and the nature and extent of any injury, the primary issue was whether Petitioner's accident on December 31, 2014 arose out of her employment with Respondent. Respondent had a representative present for the hearing – Christopher Long. Two witnesses testified at the hearing: Petitioner and Christopher Long.

Petitioner testified that she was employed with Respondent on December 31, 2014. She was 65 years old at that time and single with no dependent children. Petitioner testified that she had worked with Respondent for approximately 9 months and was then working as an account technician. Petitioner also testified that the duties of her job involved renewal of professional licenses, on paper, in person or via computer. Petitioner testified she worked in an L-shaped cubical with tables on two sides, a computer in the center, a metal shelf above it, and an armed chair with cushioning, wheels, and an adjustable back "supposedly." (See also Petitioner's Exhibit 9.) She testified that her work area was not open to the general public.

Petitioner testified that she had reported difficulty with the chair leading up to December 31, 2014 as the back, on a couple of occasions, would work its way forward and she would be unable to move it back again to the comfortable and reasonable position. On December 31, 2014 the back of the chair was completely forward which, in turn, shorted the seating area making Petitioner hit towards the front of the chair. Petitioner testified that because of that when she attempted to stand up she was off balance and tipped. Petitioner demonstrated how she would get up to stand from the witness chair with her attorney noting that she used her hands to assist her up. Petitioner testified that she would have been able to do that in her work chair, too, if she hadn't had things in her hands.

According to Petitioner she was about to leave for the day when she was gathering various stacks of paper together that needed to be filed. She had those papers in her hands and as she went to "sit up or stand up" she couldn't brace herself and as she was sort of at the front of her chair, the chair "kind of" tipped forward, she lost her balance and slammed into the shelf above her desk basically "impaling" the top of her skull on the edge of the shelf unit. Petitioner testified that as she started to stand the chair "kind of" tilted with her. There were no witnesses but a temporary worker in the next cubicle came to her assistance and then Connie Lambert did also.

Petitioner testified that one of her co-workers drove her to the emergency room where she told the medical personnel that she "fell getting out of her chair and hit her head on a metal shelf and it cut it." At that time her head was bleeding and her neck hurt. She underwent some scans, had her scalp cleaned and stapled and was discharged to go home. Petitioner testified that she had a written list of instructions given to her but she couldn't read them because nothing made sense. The next day, January 1st, was a state holiday. Petitioner, however, did return to work on January 2, 2015 because she didn't know she wasn't supposed to. Petitioner testified that she went to work on the 2nd and it became increasingly difficult to stay there because her head hurt and she had trouble reading. She was sent home thereafter, taking a partial sick day for the remainder of the workday.

Petitioner did recall being told by emergency personnel that she needed to have her staples removed in three to four days. She called on Friday to make an appointment on Monday and mentioned to the telenurse that she was having headaches also. She also recalled calling again on the 4th and having headaches and a painful neck still. She also remembered having tinnitus which began "pretty much right away" she thought. Petitioner denied any prior episodes of tinnitus.

Petitioner testified that when the seatback was all the way forward it adjusted her center of gravity forward while sitting in the chair. She indicated it was not only uncomfortable, but described that given her larger body size she was essentially sitting toward the front of the chair. She described herself as "not tiny."

Petitioner testified that she was not in a hurry, nor was she engaged in any other activity which would have increased her risk of falling. Petitioner testified that she believed the position of her body within the chair contributed to her fall as her center of balance was off because she was pushed to the front of it when she sat in it. She also believed that picking up items with her extended arms contributed to the fall because she wasn't able to brace herself when she got up like she normally would. Petitioner acknowledged that she has pre-existing post-polio syndrome, but that such syndrome had never caused her to fall out of a chair before or since, and only manifests itself with a toe drop when walking. Petitioner testified that her post-polio syndrome did not contribute in any way to the fall. She acknowledged that she has fallen in the past while walking due to "toe drag" but she's never fallen out of a chair while getting out of it.

On cross-examination Petitioner acknowledged seeing the chiropractor when she would fall when walking or picking up something very heavy. She lacks proper strength in her right leg. She then clarified that her falls would occur due to walking and not picking up things. The latter would cause issues with her neck. Petitioner denied any issues with the wheels on the chair and denied that she was backing out of the chair at the time of the accident. She agreed that she had sufficient clearance from her chair to her desk to stand up straight without needing to wheel the chair back adding "That's probably why I turned that way to get up."

Petitioner identified the chair involved in the accident as being present in the hearing room. She further testified that the back of the chair was stuck in the forward position thereby shortening the seat. She added that she is not a tiny person. Respondent's attorney then flipped the chair over, noting it was adjusted as far forward as possible. Petitioner denied that the chair fell on her; rather, she fell into the shelf. She did believe that the chair kind of tipped over when she got up which surprised her.

Petitioner recalled that once her claim was denied maintenance came by to take the defective chair away but Linda Sutherland, who then had the chair, wouldn't let it be taken away because she loved it as it fit her perfectly. According to Petitioner, Ms. Sutherland, unlike herself, is very, very tiny in stature.

Petitioner agreed that she didn't have a plastic mat in her work area, just standard issued State thin carpet. Petitioner also testified that another co-worker, a very large man, tried to help her adjust the chair one time and, he too, had a difficult time pulling the back out of the chair. Petitioner testified that she was told her department got a lot of cast-off chairs from the Department of Revenue. The chair she was using on the day of the accident was her second chair as the first one kept "scooching really low" to the floor and she couldn't stay up in it.

During cross-examination Respondent's counsel measured Petitioner's chair. The seat depth was measured at 19 ½ inches. When the seatback was moved forward, only 16 inches remained for the seating area. Petitioner remarked that she was surprised at how easily the chair back moved back and thought somebody must have fixed it. Petitioner didn't know how or why the chair tipped over, just that it did so enough to throw her off balance. At that point Respondent's counsel attempted to adjust the chair back and stated "There is the issue. I can't get it back. I had this issue before." Petitioner replied "Aha" and counsel responded "Yep." Petitioner was then asked to demonstrate what happened to her and she did so, noting that she was sitting further back than she was on the 31st and, additionally, that the chair's wheels were rolling as she got out of the chair due to a different floor surface in the hearing room. Petitioner noted the chair had five legs. Petitioner testified that it all happened very quickly – she went to rise and the next thing she knew her head was on the shelf and there was

some kind of motion underneath her that didn't seem right. She dropped the papers as she was falling and tried to catch herself but not quickly enough.

Petitioner denied any history of blood pressure problems, black-outs, or fainting spells. Maintenance, to her knowledge, had never repaired or replaced the chair. She did mention a couple of times that she was having problems but she had just received another one and was in a new job, not yet certified, and didn't want to make "a lot of noise." Petitioner did recall mentioning it to her boss.

Petitioner testified that this was the second time she'd had a problem with the back sliding forward. She further testified that there was one other chair in the room and she tried sitting in it and it was "real tippy" so she didn't want it. Petitioner also testified that she is required to file her papers at the end of the day.

Petitioner acknowledged that her neck symptoms have resolved and her tinnitus is very occasional.

Petitioner testified that she attempted to return to work on January 2, 2015, not having been able to understand the discharge instructions given to her at the Emergency Room. She indicated that her inability to understand written instructions was unusual and attributed it to her head injury. She stated that she worked for a short period of time, but her head hurt and she was having trouble reading. She told her supervisor she thought she needed to go home and did so after working about an hour. Petitioner took partial sick time for the balance of that day, which is noted to have been a Friday. She sought medical treatment, as noted above, on the following Monday.

Petitioner testified that she had always scored well on mental function examinations and was surprised by her average result.

Petitioner testified that she continues to experience sequellae associated with her injury. She testified that she was still having memory issues and still experiencing some tinnitus. Her neck pain resolved. She also indicated occasional experiences of vertigo. She testified that all three conditions had never been experienced prior to the accident. She described that she had particular difficulty with speech, especially nouns.

Petitioner described how the symptoms have interfered with her ability to perform her job and explained that there is a different process associated with the renewal of each particular professional license. She indicated that she had a very good memory prior to the accident, but that now she was walking around with a pad of paper in order to remember details. She stated this was a particular concern given her post-polio syndrome and her reliance on her mental facilities to continue working until her pension would vest at age 75.

Petitioner testified that her injury had caused her to experience difficulties of average daily living, including having to make a grocery list to go to the store. Petitioner testified that these difficulties are frustrating.

Christopher Long testified on behalf of Respondent. He is the property control manager for Respondent and is responsible for all property within the Department of Revenue. Mr. Long identified the chair involved in the accident and testified regarding its history and locations throughout the Department of Revenue. When asked if he had noticed anything significantly wrong with Petitioner's chair, he replied that he noticed counsel for Respondent had an "issue" pushing it in. He didn't know if that would be a reason to replace the chair or scrap it but the carpenter would probably look at it and see if he could fix it.

The Arbitrator concludes:

I. Accident (C).

Petitioner sustained an accident on December 31, 2014 that arose out of and in the course of her employment with Respondent. Petitioner was clearly in the course of her employment at the time of her accident. Respondent's dispute is whether or not Petitioner's accident arose out of her employment. The Arbitrator has determined that it did.

In order for an accident to arise out of one's employment it must have had its origin in some risk connected with, or incidental to the employment, so that there is a causal connection between the employment and the injury. *Technical Tape Corporation v. The Industrial Commission,* 58 Ill.2d 226, 230 (IL. 1974). Petitioner's uncontroverted testimony was that her work area was not open to the general public and was controlled by Respondent. Her chair was the property of Respondent and provided by Respondent. The position of the seatback was not something Petitioner could control and Petitioner had requested assistance with the same on more than one occasion. Due to the problems with the chair and Petitioner's stature, she did not sit squarely on it but, rather, sat more forward on the edge. When Petitioner rose from her seat with her hands outstretched holding permit applications she needed to get filed by day's end, the chair tilted forward causing her to lose her balance and hit her head on the metal shelf above her desk, all of which creates a causal connection between the employment and the injury. In the case of *Caterpillar Tractor Company v. The Industrial Commission,* 129 Ill.2d 52(1989), the Supreme Court wrote "typically an injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts…which the employee might reasonably be expected to perform incident to assigned duties. A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties." (Citations Omitted). Clearly, Petitioner was performing a function connected with or incidental to her duties when she rose to take the permit applications to the Records Room for filing as she was required to do so at the end of her work day. In addition, she was hampered in doing so by a problematic chair. Petitioner credibly explained that given her stature and the fact that her chair was difficult to adjust and, at the time of the accident, not adjusted properly for her, she was put at an increased risk of the chair tipping over as she got up and, because she was holding work papers in her hands that needed to be filed, she was unable to provide any stability while doing so.

II. Temporary total disability (TTD) benefits (K).

Petitioner's request for temporary total disability benefits is denied. Petitioner was not taken off work when seen at the emergency room on December 31, 2014. The next day was a state holiday. On January 2, 2015 Petitioner returned to work. While she testified that she did so because she didn't know that she wasn't supposed to, she provided no medical slip or testimony showing that she was taken off work on January 2, 2015. Petitioner left work that day of her own accord. While understandable, it was not done per a doctor's order. On January 5, 2015 Dr. Richards' office advised Petitioner to stay at home for 2 more days. Thereafter, no other doctor took her off work on account of her accident. Under these circumstances, no TTD benefits would be due and owing for the two days.

III. Petitioner's medical bills. (J).

Petitioner is awarded the medical bills set forth in PX 8 pursuant to the Medical Fee Schedule and Section 8(a) and 8.2 of the Illinois Workers' Compensation Act, including reimbursement to Petitioner for any

out-of-pocket expenses as set forth therein. Respondent's dispute regarding the bills was based upon liability. Respondent shall receive credit for all medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act and shall further 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.

IV. **Nature and extent. (L)**

Permanency in this case is governed by Section 8.1(b) of the Illinois Workers' Compensation Act. According to Section 8.1(b) of the Act, for injuries that occur after September 1, 2011, 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 9(a) [AMA Guidelines];
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 factor is to be the sole determinant of disability.

With respect to (i), the reported level of impairment, the Arbitrator notes that neither party submitted an impairment report. Therefore, that factor is given no weight.

With respect to (ii), Petitioner's occupation, Petitioner testified that she is employed as a technician for Respondent and continues to work in the same job capacity as prior to the work injury, though she is training for a new position. Petitioner testified that her job requires her to use mental acuity and memory skills each day, which vary depending on work load. The work is primarily mental in nature. Petitioner testified that she is able to complete all of the essential functions of her job, but not at 100% and she does require the assistance of a note pad on occasion. While Petitioner has returned to her pre-injury job category, she has done so with continued residual effects, including some diminished memory. The Arbitrator, therefore, gives weight to this factor.

With respect to (iii), Petitioner's age at the time of the injury, the Arbitrator notes that at the time of the work accident, Petitioner was 65 years old. As such, Petitioner may be considered of relatively advanced age. Petitioner is seeking to perform her job duties until age 75 in order to have a vested pension. Her injury impacts her mental ability in a job that is primarily mental. As such, the Arbitrator gives some weight to this factor.

With respect to (iv), Petitioner's future earning capacity, no evidence suggests that Petitioner's earning capacity has diminished as a result of her work accident. Petitioner testified that she is working in the same capacity as she was prior to her work injury and earning the same rate of pay. The Arbitrator gives some weight to this factor.

With respect to (v), evidence of disability as corroborated by the treating medical records, the Arbitrator notes that Petitioner has had problems with memory, headaches, tinnitus, and neck pain since the accident. The medical records of Petitioner's treating physician, Dr. Richards, document that as of her last evaluation on July 28, 2015, Petitioner reported improvement in her symptoms. Her neck pain resolved. She occasionally experiences episodes of vertigo and tinnitus. Her primary and ongoing problems center around her memory problems and affected verbal skills. While Dr. Richards has imposed some permanent restrictions for Petitioner those stem from her unrelated post-polio syndrome and have not been causally connected to her work accident.

Petitioner was a credible witness. Respondent stipulated to causal connection. While Petitioner's initial complaints of neck pain have essentially resolved, she credibly testified, and without rebuttal from Respondent, as to residual problems with memory, verbal skills, tinnitus and vertigo.

Based upon the foregoing, the Arbitrator concludes that Petitioner has sustained 10% loss of a person as a whole as a result of her work accident.

****

STATE OF ILLINOIS)	☒ Affirm and adopt	☐ 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

Taneshia Rodgers,
Petitioner,

17IWCC0786

vs.

NO: 13 WC 28781

TANF/Illinois Department of Human Services,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 24, 2017 is hereby affirmed and adopted.

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

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

DATED: DEC 7 - 2017
KWL/vf
O-12/5/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0786

RODGERS, TANESHIA
Employee/Petitioner

Case# **13WC028781**

TANF AND/IL DEPT HUMAN SERVICES
Employer/Respondent

On 5/24/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4888 LAW OFFICE KEITH SHORT
1355 N BLUFF RD
UNITS C-D
COLLINSVILLE, IL 62234

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

3291 ASSISTANT ATTORNEY GENERAL
ELIZABETH LEAHY
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

MAY 24 2017

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

17IWCC0786

Taneshia Rodgers
Employee/Petitioner

v.

TANF/Illinois Department of Human Services
Employer/Respondent

Case # **13** WC **28781**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **March 30, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **April 2, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did not* exist between Petitioner and Respondent.

In the year preceding the injury, per the stipulation of the parties, the average weekly wage was that of **$70.85**.

On the date of accident, Petitioner was **20** years of age, *single* with **1** dependent child.

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

Respondent is entitled to a credit for **all amounts paid under group health plan** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that Petitioner failed to meet her burden of proving an employer-employee relationship existed between Petitioner and Respondent. All benefits are denied; the remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

Respondent is entitled to a credit for **all amounts paid under group health plan** under Section 8(j) of the Act.

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

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

Melinda M. Pope Gallivan

Signature of Arbitrator

5/22/17

Date

ICArbDec p. 2

MAY 24 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

17IWCC0786

Taneshia Rodgers
Employee/Petitioner

Case # 13 WC 28781

v.

Consolidated cases: N/A

TANF/Illinois Department of Human Services
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that she was affiliated with a program called Temporary Assistance for Needy Families ("TANF"). She testified that she was first referred to TANF by her Illinois Department of Human Services ("DHS") caseworker when she became pregnant with her daughter. She testified that her TANF cash benefit amount was $307 per month. She testified that she met with her DHS caseworker at a DHS office once a month to receive new time sheets and bus passes to get to her job site.

Petitioner testified that she was placed at the Jesus Place, which fed the homeless and provided clothes and household supplies to people in need. When asked what she did at the store, Petitioner testified that "...we cleaned, we mopped. We served there sometimes. We'd go through clothes, throw stuff away, we'd go get other stuff from other charities and stuff like that."

Petitioner testified that her supervisor at Jesus Place was a man she referred to as "Mr. Richard." She testified that Mr. Richard worked for Jesus Place and was there almost every day. She testified that she would physically report to Jesus Place each day, five days a week. She testified that she would check in with Mr. Richard when she arrived for the day and that he would assign her tasks for that day. She testified that she would also sign in and out for the day through Mr. Richard and that she turned in her weekly time sheets to him. Additionally, she testified if she needed to make a change to her work schedule due to personal reasons, she would discuss that with her "boss at the job", Mr. Richard, in addition to informing DHS.

Petitioner testified that there was another woman, named Deborah Beasley ("Ms. Deborah"), who worked for Jesus Place and who also helped supervise her. She testified that when Mr. Richard was not there, Ms. Deborah would tell her what to do for the day. She testified that if performance or disciplinary problems came up at Jesus Place, Mr. Richard and Ms. Deborah would talk to her about it, but she still had to report those matters to DHS.

Petitioner testified that the $307 per month she received in cash assistance was paid onto an "EBT" card in one lump sum, and the amount was determined based on the size of her household, not based on the number of hours she worked. Petitioner stipulated to the fact that no taxes were withheld from her $307 monthly grant.

Petitioner testified that Jesus Place provided all supplies necessary to complete her job duties. When asked on cross examination, "If you had to mop, for instance, would Jesus Place provide those supplies for you?" Petitioner responded, "Yes, ma'am."

Petitioner testified that a representative from DHS visited Jesus Place once to ensure it was a suitable work site for the TANF program. She acknowledged that DHS was not knowledgeable about how to run a clothing store. Additionally, she testified she did not remember the name of any specific DHS job title given to her.

Petitioner testified that on April 2, 2013, her left thumb was injured when her hand went into a fan. She testified that she received emergency treatment at Gateway Regional and that after a few months of ongoing issues, she was seen and treated by Dr. McKee.

Respondent called Kevin Schmidt to testify at arbitration. Mr. Schmidt testified that he was a Local Office Administrator at the DHS Family Community Resource Center in Granite City. He testified that he has worked in this facility since 1999 and has held his current position since 2005. He testified that in his current position, he oversees an office of approximately 35 staff responsible for implementing various Public Aid programs, including TANF. He testified that he has extensive knowledge of the TANF program as part of his job and that he has received training on the TANF program and its requirements.

Mr. Schmidt testified that the basic goal of TANF is to provide a work-in-training program for people who want to receive public assistance in the form of cash, ultimately aiding the recipients in finding gainful employment and thus removing the participant's need for public assistance. He testified that the "Work Experience" option placed TANF recipients at a work site and assigned them a certain number of hours per week to work based on the size of their household and the amount of their grant. He testified that TANF recipients were expected to report to work on a regular basis, be on time and work the prescribed number of hours. He further testified that the grant amount was not decided by an hourly pay structure, but rather decided based on the number of people in that household. He also testified that recipients received their grant money electronically on a "Link" card and that no taxes were withheld.

Mr. Schmidt testified that TANF recipients were placed at their job sites by one of two ways. He testified that the recipient first met with a DHS case worker to go through his or her RSP plan. He testified that depending on the outcome of the RSP, the caseworker either directly assigned the TANF recipient to a work site or the caseworker would work with a contractor who was hired by the state to place the TANF recipient at a work site. He testified that it was also an option for TANF recipients to pick their own work site placements. He testified that that work site placements would never include an actual DHS facility.

Mr. Schmidt testified that once a TANF recipient was placed at a work site, there was not a DHS representative present on a day-to-day basis supervising or overseeing the TANF recipient. He testified that all supplies needed to perform required tasks would be supplied by the work site, not DHS. He testified that on a daily basis, disciplinary issues and problems with TANF recipients not working their assigned hours would be handled by the work site supervisor and that DHS only got involved if those matters were reported to DHS and only after it was determined that the TANF recipient and the work site supervisor were unable to resolve the matter.

The medical records of Dr. Robert Craig McKee were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The records reflect that Petitioner was seen on February 10, 2014, at which time it was noted that she was in for a late check of her left thumb. It was noted that the pins had been removed and that the wound had healed nicely. It was noted that Petitioner had a decent nail coming in, that she had sensation at the tip of the skin and that the skin seemed well perfused. It was noted that

Petitioner had fair range of motion at the interphalangeal joint and that Dr. McKee did not know if Petitioner had been working it too hard. It was noted that Petitioner was able to pinch. Petitioner was discharged. The records reflect that Petitioner was a no-show on April 26, 2014. (PX1).

The records of Dr. McKee reflect that Petitioner was seen on December 23, 2013, at which time she brought in films, which showed non-union of two relatively good quality pieces of bone. It was noted that the pins were well-positioned and that they both penetrated the fragment but that she did not heal in between. It was noted that Petitioner was complaining of pain in the thumb which she said was pretty uncomfortable. It was noted that the pins were not visible but would be right under the nail plate. It was noted that the distal fragment was slightly displaced and may account for change in the position of the nail bed. It was noted that Petitioner had debridement and internal wire fixation approximately six weeks ago, and that Dr. McKee would not anticipate additional improvement in the non-union. It was noted that the pins would be removed under local soon, that Petitioner was agreeable and that they would have to see how she progressed afterwards. The diagnosis was noted to be that of chronic non-union of the left 1st distal phalanx, status post debridement and ORIF. (PX1).

The records of Dr. McKee reflect that Petitioner was seen on November 22, 2013, at which time it was noted that she had open reduction, interfragment debridement and internal fixation with C-wires of the left 1st distal phalanx and was doing well. It was noted that Petitioner was a little hypoesthetic along one side, and that Petitioner was grateful that her thumb was less tender. It was noted that Petitioner still had the pin in place and that the alignment was better. Petitioner was instructed to follow-up in one with a new x-ray, and it was noted that she could continue light duty work with no grasping with the left hand. At the time of the October 25, 2013 visit, it was noted that Petitioner had persistent complaints in the left thumb and radial forearm and that a recent x-ray showed non-union of the distal phalanx. It was noted that the entire tuft had been broken off in April and never healed. It was noted that Petitioner stated that she went through a period of therapy, and that she did not have any therapy after the initial repair done at Gateway ER by another surgeon but follow-up there was not forthcoming. It was noted that Petitioner was complaining also of some aching pain up the radial forearm which was intermittent and frequent with use of the hand. It was noted that Petitioner had normal range of motion and was non-tender with extension and flexion of the wrist. The diagnosis was noted to be that of (1) non-union of the left 1st distal phalanx that is causing pain and some deformity; (2) musculoskeletal pain left radial forearm, no treatment. The plan was noted to be that of debridement and open reduction internal fixation non-union left thumb under local in the hospital. (PX1).

The records of Dr. McKee reflect that Petitioner was seen on October 18, 2013, at which time it was noted that she reported changes in the appearance of the distal thumb from time to time when she did certain activities. It was noted that the pad became more prominent to her, that she had decreased sensation over the dorsum of the thumb itself and that she had some aching pains that went up the radial forearm just short of the elbow which was intermittent but bothersome. It was noted that a nerve conduction study was obtained because her history was "a little hard to get out of her" and that the exam was very difficult due to over-amplification of symptoms. It was noted that the nerve conduction study was normal. It was noted that Dr. McKee reviewed Petitioner's x-rays from last April and noted that there was a fracture of the entire tuft off of the shaft and on the original films it was a little displaced. It was noted that Petitioner stated that once her stitches were out she was not permitted to go back to Dr. Schatz because he did not take her insurance. At the time of the September 24, 2013 visit, it was noted that Petitioner had complaints of roughness of the nail where the digit was apparently shortened a little bit and some overgrowth of the cuticle. It was noted that Petitioner also reported numbness, pain and weakness in the hand and forearm. The diagnosis was noted to be that of (1) potential carpal tunnel syndrome left upper extremity; (2) nail deformities of the left thumb. Petitioner was recommended to undergo a nerve conduction study of the left upper extremity. (PX1).

The records of Dr. McKee reflect that Petitioner was seen on August 19, 2013, at which time it was noted that she had complaints related to the left thumb. It was noted that Petitioner stated that the thumb was placed in a metal industrial fan on April 2nd and that she sustained some lacerations.[1] It was noted that Petitioner stated that she thought bones and soft tissue were repaired, that she was not sure and that it was done by Dr. Schatz in the emergency room at Gateway. It was noted that Petitioner followed up with him to get the stitches out and was not invited to see him again. It was noted that Petitioner developed some stiff thumb and was referred. It was noted that Petitioner had a few complaints of some tingling in the thumb and the ulnar dorsal hand, and that it sounded like maybe the bandage was tight at one time. It was noted that Petitioner had limited active range of motion of the thumb but that the site seemed to be well-healed. It was noted that Petitioner had some nail deformity. It was noted that Petitioner complained that she could not flex the thumb and did not use it very well. It was noted that Petitioner was referred back to Dr. Schatz, the original surgeon. (PX1).

The records of Dr. McKee reflect that a work slip dated February 10, 2014 was issued allowing Petitioner to return to work full time, regular duty. The records reflect that a work slip dated December 23, 2014 was issued, taking her off work at that time. The records further reflect that a work slip was issued on November 22, 2013, allowing Petitioner to return to work light duty with no grasping of the left hand. (PX1).

The medical records of Anderson Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner underwent a nerve conduction study on October 9, 2013, which was interpreted as a normal study. According to the Operative Report dated November 7, 2013, Petitioner underwent open reduction with interfragment debridement and internal fixation with C-wires for a pre- and post-operative diagnosis of chronic nonunion of the left first distal phalanx. The records reflect that x-rays of the left first finger performed on December 23, 2013 were interpreted as revealing left 1st distal phalangeal fracture, no evidence of osseous union at present. Per the History and Physical dated January 17, 2014, Petitioner did not arrive for surgery as planned for C-wire removal under local anesthetic. The records reflect that Petitioner underwent pin removal on January 22, 2014 by Dr. McKee. X-rays of the left hand performed on the same date were interpreted as revealing removal of 2 K-wires from first digit; nonunion or incomplete union at the fracture of the distal phalanx. (PX2).

The medical records of Gateway Regional Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on April 2, 2013, at which time it was noted that she was moving a van [*sic*] and accidentally stuck her left thumb into the fan blade and received lacerations to the dorsum of her left thumb. It was noted that there was a complex laceration that was jagged with active hemorrhage and that there was severe tenderness to palpation. It was noted that x-rays of the left thumb were positive for a fracture of the distal phalanx. It was noted that the case was discussed with Dr. Richard Shatz, who would see Petitioner in the Emergency Department. The Plastic Surgery Emergency Room Consultation note dated April 2, 2013 noted that Petitioner had three lacerations to the dorsum of the left thumb measuring a total of 6 cm, that the wound margins were of questionable viability on several of the wounds and would require debridement, that the nail was fractured and that there was a laceration of the underlying nail bed. The diagnoses were noted to be that of (1) open fracture of the left thumb distal phalanx; (2) lacerations of the nail bed and dorsal skin of the left thumb. It was noted that the plan was for reduction of the fracture and debridement and repair of the lacerations, and the Operative Report noted that the procedure was performed on the same date. The interpretive report for x-rays of the left hand also performed on April 2, 2013 noted that the films were interpreted as revealing a mildly distracted comminuted fracture of the distal first phalanx. (PX3).

[1] Any underlining that appears in the exhibit was not made by the Arbitrator.

The records of Gateway Regional Medical Center reflect that Petitioner underwent x-rays of the left finger/thumb on October 21, 2013, which were interpreted as revealing previous-noted fracture site of the distal first phalanx demonstrates evidence of nonunion. (PX3).

The Medical Bills of Dr. Robert Craig McKee were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The Medical Bills of Anderson Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The Medical Bills of Gateway Regional Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The Medical Bills of Dr. Richard Shatz were entered into evidence at the time of arbitration as Petitioner's Exhibit 7.

The TANF Brochure was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The brochure noted that the Temporary Assistance for Needy Families ("TANF") program was run by the Illinois Department of Human Services ("DHS") and was a program for families with children and pregnant women who needed temporary cash assistance. The brochure noted that applicants would be asked to come to the Family Community Resource Center ("FCRC") for an interview, and that DHS would make a decision on the application and notify the applicant in writing within 45 days. The brochure further noted that if the application was approved the applicant would receive monthly cash and medical benefits as long as the individual qualified for TANF, that cash benefits would be issued electronically through an Illinois Link card or deposited directly into a bank account and that the applicant would also receive a medical card that let them take part in the Healthcare and Family Services' Medical Assistance program. (RX1).

The brochure noted that if the applicant were a single parent who was able to work and the youngest child was under age 6, the individual must work or participate in a work activity for at least 20 hours per week. The brochure further noted that if the applicant was a single parent who was able to work and the youngest child was age 6 or older, the applicant must work or participate in a work activity for at least 30 hours per week. It was noted that work and training activities included unpaid work experience, on-the-job training, job search, community service programs, vocational education, subsidized employment, work-study, VISTA and Job Corps. (RX1).

The DHS Work Experience Referral Form was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The Referral Form noted that Petitioner was referred to Southern Illinois Collegiate Common Market and that she had an appointment scheduled for December 4, 2012. The DHS Employee Name was noted to be that of Lisa Coleman, and that client services were initiated on December 11, 2012. (RX2).

The Taneshia Rogers DHS Responsibility and Services Plan was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The Plan noted that Petitioner's goal was to obtain the skills needed to become employed, and the Primary Core Activity was noted to be that of Work Experience. It was noted that Petitioner was to report to Jesus Place on December 10, 2012. The Plan noted that Petitioner was to participate in the activity as assigned, turn in verification of weekly attendance, attend case management meetings at the request of the caseworker or work & training provider, check want ads, complete and submit resumes to possible employers, contact possible employers by phone, email or in person and that she was to ask her employer for more hours or advancement possibilities if working. (RX3).

CONCLUSIONS OF LAW

With respect to disputed issue (B) pertaining to whether an employer-employee relationship existed between the parties, the Arbitrator finds that Petitioner failed to meet her burden of proving an employer-employee relationship existed between Petitioner and Respondent.

The existence of an employment relationship is a prerequisite for any award of benefits under the Act. There is no specific litmus test for determining whether an employer-employee relationship exists. Instead, there are multiple factors to consider when assessing the nature of the relationship between the parties. *Ware v. Indus. Comm'n.*, 318 Ill. App. 3d 1117, 1122 (1st Dist. 2000). Among these are: (1) whether the employer may control the manner in which the person performs the work; (2) whether the employer dictates the person's schedule; (3) whether the employer pays the person hourly; (4) whether the employer withholds income and social security taxes from the person's compensation; (5) whether the employer may discharge the person at will; (6) whether the employer supplies the person with materials and equipment; and (7) whether the employer's general business encompasses the person's work. *See Robertson v. Indus. Comm'n.*, 866 NE.2d 191, 200 (Ill. 2007). Other relevant factors include the label the parties place on their relationship, and whether the parties' relationship was "...long, continuous, and exclusive." *Ware*, 318 Ill.App. at 1122, 1126. No single factor is determinative and such determination of the employer-employee relationship rests on the totality of the circumstances. *Roberson*, 866 NE.2d at 200.

In the case at hand, the evidence reveals that DHS did not control the manner in which Petitioner performed her work. Petitioner reported to work every day to Jesus Place, which was not a DHS facility. Mr. Richard and Ms. Deborah, both employees of Jesus Place, were her direct supervisors and oversaw the work she did each day. Mr. Richard assigned her tasks to do each day when she got to work. If Mr. Richard was not there, Ms. Deborah filled in and instructed Petitioner in what to do that day. Petitioner signed in and out each day with Mr. Richard. If any problems or concerns came up regarding performance or disciplinary matters Petitioner testified she would talk to Mr. Richard and Ms. Deborah about it. Additionally, Petitioner testified if she needed to make a change to her work schedule due to personal reasons, she would discuss that with her "boss at the job", Mr. Richard, in addition to calling Springfield (DHS) to let them know and bring in proof. As such, any control over the manner in which Petitioner performed her work rested with Jesus Place and not DHS.

The evidence reveals that DHS did not dictate Petitioner's schedule. A requirement of being a TANF cash assistance recipient was that Petitioner had to complete 20 hours a week at a work in training program. The number of hours Petitioner was required to work each week was set by the TANF program based on her family household size. As explained by Mr. Schmidt's testimony, Petitioner was not required to actually work at a DHS facility to fulfill her 20 hours per week work requirement and once placed at the Jesus Place worksite, the specific way in which Petitioner was to complete those 20 hours was dictated by Jesus Place, not DHS. Petitioner had to work during the hours Jesus Place could accommodate her. As such, Petitioner's supervisors at Jesus Place who oversaw the daily operations of that facility dictated Petitioner's schedule, not DHS.

Furthermore, the evidence reveals that Petitioner was not paid an hourly wage. Both Petitioner and Respondent's DHS witness testified to the fact that she was not paid hourly. In fact, Petitioner was never paid any salary whatsoever from DHS, rather she received a government benefit in the form of a cash grant. Petitioner did not receive payment from DHS, but instead, her ability to satisfy the TANF program's work requirement kept her eligible to receive $307.00 in cash each month in government benefits. Additionally, DHS did not withhold income and social security taxes from Petitioner's monthly cash grant. Petitioner stipulated to the fact that DHS never withheld taxes of any kind from the monthly cash grant.

Additionally, the evidence reveals that DHS did not supply Petitioner with any materials and/or equipment for her job at Jesus Place. One of Petitioner's job duties at Jesus Place was cleaning and mopping. Petitioner testified that Jesus Place provided all supplies necessary to complete her job duties. While DHS provides services of all kinds to many different people, the general business of DHS has nothing to do with running a clothing store or soup kitchen. Both Petitioner and Mr. Schmidt testified that DHS was not present for or knowledgeable about the day-to-day operations of Jesus Place.

Furthermore, Petitioner never applied for a job at DHS. Instead, Petitioner applied to receive benefits distributed through a government assistance program. She was a TANF recipient who was offered placement at a qualified worksite, Jesus Place, which was located outside of any DHS facility, to satisfy the TANF program's work requirement in exchange for government assistance. Petitioner testified that every task she completed at Jesus Place was in her capacity as a work experience participant. Mr. Schmidt testified that the policy behind TANF is to temporarily aid needy families and support them toward achieving self-sufficiency by eventually getting off of cash assistance and obtaining a job. This is a governmental assistance program, not an employer.

In sum, Respondent in the instant case satisfies six of the seven factors used to determine that an employer-employee relationship does not exist. To consider Petitioner an employee of DHS would have the implication of treating recipients of government benefits through any State of Illinois social program as employees of the State of Illinois. For the reasons outlined above, the Arbitrator finds that there is a difference between governmental assistance recipients and an employee within the meaning of the Act. Thus, the Arbitrator finds that Petitioner failed to meet her burden of proving an employer-employee relationship existed between Petitioner and Respondent.

In light of the Arbitrator's finding that Petitioner failed to meet her burden of proving an employer-employee relationship existed between Petitioner and Respondent, all benefits are denied. The remaining issues of medical bills, temporary total disability and the nature and extent of Petitioner's injuries are moot, and the Arbitrator makes no conclusions as to those issues.

STATE OF ILLINOIS	)	☒ Affirm and adopt	☐ 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

Emilia Hafertepe,
Petitioner,

17IWCC0787

vs.

NO: 07 WC 8764

CHOATE Mental Health Center,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 19, 2017 is hereby affirmed and adopted.

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

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

DATED: DEC 7 - 2017
KWL/vf
O-12/5/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0787

HAFERTEPE, EMILIA
Employee/Petitioner

Case# **07WC008764**

CHOATE MENTAL HEALTH CENTER
Employer/Respondent

On 6/19/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.10% 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:

5404 FOLEY & DENNY
TIMOTHY D DENNY
PO BOX 685
ANNA, IL 62906

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

0558 ASSISTANT ATTORNEY GENERAL
NICOLE M WERNER
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JUN 19 2017

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 17IWCC0787

EMILIA HAFERTEPE
Employee/Petitioner

v.

CHOATE MENTAL HEALTH CENTER
Employer/Respondent

Case # **07** WC **08764**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Herrin**, on **June 17, 2016 and September 7, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0787

FINDINGS

On **September 20, 2006**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$28,889.98**; the average weekly wage was **$555.58**.

On the date of accident, Petitioner was **48** years of age, ***married*** with **1** dependent child.

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

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

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

Respondent is entitled to a credit of for any and all medical bills paid by the Respondent's Group Health Insurance Carrier pursuant to section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner has failed to prove she sustained an accident arising out of and in the course of her employment on September 20, 2006. The Petitioner has failed to prove a compensable claim based upon a mental-mental theory. The Petitioner has failed to prove that her psychological condition was caused by a compensable work accident.

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

May 25, 2017
Date

JUN 19 2017

STATEMENT OF FACTS

Born in El Salvador, the Petitioner began working for the Respondent on 11/18/04. After training for her position as a mental health technician, she chose to work in the Senior Lower unit. She worked there with another tech, Terrence (Tony) Funk, who she testified harassed her verbally from the first day she worked there. She testified that he would call her Mexican and "wetback", and that she should go back to Mexico. She testified that she transferred to the Cypress unit to get away from him, but that Funk then transferred into the same unit. Petitioner testified that while she was taking care of an aggressive patient, one-on-one, Funk threatened to wake him up, telling her "that he going to put him on the loose so he could beat me up." She reported Funk's harassment to supervisor Linda Thompson, who said she would take care of it, but never did. When she reported it a second time, Petitioner testified that Thompson told her to be quiet about it, and that Respondent didn't like whistleblowers.

On 9/20/06, Petitioner testified that she was assigned to Group 3. A patient named Nancy called for help, and Funk was the only one who went to help her. A co-worker came into the Petitioner's Group room, and Petitioner testified: "It was unusual after that. All these years I've been thinking that she would tell me to go to check a room, and I went, and I saw Tony Funk on top of this lady, and he was making noises like he was having sex." Petitioner testified that Funk told her she hadn't seen or heard anything, and if she reported anything, he would do the same thing to her daughter. She testified that Funk knew where she and her daughter lived, and she believed he would do something to her daughter.

Petitioner testified she couldn't take it anymore and reported the incident, after which she was sent home on administrative leave. She did not specifically testify when she reported this. After being put on leave, she spoke to Dr. Lagerman, a counselor obtained through her union, about what was happening, and he referred her to Dr. Grater for treatment. She testified she would have dreams of Funk coming to her house and raping her daughter. Dr. Grater treated her as an outpatient, and Petitioner testified his treatment helped her: "it practically saved my life".

Petitioner testified it took her years to return to work, but she returned to work in the dietary unit in 2010 and continues to work there. She testified she continues to see "flashes" of Funk on top of the patient, and that she continues to take medication.

On cross examination, Petitioner couldn't recall if it was in August 2006 that she actually saw Tony Funk on top of the patient, but agreed she was put on administrative leave based on her failure to report the incident in a timely manner, and agreed she had a duty to do so. However, she said she didn't initially report it to protect her daughter, and that she believed she would be in trouble whether she did or didn't report it.

Petitioner couldn't recall if she remained on administrative leave and off work from 9/22/06 to 2/18/10, but agreed she received her full salary while on leave. She agreed she signed a settlement agreement related to an administrative hearing on her work status (Rx4) that indicated a 53 day suspension, but testified that she was never suspended from work. She testified that when she signed it she was on medication and didn't understand what it said. She did have an attorney representing her. She agreed her current position does not require patient care. Petitioner agreed that during counseling she indicated she wanted to return to work, and testified that she loved her job.

Petitioner has filed workers compensation claims for other work injuries and is familiar with the reporting requirements. Petitioner agreed she signed Rx1, a Workers' Compensation Notice of Injury, on 9/30/07, but

didn't fill it out herself. The document alleges that Petitioner was threatened by Tony Funk after she reported sexual mistreatment of a resident; that she reported it to Supervisor Thompson on 9/20/06; and, that she was alleging mental distress, PTSD and depression. Witnesses were listed (Steve Benefield, Donna Whittenton and Susan Dixon). The document notes Funk's alleged threats to her daughter if Petitioner reported the incident caused her anxiety and fear of leaving her daughter alone or coming to work because she was afraid of "consequences to me." She also indicated that Funk called her a wetback, told her to go back to Mexico, said her accent was stupid, and that other people on the unit heard this. It also states she reported it to her supervisor. (Rx1).

Rx4 (dated 6/29/10) is a "Settlement Agreement and General Release" indicating the Petitioner and Respondent stipulated, in lieu of discharge, Petitioner would accept a 53 day suspension, release Respondent from any possible civil claims, and dismiss a pending Human Rights Commission case. She agreed to work for Respondent in a non-direct patient care position in Respondent's main dining hall and take a voluntary reduction in her employment position from Mental Health Tech II to Support Service Worker. She would earn $2,761 per month and be "red-circled" for future increases. Petitioner would be reimbursed $4,831.75 in back pay, and the agreement indicates it was entered into voluntarily. (Rx4).

Petitioner agreed she was recently suspended from work for trying to obtain overtime in a job that involved patient care, which was in violation of the restrictions indicated in the agreement (Rx4). She testified she had asked a Jimmy Rawls for some sort of training, was trained, and was called multiple times to work overtime until she finally decided to work one midnight shift. She testified she has been asked by her supervisor to perform translation where there was direct patient contact, and that she sells food to patients. She believed the Respondent should have flagged positions she was not supposed to perform so she would know, and did not do so. On redirect, Petitioner testified that in addition to being asked to translate by supervisors, she has been asked on multiple occasions to work with recipients and cover overtime shifts. When she was suspended for covering the overtime shift, she testified that the supervisors who asked her to do so didn't get in trouble, including Gina Millis, the current Respondent labor relations director. She again testified she didn't read the settlement agreement paperwork and wasn't informed that she agreed not to have patient contact. She claimed that Mr. Mooreman told her she was put into the dietary job for her own protection.

Linda Thompson did not testify at hearing, but her Supervisor's report regarding the workers' compensation claim was admitted into evidence. (Rx2). The document states that Petitioner reported an alleged 9/20/06 incident on 11/15/07, and was claiming "PTSD from interaction with co-worker". The document also states Thompson was unaware of any incident or injury or evidence of injury to Petitioner. (Rx2).

Respondent's labor relations administrator for 30 years until his March 2014 retirement, Mike Moorman testified on behalf of the Respondent and indicated that his duties included administering discipline. He was present for the Petitioner's testimony, and indicated she was sent home on administrative leave on 9/20/06 because she failed to report an August 2006 patient abuse incident involving Tony Funk. Under Federal and Illinois rules regarding client protection, the Respondent is required, if someone has neglected or endangered a patient, to remove them from direct patient care. In this case, pending investigation, Funk was removed from patient care, and Petitioner was also removed from patient care because she failed to report the abuse, which put the patients in danger of further abuse. As a mental health technician, Petitioner had a duty to report abuse immediately, and she failed to do so.

Mr. Mooreman testified he never told her Petitioner she was put on leave for her protection, but rather that it was for the recipients'/patients' protection, and that she would receive full pay per the guidelines pending the outcome of an investigation. He agreed that Petitioner's leave period, from 9/06 to 2/10, was "unusually

protracted." During her leave, the Petitioner contacted him 2 or 3 times asking to return to work. He noted to her that she was receiving her full salary, but Petitioner indicated she was missing out on overtime.

Mr. Mooreman agreed the settlement agreement (Rx4) indicated Petitioner wasn't to work in a position with direct patient care due to the nature of the charge substantiated against her, patient neglect. The Respondent felt she wasn't competent to work with patients. He testified that performing translation for patients/recipients would not be considered direct patient care, because direct patient care entails attending to the needs of the patient and responsibility for the protection and care of the patient/recipient to avoid self-injury and injury from others. Based on the investigation, Mooreman testified that both the case against Petitioner and Funk were substantiated. Petitioner was originally discharged, but this was later modified per Rx4 to a suspension.

On cross exam, Mr. Mooreman testified that the first priority of direct care staff is to protect the residents/patients. Following the settlement agreement, he never asked Petitioner to work in direct patient care because it would be in violation of the agreement. He had no authority to "waive" that agreement to allow Petitioner do so, and doesn't know who would have such authority. Mooreman agreed that Tony Funk was terminated and referred to the prosecutor's office.

Respondent's interim public service administrator in labor relations for the last two years, Gina Millis testified that she had been previously been an office administrator since 1998, and worked in the Respondent's labor relations office at the time relevant to this case. She was familiar with the 2006 incident with Petitioner and Tony Funk. Petitioner was initially placed on administrative leave for this, and when she returned was suspended pending discharge. An agreement was later reached where Petitioner agreed not to accept any position involving direct patient care due to the allegation of failing to timely report sexual abuse of a client, in lieu of discharge.

Millis testified Petitioner also was recently (6/27/16) suspended for 15 days, per agreement of both Petitioner and the union, because she worked overtime as a tech involving direct patient care, in lieu of discharge or grievance. Petitioner undertook training as a tech so her training would be up to date, and signed up on the voluntary overtime list with the timekeeping department, which assigns overtime to employees. Any employee can sign up for voluntary overtime. Petitioner worked one overtime shift as a mental tech health tech, and was scheduled for the following day, when her supervisor in dietary found out when she went to sign staff assignment sheet. As soon as Millis found out, she acted to prevent it from happening again. She testified the Petitioner was not asked or ordered to work as a mental health tech by Respondent, or to participate in direct patient care. However, she agreed she was not present when Petitioner was offered the overtime. Millis testified that any employee can sign up for training, and that who signs up is not monitored by management. She agreed that the timekeeping department would not have been privy to a settlement agreement like Petitioner's, because it was private between Petitioner and Respondent, but they have since been notified without being informed of why. Millis testified this wasn't done previously because she would assume the employee, as party to the agreement, would accept the responsibility to follow the agreement. Overtime was not mandatory.

Ms. Millis testified that she believed the Petitioner filed an internal report, in September 2006, regarding harassment by Tony Funk. At that point, Respondent performed an internal investigation, and following this it was determined that Petitioner's complaint was found to be unsubstantiated ("There were several statements taken by security, and the majority did not witness any harassment."). She agreed that, at least in part based on recipient/statements, which she assumed indicated Funk had assaulted them, the charge against Funk was found to be substantiated. Ms. Millis testified that Linda Thompson, retired about 2 years prior to the hearing. Millis testified that she is familiar with Respondent's workers' compensation procedures, and if an employee reports an injury, they would receive a workers' compensation packet and would be sent to see a facility physician

immediately. According to Rx2, Linda Thompson's supervisor's report, the Petitioner's injury was reported in November 2007.

On cross exam, Ms. Millis testified that she "would assume" the center director and the employee, as well as labor relations, would be responsible for protecting patients from workers who are not supposed to be involved in direct client care. Petitioner was allowed to work with recipients in 2016 because she took it upon herself to get training and sign up for overtime. To Millis' knowledge, supervisors are not notified by her or Respondent of agreements where employees are not supposed to work in direct client care. As to the 2016 incident, she testified that as soon as it happened, the supervisors were notified that Petitioner was not to work in direct patient care, albeit after Petitioner had already worked the shift. No supervisors were disciplined based on the incident. Millis agrees the agreement (Rx4) is binding on both parties.

Respondent's interim director of operations for the 16 months prior to hearing, Chris Doctorman testified on behalf of Respondent. He was the chief engineer before that. He testified that he is Petitioner's current supervisor, that she is working full duty as a coordinator, and that he has never asked her to work overtime. On cross exam, he testified he has never seen the noted settlement agreement (Rx4) before. He agreed that he does have to approve overtime, but was not responsible for approving Petitioner's overtime shift in direct patient care.

Petitioner's Exhibit 1 constitutes the investigative file of the Illinois Inspector General with regard to Petitioner's allegations regarding Terrence (Tony) Funk. The Arbitrator notes that numerous statements were obtained from both Choate staff and recipients/patients. The statements generally indicate that Funk played "sex games" with several of them, which essentially involved simulated sex while clothed. The Arbitrator notes that the recipients/patients had some level of mental disability. Funk denied the allegations against him. The Petitioner's statements were consistent with her testimony. This included witnessing Funk on two occasions, in August 2006 and on 9/9/06, engaging in these types of actions. She also noted the ethnic harassment, sexual harassment and threats from Funk that she testified to, and there is an indication that while on a group outing Funk was actually at her home and saw her daughter, which supports that he did know where she lived. The Arbitrator does note that one of the residents alleged that Petitioner asked her to write a statement regarding Funk yelling at Petitioner, and indicated that this was because Funk wanted another tech to work on his shift instead of Petitioner, and that Petitioner was crying. The Arbitrator further notes that some of the statements involve factual discrepancies versus other statements. In any case, Mr. Funk was discharged for his actions, as was Petitioner for failing to report the incidents of August 2006 and 9/9/06 promptly. (Px1).

Petitioner's Exhibit 2 is an undated handwritten statement of the Petitioner that is generally consistent with her testimonial allegations against Mr. Funk. (Px2).

Medical Records from Saint Mary's Behavioral Medicine outpatient program were admitted into evidence as Petitioner's Exhibit 3. Based on his testimony (below), the program was administered by psychiatrist Dr. Grater and a staff of therapists. The Petitioner was initially seen there on 10/6/06. That initial report noted the Petitioner saw a male co-worker sexually abusing a female patient, Tony Funk, and that he threatened her if she reported it. She saw a second incident, and reported he then was threatening her daughter. She noted he had imagined her as a pole dancer. Petitioner also referenced racism and discrimination. She alleged that depression/anxiety stemmed from these factors. She also noted that when she had called for help at work before 9/20/06, she would not get anyone to respond. She had lost 60 pounds over the prior 2 years. Also noted were "cultural considerations" and "flashbacks", without specific information. Petitioner was very tense, shaking and crying. She was diagnosed with major depression – single episode, and was entered into the partial hospitalization program. (Px3).

The Arbitrator's review of the records initially notes that many of the records are handwritten and not always easy to decipher. Many aspects of the Petitioner's life were becoming stressful around this time, including her husband having an affair and asking for a divorce, financial problems (which appear to be due to conflict in the divorce settlement, and possibly as well as, per Petitioner's testimony, her lack of overtime while off work), issues with her 15 year old daughter, her father's death from cancer and her inability to go to see him in El Salvador, and problems with the slow process of the investigation at work and the attorney involvement in both her workers compensation claim and her divorce. The records do repeatedly reference Petitioner wanting to go back to work, but not in the unit where she had the situation with Funk. The Arbitrator notes that the specific issues with Funk and her fear of him seem to have essentially disappeared from the records relatively early in her treatment, mainly after 10/23/06 when she couldn't sleep and expressed fear he would come into her room, and the focus then was on her ability to deal with the Respondent's investigative and disciplinary process and on factors surrounding her husband and the divorce. There were references to guilt for various things, inability or lack of desire to leave her home, tearfulness and hopelessness, and there was a 12/06 reference indicating she reported attempting suicide by leaving the car running in the garage. There were references to wanting her husband to come in as well, but it does not appear that this occurred. The last note in the exhibit is dated 9/30/08. (Px3).

Ae summary of her treatment was provided by Dr. Grater on 8/24/09. He noted his diagnosis was: 1. Major depression disorder, recurrent, 2. PTSD, and 3. anxiety disorder, which Dr. Grater believed "are clearly and directly associated with the incident occurring on 9/20/06. The remainder of the letter from Dr. Grater summarizes his testimony that prior to that incident she was doing well and after the incident she became depressed, anxious with symptoms of post-traumatic stress disorder many of which remain today but are reduced. He also confirmed that as of the date of the report, the Petitioner had returned to Choate Mental Health but preferred not to work in the same unit she was on before, and the only restriction that was placed on her was to not be placed in the same unit where she previously worked and that she have no contact with anyone involved in the 9/20/06 incident. (Px3).

Medical Records from Rural Health were offered into evidence at Px4, and this appears to be her primary care provider. On 10/4/06, Petitioner was there for a follow up of a knee problem and she reported that she wants to cry very easily and this was precipitated by an incident at work were she was being harassed by a fellow worker, and that both she and the fellow worker were moved to different units, and she felt like she was being punished for reporting the situation. She reported feeling so bad several weeks prior that she started to take an overdose of pills but stopped herself because of her fifteen year old daughter. She also reported that her husband was doing some things at work "that he shouldn't have been doing". He told her not to tell on him, and when he saw her go to the supervisor's office, she says he tripped her, and that this was witnessed by other personnel. "He also told he to 'remember that she has a 15 year old daughter at home'." As noted by Dr. Jarvis, it appears that this was actually with regard to Funk, not her husband, but the Petitioner never testified that Funk tripped her at any point in time. She was diagnosed with anxiety and depression, and the report states: "I was going to increase her Effexor XR up from 75 to 150, but she states that when she takes 150 mg it makes her head feel funny." As such, her medication was changed to Zoloft, and she was to keep her appointment with a counselor she found through her union, Paula Logeman. (Px4).

On 10/11/06, a report notes Petitioner had a "familial tremor" and depression. The remainder of the records in this exhibit reference both physical and sometimes her psychological issues, with the psychological issues noted being very similar to what is indicated in Px3. On 11/1 and 12/2/13, the Petitioner reported that Dr. Johnson would no longer be prescribing psychiatric medications, and she requested that Rural Health would thus need to handle this. On 2/10/14, Petitioner reported ongoing anxiety, that she was having difficulty working due to stress, and that she was having issues with "relationships" that was also causing problems. On 3/27/14, Petitioner

reported having increased anxiety and depression, as well as approximately 2 panic attacks per week. She reported stress at work, and "some racism towards her", and that a co-worker had been fired in 2006 for such harassment. She was taking Cymbalta and Xanax at this time, and her past medications included Celexa, Effexor, Seroquel, Zyprexa, Abilify, Klonopin and Ambien, noting the latter was the only one she felt worked for her of this group. She noted a history of physical abuse from her ex-husband that went on for quite some time before they were divorced. (Px4).

There are some specific psychological notes from Rural Health as well. A 4/24/13 note indicates Petitioner has a history of depression and anxiety dating back to 2004. She said she started to work a more stressful job and struggled with her mood ever since. She also since that time was divorced and lost both parents, and had a major neck injury that kept her off work for several years. She reported suicide attempts in 2005 and 2006, noting she had been seeing Dr. Grater since 2005. She noted the incident with Funk and her allegations that he threatened her multiple times before he was fired. In dietary at her job now, she is in middle management and has difficulty being caught between her supervisor and the workers she supervises, and "she states that her anxiety is mostly over stresses at work and 'any conflict'." She had been married 23 years, had no children (her daughter is adopted), and their relationship was emotionally and at times physically abusive. He left her after they thought she would lose her job and she wasn't bringing home income, and she discovered he had lied to her about having a vasectomy. The diagnosis was major depressive disorder and anxiety. On 5/23/14, Petitioner noted she was feeling better, but had a verbal altercation with a male coworker who has been verbally abusive to other female workers in the past: "He cornered her in the elevator and yelled at her for taking the time to heat up a resident's food. She discussed the incident with her supervisor and wrote up a statement for the union representative. She states that the co-worker was angry and said threatening things to others after he was called out on the issue but since then has been very quiet and not talking to her." In discussing anxiety about her future, her thoughts immediately turned to her pain of divorce and the past. The last noted visit was 7/30/14, at which time she was continued on Cymbalta, Ambien, Xanax, propranolol and buspirone for depression and anxiety. (Px4).

Petitioner also treated at Union County Counseling with the above noted Dr. Johnson, it appears from 12/10/12 to 10/28/13. (Px5). The initial report notes Petitioner felt harassed and bullied at work, including from her supervisor (1/10/13), which was making her life harder. She specifically reported the incident with Funk and that he threatened her daughter. The records significantly note that the Petitioner essentially felt her job was miserable, and that she felt that people at work were trying to get her or to harass her. She noted the issues with her ex-husband, particularly financial issues related to a second mortgage that had been taken out on their home. The report stated also: "Patient says she was first treated for depression and anxiety about 5 to 7 years ago surrounding her divorce." The Arbitrator notes that the Petitioner had undergone what appears to have been a cervical fusion around this time as well, and there were some issues involving interaction of pain and psychological medications. She was advised several times by Dr. Johnson that if her job was that miserable, she should look for employment elsewhere. The last progress note located in the exhibit is dated 10/28/13, at which time Petitioner reported a friend had stolen her Xanax, and Dr. Johnson indicated he would not refill it, and that neck surgeon Dr. Fonn, who didn't want her to take it along with Vicodin, would be notified. (Px5).

Medical Bills were offered into evidence as Px6. The records show that the Petitioner was treating from 12/6/06 through 9/15/10.

Dr. Simeon Grater testified live before the Arbitrator. A psychiatrist since 1972, currently board certified, Dr. Grater testified he is semi-retired but still does perform work as an independent contractor. From 1994 to 2012 he was an outpatient physiatrist at Saint Mary's Hospital. Dr. Grater's Curriculum Vitae was submitted into evidence as Petitioner's Exhibit 7. He testified that he reviewed his records, as well as the records of various other therapist and counselors who worked with Petitioner, to re-familiarize himself with the Petitioner's case.

With Petitioner, one of the counselors at his outpatient office did the initial evaluation, and Dr. Grater then saw her to determine with a treatment plan. Petitioner was admitted to an intensive outpatient therapy program, which operated out of the same building where he had his office, and that involved the collaboration of several therapists.

The Petitioner was referred by Paul Logeman, a counselor in the Employee Assistance Program at Choate, as well as by her primary care provider, Dr. Earnhart. At the initial 10/9/06 visit, Petitioner provided a history of observing one of her co-workers, Tony Funk, at Choate on 9/20/06 engaged in some kind of sexual behavior with one of the patients, and that Tony then threatened to harm her and her 15 year old daughter if she reported it. She indicated Tony also told her he had fantasies of her being a pole dancer, which also frightened her a lot. She said the fear of Tony harming her or her daughter was why she didn't timely (within 24 hours) report the incident as required by her employer, and that she was reprimanded for not doing so. Petitioner also reported being harassed by co-workers, including one named Jackie, who thought she was lying. Based on what he was able to discern, the Petitioner was doing okay prior to this incident and was not being treated for any type of mental disorder.

The lack of a pre-existing history of a mental disorder was important to Dr. Grater because, at that time, the DSM-4 was the diagnostic standard for all psychiatric diagnoses, and for a post-traumatic stress disorder (PTSD) to be diagnosed, someone should be functioning relatively well until they either observe or experience an event that is outside the course of normal human events, and then develop acute onset of symptoms. Had Petitioner not been functioning well prior to such event, then "we'd be in a different ball park". She was apparently functioning well and then this incident occurred and she developed symptoms that were diagnostic, in Grater's opinion, of PTSD. This included being very lethargic in her motor behavior, hypoactive, very tense and shaking and showing a tremor. Her affect was also predominately sad and crying, she had a heightened intensity of emotion and her range of emotions was very restricted. Dr. Grater noted that her thoughts were congruent and organized, and that she was not psychotic, delusional or living in an alternate reality. She was oriented to person, place and time. She had average intelligence, and intact memory and abstract thinking. She was not suicidal, was functional and her activities of daily living were good. She did report that she was experiencing flashbacks regarding the incident with Tony and the resident, as well as Tony threatening her.

Dr. Grater attributed the primary diagnosis of PTSD to the incidents with Tony Funk. This was based on a chronological sequence of her doing well, witnessing Funk doing something he shouldn't have been doing, threatening her, her waiting to report it, and then being scrutinized for not reporting it according to the protocol. Then her co-workers claimed she was lying. Dr. Grater believed that her witnessing the event with Tony and the resident was shocking to Petitioner, as well as the "situation where you report something that you think is egregious and instead of saying good for you, people criticize you." The long term effects of PTSD, an anxiety disorder, depends on the person. Anxiety and depression, normal parts of being human, become a disorder when it interferes with functioning. For Petitioner, this event was significantly disruptive to her life and functioning. While other events occurred as well, including marital issues, the "seminal event" occurred at work.

While Dr. Grater recommended that Petitioner not return to the same unit where she observed the reported sexual abuse, she definitely wanted to return to work. The longer she was away, the more she would ruminate and the more symptomatic she became. He therefore wanted her to get back to work and functioning as soon as possible, but it was difficult because of the severity of the symptoms and, for whatever administrative reason, the Respondent wasn't reassigning her. Dr. Grater testified that Petitioner's PTSD was directly and "pathognomonically" (i.e.. symptomatically indicative of PTSD) related to the incident she saw with Funk and the subsequent harassment. He testified that pathognomonically we know that for many people that are exposed to this kind of shocking or traumatic event, they will have symptoms.

On cross examination Dr. Grater agreed that he had not seen Petitioner since October 2008, and he had no information regarding her current mental status, other than that she has returned to work in the Respondent's dietary department. His only independent recall is she was very nice but severely distraught. While outpatient programs like the one the Petitioner underwent cover a wide range of therapy and medications with various and frequency and intensity, to his knowledge Petitioner was never hospitalized overnight, but did go through the intensive program twice. Dr. Grater personally examined her during the course of her treatment, along with other staff members. He couldn't recall exactly how many times he personally examined her, but indicated it was "frequently", and she was otherwise regularly seen by counselors.

Dr. Grater testified that Petitioner experienced guilt for failing to report the Funk incident within 24 hours. According to his records, the Petitioner did not give Dr. Grater a history of being harassed by Tony Funk prior to the incident with Nancy that she reported. However, she was upset that Jackie and other staff thought she was lying, and that her supervisors didn't do anything after she reported it. At some point Petitioner also mentioned something about feeling there was some racism involved in the harassment from the other staff because she is Latino.

Dr. Grater testified that Effexor is prescribed as an anti-anxiety or anti-depressive medication. He agreed that if on 10/6/06 Petitioner reported problems in the past with an increased dose of Effexor, that would indicate she took it prior to that time. However, he testified that having depression or anxiety in and of itself is not a disorder unless and until it impacts a person's functionality. The fact that she may have taken the drug before indicates he may have had symptoms, but does not infer that she had a disorder: "The issue is the degree of her symptomatology. That's the crux of it." There is no evidence the Petitioner wasn't functioning prior to this incident. Dr. Grater did agree the signs Petitioner had – sadness, crying, emotional – could be evident in someone who feels guilt or fear of losing their job.

Dr. Grater agreed a symptom of PTSD could be memory problems, and that there was no indication Petitioner had such problems. With regard to the Petitioner reporting flashbacks on 10/6 and 10/23/06, Dr. Grater didn't recall how she described them other than seeing images of Funk. Dr. Grater agreed it is common for someone with PTSD to try to avoid situations or thins that remind them of the traumatic event, and while he agreed that Petitioner repeatedly expressed a desire to return to work, she wanted to return to a different unit. She also isolated herself in her house because she was afraid to go out. She did become more despondent the longer she did not return to work.

On further cross exam, Dr. Grater agreed that, after Petitioner started treating, she expressed family difficulties, including going through a divorce and obtaining multiple orders of protection against her husband, which he violated multiple times. She was afraid of her husband, but Dr. Grater did not believe that the family problems caused the PTSD condition because when the patient initially presented she did not report such problems as one of the stressors she was experiencing. However, he agreed that the cause of her PTSD symptoms during treatment could have become related to the problems with her husband. Dr. Grater also conceded that the diagnosis of PTSD relies in part on a patient's subjective reporting, such as whether someone is having flashbacks, which cannot be objectively determined. The diagnosis can be indicated in cases involving malingering and exaggeration.

On redirect exam, Dr. Grater testified that the Petitioner didn't understand why her supervisors weren't doing more to support her, and some co-workers blatantly told her they thought she was lying, and this raised her stress level. When diagnosing PTSD, Dr. Grater testified that you look at the credibility of the complaints by collecting collateral information, such as from the people working with her in the outpatient program, the

patient's family, and other collateral sources: "the only way to raise the spectre of someone not being forthright with us is if we get collateral information to that effect . . . or if the facts of the situation don't jibe with what the person's reporting." In this case, Petitioner's story remained consistent, but he did not obtain any such collateral information, as no one spoke to any of Petitioner's family members, and he had no information from any of Petitioner's co-workers. His information came from the Petitioner, whether his own records or the records of other treating therapists.

Dr. Jarvis testified via evidence deposition on 2/11/16. (Rx6). Dr. Jarvis testified he is a psychiatrist at the Washington University School of Medicine, Department of Psychiatry. His duties include clinical responsibilities of attending to inpatient services at Barnes Hospital, providing private outpatient services; training medical students through lectures and treating patients together. Dr. Jarvis examined Petitioner at the Respondent's request on 6/30/15 pursuant to Section 12 of the Act. He testified Petitioner told him she witnessed a coworker, Mr. Funk, sexually abusing a patient. (Rx6).

Dr. Jarvis also reviewed Petitioner's medical records, noting two outpatient treatment programs, in October 2006 and July 2007, which included group therapy, individual discussions, and treatment with Dr. Grater. He testified that the records showed that in the 2007 program, the discussion revolved around her divorce and how her husband was abusive through financial manipulation. The records show the divorce was very difficult and complicated by many issues including infidelity, abuse, threats, harassment from her husband's family, and financial issues, and that Petitioner had an order of protection against him. The earliest medical record Dr. Jarvis reviewed was from 10/4/06 which indicated Petitioner was on Effexor and had problems tolerating a higher dose in the past. Dr. Jarvis testified Effexor is a prescription antidepressant / antianxiety medication, indicating Petitioner took the medication prior to the accident date and tried higher doses. However, he could not say what led to such prior prescription, as he had no records which would indicate the basis. If this was not true, it could change his opinion. Dr. Jarvis testified that essentially after the 12/27/06 psychiatric note, Petitioner's focus was on issues with her husband, as well as wanting to return to work but remaining off. (Rx6).

Dr. Jarvis testified he does not think Petitioner has a primary psychiatric illness. He opined that she feels guilt regarding her failure to report Mr. Funk's actions in a timely manner, and embarrassment for being reprimanded. She also has emotional difficulty due to her divorce. Dr. Jarvis opined that Petitioner did not sustain any psychiatric injury on or around 9/20/06 because guilt is not a psychiatric injury. He believed Petitioner was capable of full duty employment from a psychiatric standpoint. (Rx6).

On cross examination, Dr. Jarvis testified when Petitioner first presented for psychiatric treatment, her chief complaint was depression and anxiety associated with the event she witnessed involving Mr. Funk. It was his understanding that Funk harassed Petitioner by calling her a Mexican, making sexual comments about her daughter, and talking about how her breasts moved when she walked. He testified that such harassment can conceivably cause PTSD, but it depends on the magnitude and credibility of the threat. He testified that racial slurs are not the types of things that trigger PTSD. Dr. Jarvis testified that Petitioner reported to her psychiatrist that she had flashbacks shortly after the alleged incident at work, but described them as an ever present image of the woman being molested by Funk and as a continuous movie-like replay when she tries to sleep. Dr. Jarvis testified those descriptions are extremely atypical for somebody that has PTSD and are not diagnostically helpful, as they are not the type of flashbacks you see with PTSD. Dr. Jarvis agreed that witnessing a sexual assault can be something that triggers PTSD, but testified only 20% of people who have a qualifying event will develop PTSD. Dr. Jarvis testified Petitioner told him Funk was making racial and sexual comments prior to her witnessing the assault on a patient, and the same sort of comments continued afterwards. He did not believe the continued racial and sexual innuendo directed at her daughter had much to do with the sexual assault Funk was caught in. (Rx6).

Dr. Jarvis testified he has worked at facilities where mental health patients are institutionalized and is familiar with same. He testified any job can be stressful depending upon the workers and the worker's attitude towards the job. Witnessing a sexual assault then being threatened by the assaulting party could increase a person's stress level, however, stress, in and of itself, is not a mental disorder. Dr. Jarvis testified the primary concern of Petitioner's initial treatment in October 2006 was her guilt associated with not reporting the incident and the threat of losing her job and her strong desire to get back to her job. Dr. Jarvis testified a major depressive disorder is a biological illness that is represented by a cluster of predictable and consistent features, being a persistently low or irritable mood for a certain period of time and then characterized by significant disability in terms of concentration, energy, appetite, and sleep. He agreed some of those symptoms were present in Petitioner's records and that she was diagnosed with major depression at St. Mary's. Dr. Jarvis disagreed with that diagnosis because he believed her predominant issues are her guilt and her fear of being fired. Dr. Jarvis testified these emotions would be common for someone facing a possible reprimand, and that her failure to initially report Mr. Funk would create guilt. (Rx6).

Dr. Jarvis testified PTSD is a maladaptive event that occurs after some traumatic, life-threatening overwhelming event. This generates a response that is either characterized by an intrusive rethinking of the issue, an avoidance of the issue, negative connotations, and a degree of hypervigilance that lasts over a six month period of time. Dr. Jarvis testified that none of these criteria were mentioned in Petitioner's records. Dr. Jarvis testified anxiety is an unusual degree of nervousness and that there are more specific diagnoses associated with anxiety. Dr. Jarvis testified that people can react differently to the same stressor. Dr. Jarvis testified Petitioner did not meet the first diagnostic criteria for posttraumatic stress disorder, as there needed to be a large, real life-threatening type event, which was not present here. (Rx6).

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, and WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

In Illinois, psychological injuries can be found compensable based on two possible theories: a) physical-mental, where the injury is related to and caused by a physical trauma or injury, and b) mental-mental, where the injury is due to a sudden, severe emotional shock traceable to a definite time and place and cause with no physical trauma or injury. *Pathfinder v. Indus. Comm'n*, 62 Ill.2d 556, 343 N.E.2d 913 (1976). Here, no evidence was presented regarding a physical trauma. This case involves a "mental-mental" claim.

The court in *Chicago Board of Education* noted that stressful events and conditions exist in all employment environments, which can cause mental disorders, but whether such mental illness is compensable depends on whether the employee can show that "the risk to which he was exposed arose out of and in the course of his employment and has a clear causal relationship to the disability suffered. Under our diseases act the disease must flow from that risk as a rational consequence." *Chicago Board of Education v. Indus. Comm'n*, 169 Ill.App.3d 459, 523 N.E.2d 912 (1988). The Court went on to state that, with regard to whether a causal connection is "readily apparent" or not: ". . . there is a much more tenuous link in a situation where a person suffers a gradually developing mental disability which, in retrospect, is attributed to factors such as worry, anxiety, tension, pressure, and overwork without proof of a specific time, place, and event producing the disability. To recognize

that our occupational disease law would allow compensation for any mental diseases and disorders caused by on-the-job stressful events or conditions would, in the words of one court, open a floodgate for workers who succumb to the everyday pressures of life." Further: "We conclude, upon examination of the several lines of precedent, that if nontraumatically induced mental disorders due to a gradual deterioration of mental processes are compensable under our Occupational Diseases Act, a causal connection between the employment and the disability must be established by showing that the employment exposed the employee to an identifiable condition of the employment that is not common and necessary to all or to a great many occupations. . . .Stated differently, mental disorders not resulting from trauma must arise from a situation of greater dimensions than the day-to-day emotional strain and tension which all employees must experience." *Id.* "It follows that if the conditions producing disability must be extraordinary, they must also, from an objective standpoint, exist in reality. . . . The employee must establish that the stressful conditions actually exist on the job. It is not sufficient that the employee believe, although mistakenly, the conditions exist. Under our statute there must be an actual risk connected with the employment which produces the injury. An honest perception which does not factually exist is insufficient to demonstrate a causal connection between the occupation and the disease." In this case, the Court noted that unruly students, an unresponsive administration, and the burdens of paperwork and record keeping are not unusual. However, the Court also noted that while the claimant expressed fear for his safety, despite a number of alleged stressful events over several years, there were no demonstrable symptoms of mental disturbance at the time, and the claimant's breakdown surfaced at the end of his summer vacation prior to the start of the new semester. Thus, the Arbitrator notes that it appears the claimant's breakdown in this case occurred based on a fear of returning to the school environment. *Id.*

In *Runion v. Indus. Comm'n*, 245 Ill.App.3d 470, 615 N.E.2d 8 (1993), the claimant alleged a mental condition essentially as the result of repetitive mental stress at work over an 18 month period of time. The Court denied benefits, stating: "Recovery for non-traumatically-induced mental disability is limited to those employees who can establish that: (1) the mental disorder arose in a situation of greater dimensions than the day-to-day emotional strain and tension which all employees must experience; (2) the conditions exist in reality, from an objective standpoint; and (3) the employment conditions, when compared with the nonemployment conditions, were the major contributing cause of mental disorder. . . . Mental disorders which develop over time in the normal course of the employment relationship do not constitute compensable injuries." *Id.*; *Matlock v. Indus. Comm'n*, 321 Ill.App.3d 167, 746 N.E.2d 751, 253 Ill.Dec. 930 (2001).

The Appellate Court in *General Motors. V. Indus. Comm'n* stated: "Compensation for non-traumatic psychic injury cannot be dependent solely upon the peculiar vicissitudes of the individual employee as he relates to his general work environment." *General Motors v Indus. Comm'n*, 168 Ill.App.3d 678, 522 N.E.2d 1260 (1988).

In the case at bar, Petitioner alleges a psychological work injury of PTSD as a result of witnessing a coworker sexually assault a patient, then subsequently being threatened by the coworker. Petitioner alleges a date of injury of 9/20/06. However, this is not the date which Petitioner witnessed the sexual assault. According to the evidence admitted at trial, Petitioner witnessed the coworker assault a patient in August 2006, or at least on another date prior to 9/20/06, and again on 9/9/06 (see Px1). The contemporaneous investigation makes it clear that the actual incident or incidents occurred prior to 9/20/06. Petitioner failed to report this sexual abuse until 9/20/06, against the facility policy to immediately report. After Petitioner finally reported the abuse, Petitioner was placed on an administrative leave due to an investigation being opened regarding her failure to report the abuse timely. It was not until after Petitioner was placed under investigation for her disciplinary violation that she sought treatment for her alleged psychological injury. In this case, it is difficult for the Arbitrator to conclude that these incidents were the trigger for her psychological condition given the delay in seeking treatment. This does not comport with *Pathfinder*, which indicates an employee must suffer an immediately apparent psychic injury.

The Arbitrator acknowledges that in *Board of Education of the City of Chicago v. Indus. Comm'n.*, the Appellate Court held: "*Pathfinder* does not compel the claimant to prove, in addition, that the psychological injury resulting from the emotional shock was 'immediately apparent'. Under *Pathfinder*, the emotional shock needs to be 'sudden', not the ensuing psychological injury. Thus, if the claimant shows that she suffered a sudden, severe emotional shock which caused a psychological injury, her claim may be compensable even if the resulting psychological injury did not manifest itself until some time after the shock." However, the Court also went on to stress that, in order to prevail on a mental-mental claim, the claimant must present objective evidence supporting inferences of psychological injury, causation, and disability. While not dispositive as a matter of law, evidence of a delay in psychological treatment following an alleged work accident can still be relevant, as such evidence, depending on the facts of the case, might undermine the inference that the claimant suffered a severe emotional shock that caused a psychological injury. *Board of Education of the City of Chicago v. Industrial Comm'n*,83 Ill.2d 475, 487-88, 48 Ill.Dec. 206, 416 N.E.2d 237 (1981). *Chicago Transit Authority v. Work. Comp. Comm'n*, 989 N.E.2d 608 (2013).

The Arbitrator's view here indicates that the preponderance of the evidence indicates that the delay in treatment, particularly given the intervening problems of guilt and worry about her job status, leads to the conclusion that the incidents of seeing Mr. Funk with the patient and his alleged subsequent threats were not a severe emotional shock that led to a psychological injury. The evidence indicates it was the aftermath of her reporting the incident late and the consequences of doing so. It was the impact that this had on her job status. It was the stress she felt about how the employer was handling the situation and why she wasn't returned to work faster. It was the impact that her job situation had on her family life. It was the mental and physical impact her husband was having on her at that time. It was the stress she was experiencing raising a teenage daughter. All of these things clearly, in the Arbitrator's view, had a much more significant impact on the Petitioner's mental state than what she saw and heard involving Mr. Funk. Much of the delay in Petitioner returning to work had to do with her job status and her desire to avoid working with the people she had worked with before, as opposed to her inability to work due to her ongoing mental state. Mr. Funk had been terminated well before she ever returned to work. She repeatedly indicated to Dr. Grater that she wanted to return to work. These facts support the inference that it was not her mental state that was preventing her from returning to work, it was the administrative issues involved in her initial termination, suspension and eventual reinstatement, and the feelings Petitioner had as a result.

Also, the Arbitrator does not believe the record supports a diagnosis of PTSD. The Section 12 examiner, Dr. Jarvis, opined Petitioner did not have PTSD. Petitioner began treating with Dr. Grater at Good Samaritan in October 2006. She was initially diagnosed with depression and anxiety, but the diagnosis was later changed to include PTSD. Dr. Grater diagnosed Petitioner with PTSD which he attributed to the incident because there was a chronological sequence of her doing well, then being exposed to the incident, followed by an acute onset of symptoms. However, Dr. Grater admitted that he did not review the medical records from her primary care doctor or any records outside of his own, and if Petitioner was previously prescribed Effexor, it would indicate she was symptomatic prior to the incident. Further, it is common that a person with PTSD try to avoid situations that remind them of the traumatic event, but Dr. Grater admitted that throughout her treatment, Petitioner repeatedly expressed a desire to return to work. Also, after Petitioner returned to work, Petitioner tried to pick up overtime shifts as a mental health tech, which could place her back on the unit where the alleged incident occurred. This is inconsistent with someone suffering PTSD.

Dr. Grater also testified there is an "objective" way to diagnose PTSD, but admitted that he is not a specialist in PTSD and did not analyze Petitioner on any objective rating scale when coming to his diagnosis of PTSD. Dr. Grater testified the only way to determine if someone is not being forthright with him is to get collateral

information, but agreed that no collateral information was collected in this case, and thus the only source of his information came from Petitioner.

The Arbitrator believes that the opinions of Dr. Jarvis in this case are more persuasive than that of Dr. Grater. Dr. Jarvis not only performed a mental status examination of Petitioner, but also reviewed her counseling records as well as her medical records. Dr. Jarvis testified that PTSD is a maladaptive event that occurs after some traumatic, life-threatening overwhelming event that generates a response that is either characterized by an intrusive rethinking of the issue, an avoidance of the issue, negative connotations, and a degree of hypervigilance that lasts over a six month period of time. Dr. Jarvis testified that none of these criteria were mentioned in Petitioner's records and Petitioner did not meet the first diagnostic criteria for PTSD. Dr. Jarvis testified that Petitioner's descriptions of her alleged flashbacks are extremely atypical for somebody that has PTSD and not the flashbacks you would see with PTSD. Further, Petitioner's own testimony indicated Petitioner strongly desired to return to work, which is uncharacteristic of someone suffering from PTSD.

Dr. Jarvis opined Petitioner has guilt for her failure to report Mr. Funk's actions in a timely manner and embarrassment for being reprimanded, as well as emotional difficulty due to her divorce. Dr. Jarvis further opined that Petitioner did not sustain any psychiatric injury on or around 9/20/06, as guilt is not a psychiatric injury. He believed Petitioner's predominant issues are her guilt and her fear of being fired, and the Arbitrator's review of the St. Mary's counseling records indicates that he has a solid basis for this conclusion. The records repeatedly showed Petitioner worrying over whether she would lose her job and expressing guilt for not reporting the abuse sooner. In the Arbitrator's review of these records, it appears that after October 2006, the issues indicated in these records are based almost solely on three things: the problems that revolved around the Petitioner being terminated/suspended from work, the financial impact that allegedly had on her family situation, and the serious personal problems she had with her husband, and to a lesser extent her daughter. As to the financial impact, the Arbitrator must assume this as based on the lack of overtime, because the Petitioner was being paid her full salary while off work.

Petitioner also testified that Mr. Funk called her derogatory names and used racial slurs to support her PTSD claim. However, the Arbitrator finds this unpersuasive. It has been held that the use of racial slurs does not arise to the level of a work related "mental-mental" claim. Additionally, the Arbitrator notes that Ms. Millis testified that, after interviewing Petitioner's co-workers, an investigation indicated that Petitioner's claims of harassment were determined to be unsubstantiated.

The Arbitrator also notes that there are several inconsistencies in the evidentiary records and in the Petitioner's own testimony. Petitioner gave different doctors different histories regarding her life. She told one counselor that her mother abused her and hit her often, yet told another one she had no history of physical abuse as a child. Petitioner also gave one counselor a history of being married for 20 years to an abusive husband, but then told another that her husband was never abusive towards her, just unfaithful. Petitioner told Dr. Grater that she had not received any prior treatment of medication for psychological issues; however her medical records show she had been previously prescribed Effexor, an antidepressant/antianxiety medication.

Petitioner originally testified that she witnessed Mr. Funk abuse a patient on 9/20/06 and he threatened her or her daughter at that time; however, the preponderance of the evidence indicates any such witnessed incidents occurred in August 2006 and/or on 9/9/06. When further questioned as to when she witnessed the abuse, Petitioner testified she didn't recall. Petitioner testified Mr. Moorman told her she was kept off of work for her protection, but Mr. Moorman testified he did not tell the Petitioner this, but rather that she was on an administrative leave while she was being investigated for failing to report abuse and thus suspended for the protection of the Respondent's patients/residents. Petitioner testified that she was not suspended due to her

failure to report, and when confronted with the Settlement Agreement she signed outlining her suspension, she testified she did not read that document and did not understand what it said, despite the fact she was represented by an attorney. Petitioner first testified that after her return to work, she knew she was not supposed to work in a position with direct patient care, but then later testified she did not know it was a violation of her agreement to do so. Petitioner may just be a poor historian, but given the multiple inconsistencies, the veracity of Petitioner's testimony is called into question. The Arbitrator acknowledges that the Petitioner appears to have some level of psychological problems, and given the amount of time that has passed since 2006, her memory of the timeline of when things occurred may be understandably faulty. However, that timeline is of utmost importance in this case, particularly given the degree of personal issues and concerns about her return to work that the Petitioner indicated to Dr. Grater and his staff.

Further, the evidence shows Petitioner has a pattern of taking contradictory actions. Petitioner witnessed a coworker abuse a patient for which she had a responsibility to immediately report, but did not. When she finally did report the abuse, she was placed on administrative leave and an investigation initiated. Only after she was being investigated did she seek counseling and claim a workers' compensation injury. Then, after signing an agreement in which she agreed to not accept a position with direct patient care, Petitioner voluntarily underwent training and signed up for overtime to work as a mental health tech, a position with direct patient care. Petitioner then accepted overtime as a mental health tech under her own volition. Once upper management discovered she had worked in a position with direct patient care, she was stopped from accepting additional overtime and again suspended. Petitioner once again claimed she did not understand that she was not supposed to do that and tried to blame upper management for her actions. The Arbitrator believes that these findings impact the Petitioner's credibility in a negative way.

Based upon the foregoing, the Arbitrator finds that Petitioner did not prove that her injuries arose out of and in the course of her employment and her current condition of ill-being is causally related to the alleged injury. As such, benefits are denied.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings with regard to accident, this issue is moot.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings with regard to accident, this issue is moot.

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

Based on the Arbitrator's findings with regard to accident, this issue is moot.

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

Based on the Arbitrator's findings with regard to accident, and there being no benefits awarded, this issue is moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TAMMY LEVINGSTON,

Petitioner,

vs.

NO: 14 WC 3740

17IWCC0788

SOUTHERN ILLINOIS UNIVERSITY - EDWARDSVILLE,

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 permanent partial disability (PPD) and being advised of the facts and applicable law, affirms and adopts but writes to clarify the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission agrees with the Arbitrator's well-reasoned analysis of the facts to Section 8.1(b) of the Act. However, the Decision does not indicate the weight assigned to each subsection of §8.1(b). Therefore, the Commission writes to clarify the Decision to assign the following weight to each subsection of §8.1(b):

(i) The Commission assigns no weight to this subsection;
(ii) The Commission assigns some weight to this subsection;
(iii) The Commission assigns a fair amount of weight to this subsection;
(iv) The Commission assigns no weight to this subsection; and,
(v) The Commission assigns greater weight to this subsection.

Based upon the above, the Commission affirms the award of 42.5% loss of use of the left leg.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 27, 2017 is hereby affirmed and adopted.

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

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

DATED: DEC 8 - 2017

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
D: 12/5/17
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LEVINGSTON, TAMMY
Employee/Petitioner

Case# **14WC003740**

SIU-EWARDSVILLE
Employer/Respondent

17IWCC0788

On 6/27/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4463 GALANTI LAW OFFICE
LELIE N COLLINS
PO BOX 99
EAST ALTON, IL 62024

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

3291 ASSISTANT ATTORNEY GENERAL
ELIZABETH LEAHY
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

0904 STATE UNIVERSITY RETIREMT SYS
PO BOX 2710 STATION A
CHAMPAIGN, IL 61825

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

JUN 27 2017

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

17IWCC0788

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

TAMMY LEVINGSTON
Employee/Petitioner

v.

SIU-EDWARDSVILLE
Employer/Respondent

Case # **14** WC **03740**

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 **Paul Cellini**, Arbitrator of the Commission, in the city of **Collinsville**, on **April 25, 2017**. By stipulation, the parties agree:

On the date of accident, **January 9, 2014**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$31,691.40**, and the average weekly wage was **$609.45**.

At the time of injury, Petitioner was **48** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of **$232.19** for TTD, **$N/A** for TPD, **$N/A** for maintenance, and **$N/A** for other benefits, for a total credit of **$232.19**.

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 **$365.67 per week** for **91.375 weeks**, because the injuries sustained caused the **42.5% loss of use of the left leg**, as provided in Section 8(e) of the Act.

Respondent shall be given credit of **$232.19** against the permanency award based on a stipulated TTD overpayment.

The parties have stipulated that Respondent shall pay any outstanding causally related medical expenses pursuant to Sections 8(a) and 8.2 of the Act.

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

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

Signature of Arbitrator

June 20, 2017
Date

JUN 27 2017

STATEMENT OF FACTS

On 1/9/14, while working for Respondent as a Dining Services Administrator managing a campus Starbucks, Petitioner fell off a step ladder while putting stock away, injuring her left hip. She was taken to Anderson Hospital, diagnosed with a left femoral neck fracture with a bone fragment, and surgery was performed by Dr. Bicalho the same day, involving closed reduction and percutaneous pinning using multiple screws. She denied any other locations of pain. (Px1 & Px4).

Petitioner continued to have pain, and after performing an extensive amount of physical therapy, she continued to have pain. A 9/15/14 CT scan indicated a healed fracture with no loosening and mild left hip osteoarthritis. (Px2). The Petitioner continued to have pain, and was ultimately found to have developed avascular necrosis of the femoral head with collapse. (Px3). On 9/6/16 she underwent a total left hip replacement surgery with Dr. Bicalho. (Px4 &; Px7). X-ray indicated near-anatomic alignment. (Px2). Petitioner underwent post-operative

therapy at Staunton Community Hospital. The last report of 11/21/16 indicated she was ambulating well and felt "great" with no pain. She had met all short and long terms goals, and she was discharged to a home exercise program. (Px7).

Petitioner was returned to full duty by Dr. Bicalho, on 12/12/16. At that visit, Dr. Bicalho noted that Petitioner was doing very well and walking without assistance, and he noted 5 out of 5 strength. (Px3). Petitioner testified that she returned to her regular job and performs the same duties as she did before her injury.

Petitioner last saw Dr. Bicalho on 4/17/17. He indicated that Petitioner was doing well with intermittent mild left hip pain with strenuous activity and prolonged walking and standing. She had good strength, and x-rays indicated good positioning. It appears that she was continuing to take medication including aspirin and hydrocodone, and she was advised to follow up in 6 months. (Px3).

Petitioner testified that she has ongoing problems with bending and stooping, reaching high, walking long distances and going up stairs. She has no problems going down stairs. She testified that she develops a limp after prolonged standing, but has been able to generally perform her job.

CONCLUSIONS OF LAW

WITH RESPECT TO THE ISSUE OF THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

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

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

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

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no AMA permanent partial impairment report and/or opinion was submitted into evidence.

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 Dining Services administrator at the on-site Starbucks at the time of

the accident and has returned to the same position. She was released to return to work with no stated work restrictions.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 48 years old at the time of the accident.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that no evidence was presented by either party which indicates the Petitioner suffered a diminution in her earning capacity as a result of this injury.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the Petitioner testified to more significant complaints than what is indicated in Dr. Bicalho's records, but that the complaints are consistent with her injury, surgery and the fact she has returned to full duty work.

The Arbitrator notes that the Petitioner underwent two separate surgeries to the left hip, initially undergoing a pinning of the fracture with hardware, and ultimately hip replacement after the development of avascular necrosis. She had an extended period of therapy. She is relatively young to have had a total hip replacement. The Arbitrator finds her ongoing complaints to be credible. She has done relatively well and has returned to full duty work with no indication of significant problems. Based on the above factors, the record taken as a whole, and a review of prior Commission awards for similar injuries and results, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 42.5% loss of use of the left leg pursuant to §8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria DeJesus Hermosillo,

Petitioner,

vs.

NO: 16WC 5431

Unistaff,

17IWCC0789

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 22, 2016, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: DEC 11 2017
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043

Charles J. DeVriendt

Joshua D. Luskin

To obtain benefits under the Act, an employee must prove her injury arose out of and occurred during the course of her employment. "In the course of" speaks to time, place, and circumstances of the injury. See *e.g. Caterpillar Tractor Company v. The Industrial Commission*, 129 Ill. 2d 52, 57, 541 N.E.2d 665 (1989) ("This Court has recognized that accidental injuries sustained on an employer's premises within a reasonable time before and after work are generally deemed to arise in the course of the employment"). Under certain circumstances, the employer's premise extends to an employer-provided parking lot. See *e.g. DeHoyos v. The Industrial Commission*, 26 Ill. 2d 110, 113, 185 N.E.2d 885 (1962) ("Whether or not the employer owned the parking lot is immaterial; for if the employer provides a parking lot which is customarily used by its employees, the employer is responsible for the maintenance and control of the parking lot"). Further, "slips or falls on an employer-provided lot when hazardous conditions are present are generally compensable. [citations omitted]." *Morse-Harvey v. The Industrial Commission*, 345 Ill. App. 3d 1034, 1038, 804 N.E.2d 1086 (2004). I believe Petitioner proved she fell in an employer-provided parking lot due to a hazard of snow and/or ice. Therefore, I respectfully dissent.

The majority in adopting the decision of the arbitrator fails to appreciate the distinction between "in the course of" and "arising out of." Once the parking lot exception has been established, the arising out of component is defined as an employment risk and not a neutral risk. Simply put, did Petitioner confront a hazard?

Petitioner established she slipped and fell in an employer-provided parking lot. Petitioner testified she parked in the lot adjacent to the employer's building in a specific designated area. T. 22; 27. Mr. David Dudzinski testified on behalf of Respondent and confirmed Petitioner was advised to park in a designated area. T. 94. (Petitioner was an employee of the Respondent, Unistaff, working on the premise of Power Packing. T. 11-12). Petitioner's injury occurred "in the course of" her employment.

Petitioner is also required to establish her injury "arose out of" her employment. "'Arising out of' the employment refers to the origin or cause of a claimant's injury. [citation omitted]. For an injury caused by a fall to arise out of employment, a claimant must present evidence which supports a reasonable inference that the fall stemmed from a risk associated with her employment. [citation omitted]." *Suter v. The Illinois Workers' Compensation Commission*, 2013 IL App (4th) 130049WC, ¶39. Did Petitioner confront a hazard? The overwhelming evidence establishes Petitioner slipped on snow and/or ice. Petitioner testified there existed two to three inches of snow on the ground where she fell. T. 19; 72. Petitioner testified underneath the snow was ice. T. 72-73. The arbitrator commented on the photographs offered into evidence as the same did not evidence any hazard or defect, but there is absolutely no evidence as to when the photographs were taken. As such, no reasonable inference can be made from the photographs as to the non-existence of a hazard. Further, the photographs show green grass and trees budding with leaves which is indicative of a season other than winter. Petitioner's undisputed and credible testimony is- she sustained injury when she slipped and fell on snow and/or ice.

The majority in adopting the opinion of the arbitrator applies a neutral risk analysis in denying compensation finding "the Petitioner was not in any greater risk of injury than the general public when she fell. As such, the Arbitrator concludes that the Petitioner did not sustain an accident arising out of her employment on January 11, 2016." As Petitioner proved her injury occurred on the employer-provided parking lot, such analysis is not applicable. Utilizing

17IWCC0789

the employment risk analysis, Petitioner proved her fall arose out of her employment. Accordingly, I dissent.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

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

HERMOSILLO, MARIA DEJESUS
Employee/Petitioner

Case# **16WC005431**

UNISTAFF
Employer/Respondent

17IWCC0789

On 12/22/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.64% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2553 McHARGUE, JAMES P LAW OFFICE
MATTHEW C JONES
123 W MADISON ST SUITE 1000
CHICAGO, IL 60602

2623 McANDREWS & NORGLE LLC
MICHAEL P LATZ
53 W JACKSON BLVD SUITE 315
CHICAGO, IL 60604

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

MARIA DeJESUS HERMOSILLO
Employee/Petitioner

v.

UNISTAFF
Employer/Respondent

Case # **16** WC **5431**

Consolidated cases: ___

17IWCC0789

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Geneva**, on **11/15/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **1/11/16**, 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 $**3,648.07**; the average weekly wage was $**351.50**.

On the date of accident, Petitioner was **63** years of age, *single* with **0** dependent children.

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

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

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

ORDER

Petitioner failed to prove that her accident arose out of her employment. Therefore, the claim is denied.

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

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

Signature of Arbitrator

12/21/16
Date

DEC 22 2016

FINDINGS OF FACT

In this case, Petitioner alleges that she was injured while working for the Respondent on January 11, 2016. Petitioner is a Spanish speaker and testified via an interpreter. At trial, the following issues were in dispute: 1) accident; 2) causation; 3) medical expenses; 4) prospective medical care and 5) TTD.

On January 11, 2016, 63 year-old Petitioner was employed by Respondent, a temporary staffing agency; Respondent assigned Petitioner to Power Packaging, a facility in Batavia. Petitioner worked filling packets of food spices on the packaging line. The weather that day was cold, and it had snowed the night before. When the Petitioner arrived to work that day, she parked in a place at the end of the parking lot away from the employee door. Petitioner took her last 15-minute break from work at around 2:00 p.m. During her break, Petitioner left the plant to move her car closer to the employee door.

There was extensive testimony regarding the Power Packaging parking lot. Petitioner testified that the employees were told not to park in the spots which ran along the building. The parking lot had signs that say "Only Customers." The employees could park in parking spots away from the building. The employees were not directed to park in any one area. The parking lot was used by employees, customers, and visitors to the plant.

The Petitioner stated that she moved her car to a spot closer to the employee entrance, and when she walked past the loading dock, she slipped on "black ice" and fell on her head, neck and the lumbar spine. The Petitioner stated that she put her hand to the side as she fell. According to Petitioner, two witnesses saw her fall. Petitioner reported that a co-worker helped her to her feet, but she could not identify the two witnesses to her fall. After she fell, Petitioner reported her accident at Power Packaging. She completed an accident report for Respondent on the day of the accident, and completed another one for Power Packaging the following day.

The Petitioner went to Dreyer Occupational Health on the day of her accident, and was treated by Dr. Johnson. The assessment was minor closed head injury, scalp contusion, minor left-sided cervical strain and, left wrist sprain. She was given a wrist splint to wear and returned to work with light duty restrictions. Petitioner returned to work with restrictions until February 5, 2016.

The Petitioner was referred to Dr. Rivera by her lawyer. Dr. Rivera restricted Petitioner from work and prescribed physical therapy. Dr. Rivera also referred the Petitioner to Dr. Chaadia.

Petitioner first saw Dr. Chaadia on February 29, 2016 for her left hand and wrist. Dr. Chaadia reported that Petitioner reported that she slipped on black ice and tried to catch her fall. She stated that she hit the back of her head, but did not lose consciousness. Her major pain at the time was her left hand and wrist area. Petitioner was seen at a clinic where she had an x-ray done of the left hand. The x-ray was negative. She was ordered to undergo physical therapy, but it was not approved. An MRI of the left hand was taken on March 7, 2016. The impression was mild osteoarthritis, no evidence of acute trauma or underlying erosive arthropathy and no muscle tendon injury is clearly evident. The MRI of the left hand was normal. Dr. Chaadia recommended physical therapy and medications for her left hand. The Petitioner's hand was never casted and she was never required to wear a sling. Dr. Chaadia is now recommending surgery to the left wrist.

17IWCC0789

Petitioner underwent an IME with Dr. Lieber on March 3, 2016. Dr. Lieber conducted an examination of the Petitioner and reviewed the MRI studies. Dr. Lieber said an MRI of the cervical and lumbar spine from Fox Valley Imaging dated February 16, 2016 shows no evidence of any acute disc herniation or nerve root impingement. There was evidence of degenerative stenosis. Dr. Lieber concluded that the Petitioner suffered left hand pain but there was no causal relationship between Petitioner's current symptomology and the alleged incident of January 11, 2016. Lieber concluded that the Petitioner had reached maximum medical improvement as of March 3, 2016, and no further treatment was necessary.

Respondent introduced a Utilization Review report dated April 8, 2016 which non-certified any treatment to the left wrist beyond six physical therapy sessions.

Petitioner also treated with Dr. Novoseletsky for neck and back pain. Dr. Novoseletsky's May 5, 2016 rebuttal to Dr. Lieber's report states that Dr. Lieber did not appreciate the L4-L5 herniation seen on the MRI. Dr. Novoseletsky also diagnosed left wrist deQuervain's tendonitis. Petitioner underwent epidural steroid injections to her neck on August 23, 2016. Petitioner had an epidural steroid injection with the lumbar spine on October 18, 2016. Petitioner wishes to continue treatments with Dr. Novoseletsky.

David Dudzinski was also called to testify on behalf of the Respondent. Mr. Dudzinski is the Director of Sales for Respondent and testified that Power Packaging was a long-time client of the Respondent. He investigated the Petitioner's accident and also provided testimony regarding the photos that were admitted into evidence. These photos were aerial pictures of the Power Packaging work building and the adjacent parking areas. Mr. Dudzinski explained that the lot is utilized by employees, the general public and delivery drivers.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has failed to meet her burden of proof. In support of this finding, the Arbitrator relies on the Petitioner's testimony and the evidence regarding the place where Petitioner fell. Essentially, the Petitioner fell in a parking lot utilized by employees, the general public and delivery drivers. This accident occurred after Petitioner moved her car during her break to a parking spot closer to the building where she worked. The area where Petitioner fell appeared to be a driveway area outside one of the work building entrances, in an area where delivery drivers would dock their trucks. The evidence shows that this area was open to the public and not limited to only employees. Petitioner moved her vehicle out of personal convenience; she was not required by Respondent to either move her vehicle or to park in a closer parking spot. Petitioner identified photographs of the area where she slipped and fell, and those photographs do not show any hazard or defect in the ground where Petitioner fell. These facts all show that the Petitioner was not in any greater risk of injury than the general public when she fell. As such, the Arbitrator concludes that the Petitioner did not sustain an accident arising out of her employment on January 11, 2016.

2. Based on the Arbitrator's findings above, all other issues are rendered moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
CHAMPAIGN

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brian Barnes,
Petitioner,

vs.

NO: 14WC 16094

17IWCC0790

Supervalu,
Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 7, 2016 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $30,900.00. 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: DEC 11 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BARNES, BRIAN
Employee/Petitioner

Case# **14WC016094**

SUPERVALU
Employer/Respondent

17IWCC0790

On 7/7/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2333 WOODRUFF JOHNSON & PALERMO
RUSSELL HAUGEN
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

0734 HEYL ROYSTER VOELKER & ALLEN
TONEY TOMASO
PO BOX 129
URBANA, IL 61803-0129

STATE OF ILLINOIS)
)SS.
COUNTY OF Champaign)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Brian Barnes
Employee/Petitioner

v.

Supervalu
Employer/Respondent

Case # 14 WC 16094

Consolidated cases: _____

17IWCC0790

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Urbana**, on **May 12, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **March 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 **$47,650.00**; the average weekly wage was **$916.35**.

On the date of accident, Petitioner was **37** years of age, ***married*** with **2** dependent children.

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

Respondent ***has 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 **$16,643.90** for other benefits, for a total credit of **$16,643.90**.

Respondent is entitled to a credit of **$12,158.49** under Section 8(j) of the Act.

ORDER

- Respondent shall pay Petitioner temporary total disability benefits of $610.90/week for 56 1/7 weeks, commencing 5/22/14 through 6/18/15, as provided in Section 8(b) of the Act.
- Respondent shall pay reasonable and necessary medical services, as listed in Petitioner's Exhibit 9, pursuant to the medical fee schedule, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall also pay Petitioner $1,650.00 for the travel expenses he incurred in treating for the injury.
- Respondent shall be given a credit of $12,158.49 for medical benefits that have been paid and $16,643.90 in non occupational indemnity disability benefits, and Respondent shall hold Petitioner harmless from any claims by any providers of the services of which Respondent is receiving this credit, as provided in Section 8(j) of the Act.
- Respondent shall pay Petitioner permanent partial disability benefits of $549.81/week for 43 weeks, because the injuries sustained caused the 20% 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.

D. Dyas McCarty

7/3/2016

Signature of Arbitrator

JUL 7 - 2016

Date

FINDINGS OF FACT 17IWCC0790

The Petitioner, Brian Barnes, was employed by the Respondent, Supervalu, as an Order Selector. His job duties involved picking cases of merchandise that weighed anywhere from 10lbs to 100lbs, loading the cases of merchandise onto pallets, and wrapping the pallets with shrink wrap. The Petitioner testified that as an Order Selector he was required to make a certain daily and weekly percentage which was based on how many orders he was able to complete on a daily or weekly basis. The Petitioner further testified that as of March 6, 2014, he had been working as an order selector for approximately 13 years.

The Petitioner testified that on March 6, 2014 he arrived at work without any pain or discomfort in his right hip. He further testified that while wrapping shrink wrap around a pallet, in which he was wrapping from the bottom to the top, he planted his left foot and tore off the shrink wrap. In doing so, he twisted his body in a downward motion and felt a pop in his right hip. The Petitioner further testified he had an immediate onset of pain in his right hip and a sensation of blood rushing towards the area of his right hip. Petitioner further testified that he had never experienced that type of pain or sensation prior to this accident. He further testified that he continued to work but stopped after a short time since he knew something was wrong. He testified that he went to the supervisor's office where he reported the work accident and filled out an accident report.

The Petitioner filled out an injury/incident report on March 6, 2014. The report indicates that the date of accident was 3/6/14 and the time of accident was 10:15 AM. The description, which was filled out by the Petitioner, states, "wrapping pallet, felt pain in hip, been having discomfort in back and hip, felt fine for days then soreness begins. I use ice, and tylenoel to feel better." (RX 4). The Petitioner testified that when he filled out this section he was explaining the sciatic-type symptoms he was previously experiencing along with the hip pain that started that day.

Prior to March 6, 2014, the Petitioner treated with Dr. William Hemmer at the Tuscola Pain & Wellness Center from October 9, 2013 to October 28, 2013. In the Fact Finding Confidential Patient Questionnaire, it indicates that the Petitioner was complaining of hip discomfort. Petitioner testified that he sought treatment with Tuscola Pain & Wellness Center since he was experiencing pain in his lower back which was radiating into both hips and down both legs. In the initial report, Dr. Hemmer indicated that Petitioner complained of neck and back pain which was made worse by prolonged standing. On examination, Petitioner had reproduced pain with flexion and rotation of his lumbar and cervical spine, a negative sitting straight leg raise, a negative valsalva's maneuver, and a positive minor's sign. Dr. Hemmer's recommended treatment plan was soft tissue manipulations in the area of the cervical spine, thoracic spine, lumbar spine, and sacrum. This was recommended for three times a week for a total of three weeks. Petitioner underwent this treatment on 10/9/13, 10/14/13, 10/21/13, and 10/28/13. On October 9, 2013, the Petitioner reported "a little pain in hips, but not as bad." At the time of his last visit, the Petitioner was reporting moderate pain in the mid through lower back. Dr. Hemmer indicated that Petitioner had reached a point of stability regarding his condition and that Petitioner should schedule any future care on an as needed basis. (PX 5).

The Petitioner testified that he continued to work full-duty as an Order Selector for Respondent from October 2013 up until the March 6, 2014 accident. The Petitioner further testified that he didn't have any issues completing the assigned tasks as an Order Selector during that period of time. He further testified that it was possible that he may have seen the onsite nurse, Linda Hogan, at some point in February of 2014. However, he couldn't specifically remember seeing her but if he did, it was for sciatic-type symptoms he was experiencing in his low back.

On March 6, 2014, the Petitioner was evaluated by Dr. David Fletcher at SafeWorks Illinois. Petitioner testified that he was sent to SafeWorks by the Respondent. By history, the Petitioner reported having issues with his hip and back since October 2013 but today he was pulling his stretch wrap to wrap his pallets and he got a sharp pain in his right hip that won't go away. On examination, the Petitioner had restricted range of motion of the lumbar spine. Dr. Fletcher's diagnosis was lumbar spine herniated disc, rule out L3-L4 disc. Dr. Fletcher's assessment was that Petitioner had features of right L4 radiculopathy with right thigh atrophy and decreased right knee flexion. Dr. Fletcher indicated that the Petitioner needed an MRI since he had been symptomatic since October 2013 but aggravated it today. Dr. Fletcher further indicated that the cause of this problem was related to work activities. Petitioner was put on modified duty and instructed to return after his lumbar spine MRI. (PX 3).

On March 26, 2014, the Petitioner underwent an MRI to his lumbar spine which revealed mild disc bulging at L4-L5 with no significant abnormalities in the lumbar spine. The Petitioner returned to Dr. Fletcher on April 2, 2014. The description of accident indicated that Petitioner had been experiencing hip and back pain since October 2013 but on March 6, 2014 he was pulling his stretch wrap to wrap his pallet and got a sharp pain in the right hip that won't go away. Upon review of the MRI, Dr. Fletcher opined that there appeared to be stenosis at L4-L5 and some slight right-sided L5 nerve root impingement. His assessment was right L4-L5 radiculopathy from disc bulge, rule out hip pathology "doubtful in my opinion", and rule out SI joint dysfunction. Dr. Fletcher recommended a consultation with a spine surgeon, the possibility of epidural steroid injections, physical therapy, and ongoing light-duty restrictions. Petitioner underwent a physical therapy initial evaluation at 217 Rehabilitation & Performance Center on April 9, 2014. At that time, Petitioner reported an onset of sharp pain in his right lateral hip while wrapping a pallet at work on March 6, 2014. The assessment was left mid back strain and right hip pain. On examination, Alan Koch, PT noted that there appeared to be labral pathology present. Petitioner was a good candidate for physical therapy and recommended to undergo a course of skilled therapy three times a week for four weeks. Petitioner underwent physical therapy on 4/9/14, 4/10/14, and 4/15/14. Petitioner returned to Dr. Fletcher on April 16, 2014. At that time, Dr. Fletcher recommended a hip MRI/Arthrogram, a consultation with Dr. Li, and ongoing physical therapy. Petitioner continued with physical therapy at 217 Rehab on 4/16/14, 4/18/14, 4/23/14, and 4/24/14. On April 24, 2014, Alan Koch, PT indicated that the Petitioner was reassessed and tested positive for a labral tear of his right hip. Mr. Koch opined that Petitioner's mechanism of injury would have placed his right hip into external rotation and physical therapy was put on hold until Petitioner obtained the MRI of his hip. (PX 3).

On April 29, 2014, Petitioner underwent an MRI of his right hip with contrast at Christie Clinic. The impression was a small tear at the base of his right acetabular labrum. Petitioner returned to Dr. Fletcher on April 30, 2014. At that time, Dr. Fletcher opined that the MRI Arthrogram confirmed his diagnosis and that Petitioner was being placed on hold from physical therapy until after surgical intervention. Dr. Fletcher indicated that there were very few orthopedic surgeons that do hip repairs and suggested Dr. Herrin in Springfield or Dr. Bush-Joseph at Rush in Chicago. Dr. Fletcher notes that the cause of this problem is related to work activities and that Petitioner's mechanism of injury would have placed his right hip into an external rotation. On the Certification of Healthcare Provider for Employee's Serious Health Condition, which was completed by Dr. Fletcher on May 23, 2014, it stated that the condition commenced on March 6, 2014 and that Petitioner was on restrictions until surgery and rehab completed. It also states that Petitioner was waiting on work comp authorization for the surgical referral. (PX 3).

Petitioner testified that following the surgical recommendation from Dr. Fletcher, any further treatment at SafeWorks was denied by the work comp carrier so he had to seek treatment at a different facility. As such, Petitioner was seen by Dr. Richard Goding at Christie Clinic on May 29, 2014. The Petitioner reported a right hip and back injury on March 6, 2014 when he was wrapping a shipping pallet as he tore the wrap and twisted he felt a pop in his right hip with an immediate onset of serve pain in his right hip and groin area going down his right leg. Petitioner indicated that he had undergone physical therapy which did not relieve his pain. On examination, Petitioner walked with a mildly antalgic gait, an audible and palpation clicking in the anterior portion of his hip, a positive straight leg test on the right, and a normal range of motion in the hip. Dr. Goding's assessment was a herniated disc and sprain of the hip. Dr. Goding opined that Petitioner had an injury April 6 which resulted in a labrum tear and herniated disc. Dr. Goding further indicated that the mechanism of injury is likely consistent with the complex of injuries and opines that the treatment should be the responsibility of workers' comp since the injury clearly occurred March 6, 2014 at work. Dr. Goding recommended physical therapy. (PX 4).

On June 13, 2014, Petitioner underwent a physical therapy evaluation at Christie Clinic. At that time, Petitioner reported an onset of right hip pain on March 6, 2014 while he was tearing wrapping off a shipping pallet and twisted and felt a pop in his right hip which was followed by immediate pain. Petitioner was recommended to undergo a skilled course of physical therapy for six weeks at two visits per week. Petitioner underwent physical therapy on 6/16/14, 6/19/14, 6/23/14, 6/26/14, 7/7/14, and 7/10/14. (PX 4).

Petitioner returned to Dr. Goding on July 10, 2014. At that time, Petitioner indicated that he had been in physical therapy and continued to have right hip pain. Dr. Goding indicated that Petitioner had a hip labral tear and was awaiting confirmation of workers' compensation status so he could send Petitioner for a hip arthroscopy. Petitioner continued with his physical therapy at Christie Clinic on 7/14/14, 7/17/14, 7/21/14, and 7/24/14. (PX 4).

On September 4, 2014, Petitioner was seen by Dr. Benjamin Domb at Hinsdale Orthopaedics. By history, Petitioner reported an onset of right hip pain since March 6, 2014 when he was turning to load his pallet and twisted his body and felt immediate pain in his right

hip and groin area. Petitioner testified that Dr. Goding referred him to Dr. Domb and the office note from September 4, 2014 indicates that the requesting physician is Dr. Richard Goding. On examination, Petitioner had a right antalgic gait, a negative logroll test, a positive anterior impingement test among other provocative findings. Dr. Domb reviewed x-rays, the right hip MRI Arthrogram from April 29, 2014, and the lumbar MRI from March 28, 2014. Dr. Domb's assessment was right hip pain since March 6, 2014 after an injury at work while twisting to load his pallet which resulted in a right hip labral tear. Based on Petitioner's inability to improve with conservative measures, Dr. Domb recommended a right hip arthroscopy with labral repair versus a debridement versus reconstruction, femoroplasty, iliopsoas fractional lengthening, capsular plication, possible microfracture and possible periacetabular osteotomy. However, Dr. Domb wanted Petitioner to be evaluated by Dr. LaRue for consideration of concurrent periacetabular osteotomy. Dr. Justin LaRue examined and evaluated the Petitioner on September 4, 2014. Dr. LaRue's assessment was right hip dysplasia with noted labral tear on MRI. Dr. LaRue recommended a dGemric MRI to further evaluate the cartilage inversion of the hip prior to making a final recommendation. Petitioner underwent a dGemric MRI to his right hip on September 10, 2014 at Hinsdale Orthopaedics. The findings of the MRI revealed superior and posterior-superior acetabular labral tear, moderate insertional tendinosis of gluteus minimus and gluteus medius, and normal chondral thickness. (PX 6).

Petitioner returned to Dr. LaRue on September 29, 2014. After a review of the dGemric MRI, Dr. LaRue advised Petitioner that he was not a candidate for a PAO and recommended that he move forward with the arthroscopy surgery to address the labral tear with Dr. Domb. Petitioner was provided with a work status report indicating that he was unable to work pending further testing and consultation. (PX 6).

Petitioner underwent a pre-surgical medical consultation with Dr. Dandan Li at Carle on November 21, 2014. Petitioner was medically cleared for surgery. (PX 8).

Petitioner was re-evaluated by Julie Morgan, PA-C at Hinsdale Orthopaedics on December 2, 2014. At that time, it was indicated that Petitioner was a candidate for right hip arthroscopy with labral repair versus debridement versus reconstruction. Petitioner was provided with a post-operative brace. On December 8, 2014, the Petitioner underwent surgical intervention with Dr. Domb. At that time, Dr. Domb performed an arthroscopic labral debridement, ligamentum teres debridement, iliopsoas bursectomy, femoroplasty, and capsular plication. The pre-operative and post-operative diagnosis was labral tear, ligamentum teres tear, iliopsoas bursitis, cam lesion, and instability. Following the procedure, Petitioner was recommended to remain on crutches for two weeks with limited weightbearing on the right leg. Petitioner was subsequently recommended to undergo a course of physical therapy. (PX 6). Petitioner completed a course of physical therapy at Christie Clinic from December 15, 2014 through March 13, 2015. This involved a total of 21 sessions of physical therapy concentrating on Petitioner's right hip range of motion, flexibility, and strengthen. As of March 13, 2015, Rachel Zubricky, DPT was recommending ongoing physical therapy with a progression to a home exercise program. (PX 4).

On April 16, 2015, the Petitioner returned to Dr. Domb. At that time, the Petitioner reported that his pain was improved but that he still was having discomfort and weakness. Dr. Domb indicated that the Petitioner was not strong enough to return back to work and recommended work conditioning to improve the Petitioner's strength. (PX 6).

The Petitioner underwent a course of work conditioning at Carle Therapy Services from May 13, 2015 through June 11, 2015. As of June 11, 2015, the Petitioner reported bilateral hip pain at a 1 out of 10 and Petitioner was discharged and instructed to follow-up with Dr. Domb. The Petitioner had completed a total of 16 sessions of work conditioning and had progressed well with his range of motion, strengthening, and balance. (PX 8).

On June 18, 2015, the Petitioner was re-evaluated by Dr. Domb. At that time, Petitioner reported no pain but occasional discomfort. Dr. Domb released the Petitioner to return to work without restrictions and instructed him to follow up with Julie Morgan. Petitioner was seen by Julie Morgan, PAC on December 1, 2015. Petitioner reported that he feels better than he did before the surgery but that he has soreness, discomfort, and occasional popping. Petitioner was instructed to return in December 2016. (PX 7).

Petitioner testified that he has returned to work for the Respondent as an order selector. He further testified that he is able to complete the tasks of his positions as an order selector. He continues to have discomfort in his hip. He takes Tylenol and Ibuprofen to treat the discomfort. He also used ice and heating pads. He testified that he has discomfort when he stands too long, sits too long, or does a lot of bending over.

Jimmy Gonzalez testified on behalf of the Respondent. Mr. Gonzalez is the risk control manager for Respondent which is a position he has held since August 2012. Mr. Gonzalez testified that he has worked with Petitioner for at least 10 years and has viewed Petitioner complete his tasks as an order selector on many occasions. He further testified that he made a video of the tasks required in shrink wrapping a pallet. (RX 1). This video was completed at the request of Respondent's counsel and was completed after the March 6, 2014 accident. Mr. Gonzalez testified that on March 6, 2014, he was notified that Petitioner had reported a work accident. He subsequently viewed the pallet and confirmed that the shrink wrap was at a height from his knees to above his head. He further testified that prior to the March 6, 2014 accident and following Petitioner's return to work in June 2015, Petitioner didn't have any problems with meeting the rates that are required for order selectors.

Dr. Benjamin Domb testified by way of an evidence deposition on December 9, 2014. Dr. Domb is a board certified orthopedic surgery with a specialty in hip arthroscopy. Dr. Domb testified that he is only one of five surgeons in the country that perform the volume of hip arthroscopy procedures and none of them are in the Champaign area. (PX 1, p. 32-33). Dr. Domb testified that Petitioner sustained a labral tear due to the twisting injury while at work on March 6, 2014. (PX 1, p. 8-10, 14-15). He further testified that this mechanism of injury is a very common cause of labral tears. (PX 1, p. 36-39). He testified that Petitioner's hip dysplasia was not a predisposing factor that caused the labral tear. (PX 1, p. 25-26). He also testified that Petitioner will see improvement but may continue to have pain or weakness or restriction of motion and will likely need future treatment for his hip. (PX 1, p. 26-27).

Petitioner was examined by Dr. Jeffrey Coe at the request of his attorney pursuant to Section 12 of the Act. Dr. Coe issued a report following his examination of Petitioner on April 21, 2015 (PX 2, Exhibit 2). Dr. Coe also testified at an evidence deposition on August 14, 2015. (PX 2). As a board certified occupational medicine specialist, Dr. Coe performs examinations, works as an advisor or consultant in treating companies' employees, performs independent examinations, and is a professor at the University of Illinois. (PX 2, p. 4-8). Dr. Coe reviewed the medical records from Safeworks Clinic, Christie Clinic, Dr. Domb and Dr. Hemmer. (PX 2, p. 11-12, 20). He took a history from Petitioner and a physical examination of Petitioner. PX 2, p. 10-11, 21-25). Dr. Coe testified that there is a causal relationship to the work activities Petitioner was performing on March 6, 2014 and the right hip condition of ill being. (PX 2, p. 25). Dr. Coe also testified that he reviewed the video (RX 1) and that did not change his opinion with respect to causation. He also reviewed the deposition transcript of Dr. Fletcher (RX 2). Dr. Coe testified that he disagreed with Dr. Fletcher's opinion since there was clearly a specific injury that occurred to Petitioner on March 6, 2014. (PX 2, p. 28-29). Dr. Coe further testified that there is no medical literature to quantify or determine the exact amount of force needed to cause a labral tear. (PX 2, p. 29).

Dr. David Fletcher testified at an evidence deposition on December 19, 2014 (RX 2). Dr. Fletcher is board certified in preventative medicine and occupational medicine. He has had an 11-year relationship with the Respondent as their occupational physician which also included providing an on-site nurse at its facility. (RX 2, p. 8-9). Dr. Fletcher testified that he has visited Respondent's facilities almost a hundred times and has a strong familiarity with the job demands. (RX 2, p. 8-9). Dr. Fletcher testified that he reviewed Dr. Hemmer's medical records which were significant in showing that Petitioner had back and hip complaints going back to October 2014. (RX 2, p. 24-25). Dr. Fletcher testified that he eventually diagnosed Petitioner with a labral tear and he was going to refer Petitioner to Dr. Charles Bush-Joseph since there are no doctors in the area that could perform treatment on Petitioner. (RX 2, p. 47). After speaking with Jimmy Gonzalez, who provided him with a recorded statement from Petitioner, and observing the job tasks of wrapping a pallet, Dr. Fletcher opined that the hip labral tear was not connected to Petitioner's employment. (RX 2, p. 55-58). On cross examination, Dr. Fletcher admitted to having a discussion with Mr. Tomaso (Respondent's Counsel) prior to the deposition outside the presence of Mr. Haugen (Petitioner's Counsel). Dr. Fletcher further testified that he was unaware that Petitioner withdrew his consent that allowed Supervalu to communicate with his treating physicians. (Rx 2, p. 64-67, Exhibit 6). Dr. Fletcher confirmed that there were not any notes generated from his on-site nurse, Linda Hogan, prior to the March 6, 2014 accident as it pertains to Petitioner's right hip. (Rx 2, p. 69-70).

CONCLUSIONS OF LAW

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

The Arbitrator adopts the statement of facts detailed above and finds that an accident occurred that arose out of and in the course of the Petitioner's employment with Respondent on March 6, 2014. The Arbitrator notes that Petitioner testified in a credible manner and that his testimony was consistent with the treating medical records.

The Petitioner had an immediate onset of pain in his right hip after twisting his body while pulling the shrink wrap around his pallet. Within five minutes of this occurring, he reported the accident to his supervisor and filled out an accident report. (RX 4). The history Petitioner provided to Dr. Fletcher at SafeWorks, his physical therapist at 217 Rehab, Dr. Goding at Christie Clinic, Dr. Domb at Hinsdale Orthopaedics, and Dr. Coe at Occupational Medicine Associates, is consistent with his testimony and the accident report.

Prior to this accident, the Petitioner was successfully performing the job duties of an order selector which required him to lift up to 100 lbs. The Petitioner wasn't having any difficulties keeping up with the required rates and percentages the Respondent required for all order selectors. The Arbitrator does not find it significant that Petitioner was treating for "hip discomfort" and back pain with Dr. Hemmer in October of 2013. As of October 28, 2013, the Petitioner was having minimal complaints and was released. Furthermore, a review of Dr. Hemmer's records shows that all of the treatment received was for problems which originated in the Petitioner's lower back and neck. It is clear from a review of the notes in their entirety that the Petitioner's hip complaints, if they could be called hip complaints, were much different than his right hip symptoms noted in all of the post accident medical reports. There are no medical records in the evidence that indicate the Petitioner was treating for hip pain between October 28, 2013 and March 5, 2014. The Arbitrator finds that it would have been difficult for Petitioner to complete the tasks of an order selector from October 2013 until March 6 2014, if he had a pre-existing labral tear or an "insidious" condition.

Jimmy Gonzalez confirmed that the pallet Petitioner was wrapping immediately prior to reporting the work accident had plastic shrink wrap on it at the height of his knee to above his head. Mr. Gonzalez also confirmed that it is customary for some of the order selectors to wrap the pallets with the shrink starting at the bottom and ending at the top. The Petitioner testified that at the time of the accident he was wrapping his shrink wrap from the bottom to the top. So, when he got the end of wrapping the pallet, the shrink wrap was above his head which required him to pull and twist in a downward motion to rip the shrink wrap.

Therefore, the Arbitrator finds that Petitioner suffered an injury to his right hip that arose out of and in the course of his employment with Respondent on March 6, 2014.

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

The Arbitrator finds that Petitioner's current condition of ill-being is causally related to the March 6, 2014 injury. In reaching this decision, the Arbitrator relies upon the treating medical records and the opinions of Dr. Goding, Dr. Domb, and Dr. Coe.

In the May 29, 2014 office note, Dr. Goding opines that Petitioner's March 6, 2014 accident caused a labrum tear and that the mechanism of injury as described by Petitioner in the history, which was consistent with Petitioner's testimony, was consistent with this type of injury. (PX 4). Dr. Domb testified that the March 6, 2014 accident was the cause of Petitioner's right hip labral tear. Dr. Domb opined that the Petitioner's hip dysplasia was not a causative factor to the labral tear. He further testified that the twisting-type injury Petitioner sustained on March 6, 2014 is a common mechanism of injury to cause a labral tear. Lastly, Dr. Coe credibly testified that Petitioner's March 6, 2014 accident was a contributing factor to the right hip labral tear following a review of the treating medical records and the video of Jimmy Gonzalez wrapping the pallet. Based on a reliance of these doctor's opinions, the Arbitrator finds a causal relationship between Petitioner right hip labral tear and the March 6, 2014 accident.

The Arbitrator does not find persuasive the opinions of Dr. Fletcher concerning causation. First of all, Dr. Fletcher testified that he is very familiar with the job which the Petitioner performs based upon his eleven year history as medical provider for the Respondent. He testified in great detail that he had many times observed order selectors performing their jobs. He had seen them wrap pallets and observe their body mechanics. (RX 2 at 12-16) With said knowledge and with the diagnosis of a labral tear firmly established, Dr. Fletcher on April 30, 2014 wrote that the mechanism of the injury would have placed the Petitioner's right hip into external rotation and concluded that his problem was related to his work activities. (PX 3) Dr. Fletcher's attempts to explain his change of opinion were unpersuasive. In his deposition, the doctor said that his causation opinions through his April 30 visit with the Petitioner had to do with his lumbar spine pathology. (RX 2 at 54) The statement is clearly false, given the language in his note of that date, as stated above.

Also, as referenced above, Dr. Fletcher based his opinion in part on the inaccurate premise that Dr. Hemmer's chiropractic notes showed a long standing hip condition. It is telling, however, that Dr. Fletcher rendered his causation opinion in letter form prior to ever reviewing said chiropractic notes. (Id at 75)

The Arbitrator further finds that there was no violation of the Petrillo doctrine, as claimed by the Petitioner. Petrillo applies to treating physicians only. Parties or their attorneys are banned from having ex parte communications with treating physicians. Assuming for the sake of argument that Dr. Fletcher was a treating physician for the Petitioner, that relationship ended on April 30, 2014, long before the attorney for the Respondent discussed the case with Dr. Fletcher, prior to taking his deposition. After April 30, Dr. Fletcher's role was that of a plant physician, focusing on providing opinions on causation. As he explained, his role with the Respondent is multi-faceted. (Id at 57-58) Just as Petrillo would not prohibit Respondent's attorney from discussing issues with a Section 12 examiner, it does not prohibit discussions with a plant physician whose role is to determine causation.

Dr. Domb obviously has a much greater understanding of the Petitioner's hip condition than that of Dr. Fletcher. He explained persuasively why the Petitioner's dysplasia was not a risk factor for the labral tear. (PX 1 at 25-26) The Arbitrator adopts his opinions on causation and finds the Petitioner's labral tear, partial tear of the teres ligament and bursitis causally related to the Petitioner's 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?

In finding that Petitioner's March 6, 2014 injury arose out of and in the course of Petitioner's employment with Respondent and finding a causal relationship, the Arbitrator finds that the Respondent is responsible for the reasonable and related medical bills Petitioner incurred to treat his right hip condition of ill being as documented in Petitioner's Exhibit 9. Both Dr. Domb and Dr. Coe testified that Petitioner's treatment was reasonable and necessary to treat his condition of ill being. The Respondent provided no evidence that this treatment was either unreasonable or unnecessary. As such, the Respondent is responsible for the bills submitted by Petitioner (PX 9). The Respondent is entitled to a credit for the bills they have paid and the bills that were previously paid by the group carrier.

Furthermore, the Arbitrator finds that Respondent is responsible for the travel expenses Petitioner incurred while treating with Dr. Domb at Hinsdale Orthopaedics. Dr. Fletcher and Dr. Domb testified that there were no doctors in the Champaign area that could treat Petitioner's injuries. Petitioner testified that he had to travel approximately 300 miles round trip every time he treated at Hinsdale Orthopaedics. The medical records indicate that Petitioner was seen at Hinsdale Orthopaedics for a total of ten visits. As such, the Arbitrator finds that Petitioner is entitled to $1,650.00, which represents a $0.55 mileage rate for the ten trips Petitioner was required to travel for reasonable and related medical treatment.

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

The Respondent did not dispute the time period of temporary total disability but rather disputed the liability for paying these benefits. In finding that Petitioner sustained an accident on March 6, 2014 and finding the requisite causal relationship between the work accident and Petitioner right hip condition of ill being, the Arbitrator awards temporary total disability benefits from May 22, 2014 through June 18, 2015.

The Arbitrator notes that Petitioner received short term disability benefits in the amount of $16,643.90. As such, the Respondent is entitled to a credit for these benefits that were previously paid to Petitioner.

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

The Arbitrator adopts the findings of fact and conclusions of law contained above with respect to the issues of accident and causal connection and incorporates them herein by this reference.

The Petitioner testified that he continues to have discomfort in his right hip. He further testified that this discomfort is brought on by standing too long, sitting too long and bending. He is required to treat this discomfort with Tylenol, Ibuprofen, ice, and heating pads on a regular basis. Petitioner has returned to work for Respondent as an order selector and is able to complete the requirements of his position.

Pursuant to Section 8.1b of the Act, for accidental injuries occurring after September 1, 2011, permanent partial disability shall be established using five enumerated criteria, with no single factor being the sole determinant of disability. 820 ILCS 305/8.1b(b) states the criteria to be considered are as follows: (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. Applying this standard to this claim,

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

i. Petitioner did not undergo an AMA Impairment Examination.

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

ii. Petitioner was employed as an order selector at the time of the accident and at the time of Arbitration hearing. The evidence established that this is a very labor intensive job in which Petitioner would be required to lift up to 100 lbs. The evidence also established that Petitioner is required to perform this work at a satisfactory speed to complete all the assigned orders on a daily basis. The Arbitrator assigns greater weight to this factor.

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

iii. Petitioner was thirty-seven (37) at the time of the accident and is currently thirty-nine (39) years old. The Arbitrator assigns weight to this factor, as the Petitioner will have to work for a number of years with the problems and symptoms referenced above

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

iv. At the present time, there is no evidence that Petitioner's future earning capacity has diminished as a result of the injury. The Arbitrator assigns little weight to this factor.

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

v. The Arbitrator finds that Petitioner has demonstrated evidence of disability. Petitioner credibly testified that he continues to experience discomfort in his right hip. Dr. Domb notes that Petitioner continued to complain of discomfort and weakness in his hip following the right hip arthroscopic labral debridement procedure which was performed on December 8, 2014. Dr. Domb testified that Petitioner may have ongoing symptoms of weakness and may need further treatment to address his right hip in the future. Dr. Coe, however, found only mild hip flexor strength reductions during his examination of April 21, 2015. (PX 2 at 38) He further opined that he expected the Petitioner to continue to improve. (Id at 40) Dr. Domb released the Petitioner to full duty work as of December 1, 2015, though he found the Petitioner to have a mildly positive Faber's sign, as well as with the anterior impingement test. (PX 7)

Therefore, after applying Section 8.1b of the Act and considering the relevance and weight of all the factors for which evidence was presented, the Arbitrator concludes that Petitioner has sustained a 20% permanent loss to the right leg. As such, Respondent shall pay Petitioner permanent partial disability benefits of $549.81/week for 43 weeks.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARY H. SHANKLIN,

Petitioner,

vs. NO: 13 WC 15900

CITY OF SPRINGFIELD,

Respondent.

17IWCC0791

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Appellate Court, Fourth District Workers' Compensation Commission Division, whose July 18, 2017, Supreme Court Rule 23 Order found that "the manifest weight of the evidence clearly supports the findings of the dissenting commissioner." *App. Order at 14.* The Court remanded this cause to the Commission "for further proceedings to determine what benefits claimant is entitled to and any other proceedings, if any, which may be appropriate." *Id.* As background, the Commission, with one Commissioner dissenting, issued a decision on October 28, 2015, which affirmed and adopted the decision of the arbitrator who found that Petitioner had failed to prove that her bilateral carpal tunnel syndrome and DeQuervain's tenosynovitis were causally related to her employment. Based on the findings of the Appellate Court and its remand instructions, the issues before the Commission are medical expenses, temporary total disability, and permanent partial disability.

The Request for Hearing form indicates that the parties agreed that Petitioner was off work for six (6) weeks from April 4, 2013 through May 16, 2013. Respondent's only dispute was liability. It was also stipulated that Petitioner's average weekly wage in the year preceding her injury was $1,433.26. We hereby award temporary total disability benefits of $955.51 for six (6) weeks.

We find that Petitioner is entitled to $13,815.00 in medical expenses (Px1 through Px5), subject to the fee schedule in §8.2 of the Act.

On the issue of permanency, we apply the five factors listed in Section 8.1b is as follows:

1) No AMA impairment rating was submitted so we give that no weight.
2) Petitioner's occupation is a Laborer Foreman, which involves heavy manual labor, and we afford that significant weight.
3) Petitioner was 53 years of age at time of her injury, which we give no weight since there is no evidence as to how her age affects her disability.
4) There was no evidence that Petitioner's injury diminished her future earning capacity and she has returned to her previous job so we give this factor no weight.
5) We give the greatest weight to the evidence of disability corroborated by the treating medical records. Petitioner testified that since the surgery, "I can close my hands which I couldn't before. They're better than what they were." She gets swelling if it's real hot (retains water), sometimes takes ibuprofen, and has "not really" gotten her strength back. T.33. On cross-examination, Petitioner testified that she told Dr. Watson on May 1, 2013, that all of her carpal tunnel symptoms were gone. On May 15th, she told him that she had no numbness or tingling in either hand, the pain was minimal, and she had "near normal" strength. In July, she returned to him with some other problems but told him that she no longer had any carpal tunnel symptoms and her sensation was normal. T.43-44.

The last medical record from Dr. Watson, on July 3, 2013, indicates that Petitioner returned with a three-week history of right-sided wrist pain, which is worse with power gripping. Petitioner had been working and doing a lot of heavy labor, which contributes to her troubles, but she no longer had carpal tunnel symptoms. On examination, the surgical incision was healed, sensation was normal, all tendons were functional, and she had 5/5 strength. However, she was tender along the extensor retinaculum and the dorsum of the wrist and had pain with hyperflexion. Dr. Watson's impression was recurrent extensor tendinitis of the wrist, for which he performed an injection and recommended physical therapy. Dr. Watson's note indicates that he offered to restrict Petitioner from work but that she preferred to continue working without restrictions despite her discomfort.

Dr. Watson testified that he released Petitioner to work without restrictions on May 16, 2013, and his last visit was July 3, 2013. Petitioner responded well to her surgeries in that all of her carpal tunnel symptoms were resolved but she continued to have soreness and swelling in her wrists when she returned to work. He testified that, when given the option, Petitioner did not want to stop working and preferred to work through the pain hoping that it would eventually resolve. Dr. Watson testified that Petitioner had residual tendinitis and swelling in the wrists as a result of her work responsibilities. (Px8).

Based on the above analysis of the five factors, we find that Petitioner is entitled to permanent partial disability of 10% loss of use of each hand due to the bilateral carpal tunnel syndrome. Considering Petitioner's date of accident (October 16, 2012) and her average weekly wage, we find that she is entitled to the applicable maximum permanent partial disability rate of $712.55. Pursuant to §8(e)9 of the Act, since her accident occurred on or after June 28, 2011, and involves carpal tunnel syndrome due to repetitive or cumulate trauma, the permanent partial disability award is based on 190 weeks for each hand. This results in an award of 19 weeks (10% x 190) for each hand. We find that Petitioner failed to prove any permanency specifically

related to the DeQuervain's condition. 17IWCC0791

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $955.51 per week for a period of 6 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the reasonable and necessary medical expenses of $13,815.00 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 the sum of $712.55 per week for 38 weeks, because the injuries sustained caused the 10% loss of use of each hand, as provided in §8(e) of the Act.

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

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

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

DATED: DEC 11 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 11/1/17
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STATE OF ILLINOIS)
) SS.
COUNTY OF Jefferson)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Carol Taylor,

Petitioner,

vs. NO: 12WC 10564

State of Illinois
Warren G. Murray
Developmental Center,

17IWCC0792

Respondent,

DECISION AND OPINION ON REVIEW

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision.

17IWCC0792

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

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

DATED: DEC 12 2017

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CJD/rlc
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Charles J DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

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

TAYLOR, CAROL
Employee/Petitioner

Case# **12WC010564**

12WC010565

ST OF IL WARREN G MURRAY CENTER
Employer/Respondent

17IWCC0792

On 9/29/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.42% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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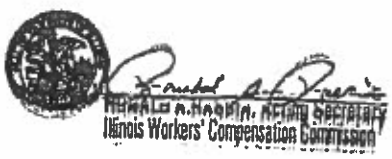
CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

SEP 29 2016



17IWCC0792

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(a)

CAROL TAYLOR
Employee/Petitioner

v.

STATE OF ILLINOIS / WARREN G. MURRAY CENTER
Employer/Respondent

Case # **12** WC **10564**

Consolidated cases: **12 WC 10565**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **May 4, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0792

FINDINGS

On the date of accident, **August 22, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$31,497.44**; the average weekly wage was **$605.72.**

On the date of accident, Petitioner was **53** years of age, *single* with **0** dependent children.

Respondent may or may not have 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**. No credit is awarded because the parties stipulated that all lost time benefits have been paid by Respondent.

ORDER

The Petitioner has failed to prove that she has any current condition of ill being with regard to her low back or her left hip, and as such has failed to prove a causal connection from any current condition to the August 22, 2010 accident

Respondent shall pay reasonable and necessary medical services contained in Px1 which are causally related to the August 22, 2010 accident, as provided in Sections 8(a) and 8.2 of the Act, and shall pay same directly to the providers. Respondent is entitled to credit for any of the awarded medical expenses which were paid prior to the hearing date.

The Petitioner has failed to prove that she is entitled to any prospective medical treatment related to the August 22, 2010 accident.

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

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

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

Signature of Arbitrator

September 22, 2016
Date

STATEMENT OF FACTS

A consolidated hearing was held in this matter for case numbers 12 WC 10564 and 12 WC 10565, however two separate decisions are being issued by the Arbitrator. The Arbitrator notes that prior to hearing, the Petitioner presented an oral motion to amend the Application for Adjustment in the 12 WC 10564 claim to change the accident date from 8/23/10 to 8/22/10, and this was granted on the record instanter without objection from Respondent.

The Petitioner was employed by the Respondent as a Medical Tech II. She was injured in 2010 and 2012. On 8/22/10, she testified that she was attacked by a patient and hit her left back and left hip. She testified that she had x-rays, pain medication and chiropractic treatment, and it helped her.

The records of St. Mary's good Samaritan hospital from 8/24/10 and 9/19/10 support her complaints of low back and left hip pain following an 8/22/10 accident where she was assaulted by a patient. The latter report indicates the petitioner had received a brace and had been going to work safely. Lumbar x-rays indicated mild chronic degenerative osteophytes and facet changes, mainly at the lower levels, with a normal lumbar lordosis. Left hip x-rays noted chronic degenerative osteophyte formation, but no acute osseous abnormalities. The diagnosis was a lumbosacral strain. (Px3).

On 9/20/10 the petitioner underwent lumbar MRI. The films were interpreted to show minimal to mild degenerative changes from L2 to L5. There was borderline central canal stenosis at L2/L3 with no neural for aminal stenosis. At L3/4 there was mild to moderate central canal stenosis and moderate left and mild to moderate right neural for aminal stenosis. At L4/5 there was severe bilateral neural for aminal stenosis. There were no disc herniation's noted, but there were mild disc bulges from L2 to S1. (Px3).

The petitioner treated at Williams chiropractic from 9/17/10 to 11/3/10. The records note that a patient had pushed her down to the floor. The initial report noted the petitioner had undergone three or four sessions of physical therapy, and now had pain from the left side of the neck to the left shoulder, left hip pain into the buttocks and down the front of the left leg to the ankle. She noted burning, tingling, numbness and throbbing pains. The notes indicate she was return to light duty on 9/27/10 on a trial basis, and to regular duty as of 10/13/10. (Px4).

The Petitioner was paid full salary while off work. Asked how her low back and left hip were doing from the 2010 accident as of the hearing date, the Petitioner testified: "I am not having any problems with it".

The Petitioner testified that she had never had any prior low back or left hip injuries or treatment, and had never filed a workers' compensation claim prior to 8/22/10. She testified that after her full duty return to work, she didn't miss any additional work until after her 1/17/12 accident.

CONCLUSIONS OF LAW

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

The Arbitrator finds that the Petitioner's low back and left hip conditions are no longer causally related to the 8/22/10 accident. This is significantly based on the Petitioner's testimony indicating she has no ongoing problems with these body parts, and based on the Petitioner's lack of treatment for same since 2010.

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 Petitioner is entitled to medical expenses related to the low back and left hip which are reasonable and necessary and which were incurred through 11/3/10, which is when the Petitioner reached maximum medical improvement with regard to the 8/22/10 accident. She last treated on 11/3/10, had already returned to full duty work, and there was no evidence of further problems after 11/3/10.

The Respondent is entitled to credit for all awarded medical expenses that were previously paid prior to hearing. For any outstanding awarded expenses, as stipulated by the parties, any such expenses shall be paid by Respondent directly to the providers. All of the awarded medial expenses are also subject to the medical fee schedule contained in Section 8.2 of the Act.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings above with regard to causation, the Arbitrator further finds that the Petitioner is not entitled to any further medical treatment to the low back or left hip.

WITH RESPECT TO ISSUE (O), EXTENDED CHOICE OF PHYSICIAN / TWO DOCTOR RULE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that this issue, while noted on the Request for Hearing form (Arbitrator's Exhibit 1), is not applicable to this case. Based on the evidence presented, the Respondent's dispute with regard to this issue is applicable to the 12 WC 10565 claim. As such, in this claim, 12 WC 10564, the issue is moot, as the Petitioner did not treat with multiple physicians.

STATE OF ILLINOIS)
) SS.
COUNTY OF Jefferson)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Carol Taylor,

Petitioner,

vs.

NO: 12WC 10565

17IWCC0793

State of Illinois
Warren G. Murray
Developmental Center,

Respondent,

DECISION AND OPINION ON REVIEW

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision.

17IWCC0793

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

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

DATED: DEC 12 2017

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CJD/rlc
049

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

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

TAYLOR, CAROL
Employee/Petitioner

Case# **12WC010565**
12WC010564

ST OF IL WARREN G MURRY CENTER
Employer/Respondent

17IWCC0793

On 9/29/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.42% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0558 ASSISTANT ATTOENY GENERAL
KENTON OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

SEP 29 2016

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

17IWCC0793

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(a)

CAROL TAYLOR
Employee/Petitioner

v.

STATE OF ILLINOIS / WARREN G. MURRAY CENTER
Employer/Respondent

Case # 12 WC 10565

Consolidated cases: 12 WC 10564

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **May 4, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0793

FINDINGS

On the date of accident, **January 17, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$34,223.80**; the average weekly wage was **$658.15**.

On the date of accident, Petitioner was **54** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**. No specific credit is awarded because the parties stipulated that all lost time benefits have been paid by Respondent.

ORDER

The Arbitrator finds that the Petitioner's cervical condition remains related to the 1/17/12 accident, but that the Petitioner reached maximum medical improvement with regard to the condition as of 12/31/13.

Respondent shall pay the reasonable and necessary causally related medical expenses contained in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act, which were incurred prior to 1/1/14.

Respondent shall be given a credit for medical benefits that have been previously paid.

The Petitioner has failed to prove that the cervical surgery recommended by Dr. Raskas is reasonable and necessary as contemplated by 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

September 26, 2016
Date

SEP 29 2016

17IWCC0793

STATEMENT OF FACTS

A consolidated hearing was held regarding case numbers 12 WC 10564 and 12 WC 10565, however two separate decisions are being issued by the Arbitrator. The Arbitrator notes that prior to hearing, the Petitioner presented an oral motion to amend the Application for Adjustment in the 12 WC 10564 claim to change the accident date from 8/23/10 to 8/22/10, and this was granted on the record instanter without objection from Respondent.

The Petitioner was employed by the Respondent as a Medical Tech II. She was injured in 2010 and 2012. On 8/22/10, she testified that she was attacked by a patient and hit her left back and left hip. She had x-rays, pain medication and chiropractic treatment, and she testified this helped her. She was paid full salary while off work, and eventually was released to full duty as of 11/3/10. Asked how her low back and left hip were doing from the 2010 accident as of the hearing date, the Petitioner testified: "I am not having any problems with it". The Petitioner testified that she had never had any prior low back or left hip injuries or treatment, and had never filed a workers' compensation claim prior to 8/22/10. She testified that after her full duty return to work, she didn't miss any additional work until after her 1/17/12 accident.

The Petitioner did well until 1/17/12. On that date she was attacked by another patient and injured her neck. Various records of the Respondent (Rx4) and medical providers support her testimony that she was grabbed by the neck and pulled downward. She testified that she had no prior neck injuries or treatment, and no prior workers compensation claims with regard to her neck. The neck injury resulted in stiffness, a burning sensation and difficulty moving the neck from side to side. The pain radiated down her right arm to her hand, with no problems in the left arm.

The Petitioner initially sought treatment with her primary care physician, Dr. Winkeler, on 2/2/12. (Px6). Dr. Winkler noted an 8 day history of low back and neck pain starting when her neck was pulled forward at work during an altercation. The pain was most prominent in the lower, right lumbar spine and radiated to the neck, right buttock, and right posterior thigh. The pain was moderate but constant, burning and cramping with numbness in the right thigh and weakness of the right upper leg. The pain was worse with walking, back flexion, hip flexion, and prolonged sitting or standing. Petitioner noted her prior 2010 injury, and Dr. Winkeler's report states: "this seems to aggrevationj [sic] of this." Following his examination, Dr. Winkeler diagnosed sciatica and prescribed medication. (Px6).

Petitioner called Dr. Winkeler's office 5 days later, indicating no improvement, and complaining of headaches she thought were coming from the neck. She was working in a desk job at that time. X-rays were requested. The Petitioner then called the next day indicating she wanted an off work slip due to her ongoing difficulties and use of medication at work. (Px6). On 2/13/12, Dr. Winkeler noted x-rays showed no fracture, but there was some mild facet joint arthropathy and mild osteoarthritis changes. Petitioner's pain had improved, but she complained of ongoing left buttock pain into the left leg with no numbness or weakness. She was referred for physical therapy. (Px6).

On 3/22/12, Petitioner returned to Dr. Winkeler with complaints of hand swelling, left greater than right with some weakness, numbness and tingling. Petitioner reported having neck pain, headaches and shoulder pain since the accident, "and now the numbness/tingling of arms with some weakness." Therapy did not seem to be helping or hurting her. Her right leg was slightly improved, but Petitioner noted the Respondent was not covering therapy for this. Exam noted edema over the dorsal hand and pain over the carpal tunnel. The assessment was cervical radiculopathy and anxiety, and cervical MRI was prescribed. She was to continue

therapy, light duty and medication. (Px6). It appears that a DEXA scan also was ordered, and the 3/24/12 results appear normal with regard to bone density. (Px7).

The 3/31/12 cervical MRI reportedly showed non-compressive disc protrusions from C3 to C7 without evidence of significant stenosis and no cord compression. (Px7). On 4/2/12, Dr. Winkeler reviewed the MRI, noting it showed mild to moderate arthritis and disc bulging from C3 to C7 with some canal stenosis. The body of the report noted mild canal stenosis at C5/6 but no cord compression, and the bony foramen throughout were patent. The C6/7 protrusion was slightly greater on the right than left. Dr. Winkeler referred Petitioner to a chronic pain specialist at St. Elizabeth's for evaluation of neck pain with C5/6 and C6/7 bulges with pain, specifically recommending injections and therapy. The last therapy note from St. Elizabeth's on 4/2/12 noted minimal progress had been made, and there even may have been some worsening of right shoulder symptoms. (Px6).

The Petitioner first saw Dr. Naseer at St. Elizabeth's on 4/11/12 with a chief complaint of neck and right arm pain. Dr. Naseer noted the Petitioner reported pain since the January 2012 work incident, where she was attacked by an individual who jumped up in the air, and on his way down grabbed her neck and twisted it, with sudden onset of neck pain. Petitioner reported a feeling of pain, numbness, and burning in her neck and right arm ever since. The pain was shooting, throbbing, dull, aching, sharp, electric shock, burning pain that is severe, constant, getting worse as time goes on, associated with nausea, weakness, headache, numbness and tingling. She also reported many activities that made the pain worse: coughing, going from bed to standing, taking stairs, driving, sitting, sneezing, moving from sitting to standing, cold, lying down, weather changes, stress and fatigue. (Px7).Dr. Naseer performed epidural injections on 4/11/12 (right C6/7), 4/30/12 (right C7/T1) and 5/23/12 (bilateral C6/7), noting at the 5/23/12 visit that the chief complaint was now neck and bilateral arm pain. All of them appear to have provided temporary relief. (Px7).

Petitioner followed up with Dr. Winkeler during the course of these injections. On 4/13/12 he noted she was better with the initial injection but still had pain. She also noted she wanted to remain on light duty pending the next injection, that she felt therapy wasn't helping and actually caused more soreness, and that she had more stress because her daughter was back in town. On 5/1/12, the Petitioner noted the injections were helping, but she had some pulling when lifting a bag of dog food a few days prior. On 5/11/12 the Petitioner reported her symptoms were the same as before the injections. She had increased her activities and developed increased shoulder burning and numbness down the arm into the fingers. The report notes pain in both shoulders. She was referred to an orthopedic surgeon, Dr. Meyer. (Px7).

The Petitioner saw Dr. Meyer on 5/22/12. (Px8). He noted she complained of pain in the right shoulder and arm related to a 1/10/12 work injury, noting a patient jumped across the table and grabbed her, taking her to the floor by grabbing her by the neck. The Petitioner reported sharp, severe pains from the neck all the way down to the arm to the fingers when it occurred, and that this had persisted since. Dr. Meyer noted that Dr. Winkeler had determined she had a cervical problem, and referred her to Dr. Naseer for injections. Petitioner reported that the cervical injections each helped for about a week, but hadn't cured the problem. She reported dizziness and headaches, noting she was working on light duty with a lifting limit. Physical therapy seemed to just aggravate the problem, and Flexeril hadn't really helped, while steroids helped somewhat. She denied any prior problems with the neck or right arm before the accident. (Px8).

Dr. Meyers' examination was significant for reduced range of motion but some guarding, tenderness over the trapezius and scapular area, and normal neurological exam other than subjective indication of decreased sensation in the right 3rd, 4th and 5th fingers. X-rays were obtained which showed C4 to C6 spurring and C5/6 disc space narrowing in the cervical spine, and spurring of the AC joint in the right shoulder. (Px7). Dr. Meyer also noted the cervical MRI findings, and diagnosed right cervical radiculitis versus right brachial plexitis and

AC joint arthrosis with exacerbation. He injected the right shoulder, continued light duty restrictions and requested EMG/NCV testing. Noting she also had a pending epidural with Dr. Naseer, Dr. Meyers asked the Petitioner to follow up in 2 or 3 weeks. (Px8).

Upper extremity EMG/NCV testing was performed by Dr. Khan on 7/24/12, and showed no abnormalities. (Px9). Dr. Winkeler's records indicate the Petitioner called stating: "She has been trying to get a hold of Dr. Meyer's office regarding her (EMG/NCV) and they won't call her back, she has not been happy with the office can we send her someone else." (Px6). No medical reports were submitted into evidence indicating that Petitioner ever followed up with Dr. Meyer after the EMG/NCV. Petitioner reviewed the test results with Dr. Winkeler on 7/31/12. His report noted Petitioner complained of upper neck pain into the bilateral shoulders with radiation into the right arm, and that she was swelling on the entire right side of her body. The diagnosis was cervical radiculopathy, anti-inflammatories were prescribed, and he noted if the mediation didn't help, she would be referred back to pain management. An 8/3/12 note of Dr. Winkeler's office noted the Petitioner called, her light duty was up and could no longer work, and requested a referral to Dr. Heffner or someone at Barnes Hospital. On 10/18/12, Dr. Heffner's office called Dr. Winkeler's to indicate that the Petitioner had called to confirm her visit and then was a no show that day. (Px6).

Dr. Heffner examined the Petitioner on 11/19/12. The petitioner reported with neck and arm pain, noting it was from a January attack at work where her neck was pulled down with sudden pain in her neck. Since that time the pain radiated into her right shoulder and arm, and she reported headaches. She indicated the left-sided not been affected and she did not have any problems with her neck before the injury. The Petitioner reported she had worked late duty until August 8, and was off work since then, feeling she was not making progress. Examination indicated pain with range of motion, but normal neurologically. Dr. Heffner noted in the cervical MRI showed multilevel degenerative changes and disc protrusion's, noting the most significant appearing abnormality was the central and somewhat left sided protrusion at C5/6. Given that the disc was left-sided what the symptoms were more right-sided, a CT myelogram was prescribed to determine if surgery was applicable. She was taken off work pending the CT. (Px5).

The 4/2/13 CT myelogram scan reflected mild cervical spondylosis without focal disc herniation. There was mild left-sided hypertrophic changes but no foraminal stenosis, and a disc osteophyte complex which flattened the ventral thecal sac but without central canal stenosis or foraminal stenosis at C5/6. The remaining cervical levels were all normal. (Px10).

On 4/22/13, Dr. Heffner noted complaints of very diffuse pain, pain in the neck, upper back and lower back, with sensation of swelling in her shoulders, left greater than right, and sensation of knee pain. His review of the CT myelogram films indicated they were unremarkable. In fact, he noted that the C5/6 disc appeared to be improved versus the prior cervical MRI. As there was no indication of nerve compromise, he did not believe neurosurgery was needed. He noted that her symptoms were much more widespread and diffuse than the last visit, and believed it was more of a diffuse muscular pain syndrome. He referred her to Dr. Choudhry, prescribed Lyrica and discharged her from care. (Px5).

Respondent had Petitioner examined by Dr. Petkovich on 12/31/13. (Rx7). On examination, he noted mild tenderness to right paracervical palpation, but normal neurological exam with no spasm. After reviewing the Petitioner's medical records and examining her, his diagnoses were cervical strain and mild degenerative disc condition at C5/6. The strain was related to the accident, but he opined that the degenerative condition was preexisting, and the accident did not aggravate or accelerate that condition. He believed her subjective complaints were out of proportion to her objective physical findings. He indicated she had reached maximum medical improvement and could return to unrestricted work duties.

There is no indication that the Petitioner sought further treatment after that time until being seen by chiropractor Dr. Renner on 2/7/14. Dr. Renner treated the Petitioner through what appears to be 6/25/14. The treatment involved chiropractic adjustments, physical therapy, strengthening involving ball and bands and other exercises. His findings on examinations included muscle spasm, trigger points, and limited ranges of motion. As of Petitioner's last visit, Dr. Renner noted weakness in Petitioner's cervical paraspinal musculature and subluxations present at C5-6. A review of the records does not reflect any significant improvement.. (Px11).

On 2/10/15, the Petitioner sought treatment with Dr. Truong. The Petitioner testified that her prior family doctor (Winkeler) relocated, and this became her family doctor. She reported her work accident and noted constant neck pain since, that had worsened over the last three days. She also reported chest pain three days prior that lasted about five seconds, with ongoing feeling of chest pressure. The pain was in her lower neck radiating to both shoulders, noting the bilateral upper extremity's including all fingers with pins and needles sensation. Multiple active problems were noted: respiratory infection, bipolar disorder, foot cellulitis, cervicalgia, cigarette smoker, hyperlipidemia, hypertension, low back pain, restless leg syndrome, vertigo and CPAP, along with delayed wound healing. Her list of current medications indicated 17 different medications were being taken. With regard to the cervical spine, meloxicam was prescribed, she was advised on a home exercise program, and it was noted she may need a neurosurgical or neurology referral. (Px12). An updated cervical MRI was also obtained on 2/26/15, and compared to the prior 3/31/12 study. The radiologist's report indicates films showed degenerative disc disease from C-2 through C7, increasing osteoarthritis of the left facet and left uncovertebral joint at the C4/5 level with resulting left neuroforaminal narrowing which was increased in severity versus the prior study. There was a decrease in disk height at C5/6 with hypertrophic spur and disc protrusion, which was minimally decreased from the prior study, particularly in the central spinal canal resulting in minimal thecal sac and neuroforaminal narrowing and being present. (Px12).

On 4/23/15, the Petitioner saw Dr. Poulos, apparently on referral from Dr. Truong. She reported constant posterior neck pain that was sharp, aching and burning which radiated to the top of both shoulders and down her spine to the bilateral hips and buttocks. The neck pain radiating to the bilateral arms circumferentially to all fingertips. Arm pain was constant, sharp, stabbing and burning. The Petitioner reported numbness and tingling all over her body that was worsening. The doctor noted the Petitioner said she was currently taking an online psychology course in neurosurgical referral. The Petitioner also for the first time indicated she felt a pop in her neck at the time of the November 2012 accident. The Petitioner reported that chiropractic care provided short-term help; injections, which helped temporarily; physical therapy, which had also provided short-term relief; prescription medication, which helps temporarily; over-the-counter medication, which helps minimally; and had exhausted every form of conservative treatment. The Petitioner was taking 12 different medications for a variety of problems. Examination showed limited cervical range of range of motion limited with cervical pain provocation in all directions and tenderness to palpation in Petitioner's right shoulder with limited abduction. Dr. Poulos reviewed the results of the 2/26/15 MRI, indicating it showed diffuse degenerative disc disease at most levels of the cervical spine, severe at C5-6 with bilateral mild foraminal stenosis, and mild left foraminal stenosis at C3/4. His assessment was 1) muscle spasms of the neck; 2) degenerative disc disease; 3) foraminal stenosis of cervical region. However, he also stated that he suspected her primary cervical pain complaints were muscular. Dr. Poulos recommended pain management referral for C3/4 epidural injection, however it does not appear that this occurred. (Px13).

On 8/21/15, the Petitioner saw Dr. Raskas at her attorney's recommendation. He took a history of both incidents and noted that the first injury resulted in symptoms to her low back with left low back pain into her buttock and thigh since that time. The second incident in 2012 resulted in symptoms to her neck, and her current complaints were right-sided neck pain with radiating right arm pain to the hand with weakness. Examination showed pain

with right-sided shoulder range of motion, positive weakness in the right biceps and triceps versus the left, and limited right shoulder range of motion with Petitioner's right arm. Dr. Raskas indicated x-rays showed degenerative changes, and the February 2015 MRI showed a herniated disc at C5-6 compressing the spinal cord, though he noted that the images were of less than ideal quality. Noting her low back and left leg complaints as well as the cervical problems, Dr. Raskas opined that Petitioner had symptoms consistent with cervical myelopathy, and that this was directly related to the work accident. He prescribed repeat cervical and lumbar MRIs on a higher-quality machine. Those films were obtained on 9/8/15 (Px15), and showed degenerative disc disease with broad-based disc herniations at C5-6 and C6-7 with accompanying osteophytes, particularly at C5-6, with bilateral foraminal stenosis where either the C6 or C7 nerve roots could be affected. The lumbar films showed central disc herniations throughout Petitioner's lumbar spine with diffuse foraminal stenosis. (Px15).

Petitioner followed up with Dr. Raskas after the MRI, and he opined that the films showed broad-based disc herniations at C5-6 and C6-7 resulting in foraminal stenosis at C6 and C7 bilaterally, accounting for Petitioner's radiating arm pain. Noting all conservative measures had failed, Dr. Raskas recommended an interior decompression and fusion at C5-6 and C6-7. For Petitioner's lumbar spine he recommended lumbar epidurals and facet blocks at L3-4. (Px14).

Dr. Heffner's deposition was taken on 7/31/14. (Px16; Rx9). He testified that after he saw the initial cervical MRI films, he believed the Petitioner had cervical spondylosis, degenerative disc disease and disc protrusion with neck and arm pain. The most significant abnormality was at C5/6, but it was left-sided. As this did not match her right-sided complaints, he obtained the April, 2013 CT myelogram. He testified that this study looked better than the MRI, as the C5/6 protrusion was improved, and there was no significant nerve compromise. It was his opinion that there were no surgical indications. Additionally, he testified that the Petitioner's pain was more nonspecific at that point, with complaints of pain in the neck, upper back, lower back, with strange sensations in her shoulders. He didn't feel there was any correlation of these symptoms to any area of the spine. His impression was neck and back pain, and he recommended she see a physical medicine specialist. He did opine that it was reasonable to conclude that the Petitioner sustained an aggravation of her underlying degenerative condition, as she did not report symptoms prior to the injury. On cross examination, Dr. Heffner testified that the Petitioner's subjective complaints of neck pain into the right arm did not correlate with his findings on the films and his physical exam. With regard to any activity restrictions, he testified he would defer that to the physiatrist or physical medicine specialist. On redirect, he indicated that "potentially" the neck area symptoms could be due to an aggravation of the degenerative cervical condition. (Px16; Rx9).

Dr. Raskas' testimony was obtained via deposition on 2/24/16. (Px17). Dr. Raskas testified consistent with his report regarding records reviewed. He testified that he ordered the new MRI with a larger magnet because the previous tests were not of great quality. This allowed for foraminal views where the images are more oblique, so they track the nerve roots as they come out of the spine. His review of the new MRI films indicated the Petitioner had some degenerative disease at C5-6 and C6-7 with broad-based disc herniations at these levels and accompanying osteophytes producing mild central spinal canal stenosis, particularly at the C5-6 level, and there was foraminal stenosis at both levels where the C6 and C7 roots could be affected. His diagnosis was cervical radiculopathy, which he believed was caused by the 2012 accident. He believed that Petitioner had lumbar symptoms which were more axial in nature related to the 2010 incident, but the cervical problem was more severe and concerning. When asked what was causing Petitioner's condition, Dr. Raskas indicated the cause was multifactorial, with preexisting asymptomatic degenerative findings in her neck, and an injury to her neck resulting in radicular symptoms superimposed on the preexisting asymptomatic changes. He disagreed with Dr. Petkovich's diagnosis of a strain, as her symptoms would have resolved within a few months if that were the case. On cross-examination, Dr. Raskas advised that he reviewed Dr. Heffner's deposition, and that there was no inconsistency in Petitioner's symptoms when compared with the findings on the MRI, stating that a ventral

disc osteophyte complex can result in symptoms on the left or the right. He also argued that Dr. Heffner did not have the opportunity to see the most recent films which included oblique images that evaluate the foramen more thoroughly. (Px17).

Dr. Petkovich testified on 2/1/16. (Rx8). An orthopedic surgeon, he testified that he no longer performs surgeries, but rather sees patients with complex problems, including some who previously had surgery but aren't happy with their results. Dr. Petkovich believed the Petitioner suffered a cervical strain in the January 2012 accident, that her examination was normal, that she could work full duty, and that she did not need any further medical care or treatment. He agreed that he had not had the opportunity to compare any of the films recently received with any of the films taken in February of 2015. (Rx8).

The Petitioner testified that her neck pain has continued unabated since 2012. She indicated she has burning and "feels like I have rocks in my neck". She testified that she had resigned her employment as of 8/31/12 because she felt she was unable to perform her job. At the time of hearing, she was a full time student at Vatterott College, studying medical assisting, which would allow her to work a more sedentary job in a hospital or doctor's office. She testified such jobs would fit within the activity restrictions issued by Dr. Raskas. The Petitioner has not performed any physical labor jobs since her resignation, and she has had no new accidents or neck injuries since 1/17/12. The Petitioner indicated she has some prior college education in general studies. She testified that she would like to have the neck surgery that Dr. Raskas has recommended.

On cross examination, the Petitioner agreed that she was referred to Dr. Heffner by her family doctor, Dr. Winkler, and that Dr. Heffner indicated there was nothing he could do for her neck. She also agreed she saw Dr. Poulos on 4/23/15, also on referral from her family doctor. Dr. Poulos also evaluated her neck and indicated there was nothing he could do for her. While the Petitioner testified that she followed up with Dr. Poulos, as his 4/23/15 note requested, the records of Dr. Poulos submitted into evidence do not reflect any additional visits. The Petitioner acknowledged seeing Dr. Kahn for a EMG/NCV testing in July, 2012, and that she was told the testing was normal.

The parties noted that, based on the Petitioner's alleged injuries being due to attacks by patients, per contract, Petitioner received full wages through the time she resigned. The parties also acknowledged that some of the Petitioner's medical records reflect the last name Hartlett, which was her maiden name.

CONCLUSIONS OF LAW

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

The Arbitrator finds that the Petitioner's cervical condition remains causally related to the 1/17/12 work accident, but that the Petitioner reached maximum medical improvement as of her 12/31/13 examination to Dr. Petkovich. The Arbitrator also finds that the Petitioner sustained a musculoskeletal injury of some sort at that time and may have aggravated a preexisting cervical condition. However, her complaints of radicular symptoms resulting from the accident and injury are not supported by the facts of the case.

Initially, the records reflect discrepancies as to whether the Petitioner originally injured her neck on 8/22/10 or 1/17/12. The initial cervical MRI of 3/31/12 reflected no evidence of significant foraminal or central canal stenosis. Epidural injections provided only temporary relief of up to one week. Dr. Meyer on 5/22/12 ordered EMG/NCV testing, noting a normal neurological exam other than subjective decreased sensation in the right 3rd,

4th and 5th fingers. The EMG/NCV testing showed no abnormalities. The Petitioner was supposed to follow up with Dr. Meyer, but did not do so. She complained to Dr. Winkeler that Meyer's office would not call her back and she was not happy with them, so she requested a referral to Dr. Heffner.

Dr. Heffner also noted a normal neurological exam, and prescribed a CT myelogram on 11/19/12. This was after he questioned the Petitioner's right-sided complaints since his review of the prior cervical MRI reflected only a left sided disc protrusion at C5/6. He indicated the CT myelogram not only did not show a right sided problem at C5/6, but also that the disc protrusion at that level had improved versus the 3/31/12 cervical MRI. At the next visit of 4/22/13, after the CT myelogram had been performed, Dr. Heffner noted both that the Petitioner's symptomatic complaints were much more widespread and diffuse than at their first visit, and that based on this and the CT myelogram findings, the Petitioner was not a surgical candidate. He believed she had diffuse muscular pain, and recommended a pain physician.

The Petitioner then underwent a Section 12 examination with Dr. Petkovich, who opined that the Petitioner had suffered a cervical strain with a mild degenerative disc condition at C5/6, but that her subjective complaints were out of proportion to her objective findings.

Subsequent to this, the Petitioner underwent an additional four plus months of chiropractic care with Dr. Renner with no evidence of any real improvement. Dr. Poulos, on 4/23/15, noted possible diagnosis of cervical foraminal stenosis, but also diagnosed muscle spasms and degenerative disc disease, and opined that her primary cervical complaints were likely muscular in nature.

Dr. Raskas opined that the Petitioner had cervical radiculopathy and obtained new MRI films, which he indicated were of better quality than prior films. However, the Arbitrator notes that both a cervical MRI and a CT myelogram had previously been obtained with no evidence whatsoever of a herniated disc, and this despite the films being reviewed by multiple physicians and surgeons.

The Arbitrator simply believes that the greater weight of the evidence in this case supports the finding that the Petitioner suffered a cervical strain at the time of the 1/17/12 accident, and may have temporarily exacerbated a preexisting mild degenerative cervical disc condition. The length of time she went with no improvement despite multiple modalities, and the medical opinions indicating her cervical problems were likely muscular, carry more weight in the Arbitrator's view. By the time she saw Dr. Petkovich, the Petitioner had been treating for almost two years. The Arbitrator feels that this was a more than reasonable period of time for the Petitioner to have sustained some stable improvement and recovery, and therefore that 12/31/13 was when she reached maximum medical improvement. She does have subjective ongoing complaints which the Arbitrator believes remain causally related to the accident, but the Arbitrator also believes that these complaints are muscular or musculoskeletal in nature, not neurological, and not involving a need for surgery or any other further treatment.

With regard to the lumbar spine, the Arbitrator finds that any lumbar condition is not causally related to the 1/17/12 accident. While there was an initial indication by Dr. Winkeler of low back symptoms after the accident, such complaints were very short lived, the Arbitrator noted no significant lumbar complaints after 3/22/12. Additionally, the history she gave to Dr. Raskas was that the low back problems began with the 8/22/10 accident.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner is entitled to the causally related medical expenses contained in Petitioner's Exhibit 1 which were incurred by the Petitioner prior to 1/1/14, and Respondent shall be liable for same pursuant to Sections 8(a) and 8.2, which includes the medical fee schedule. The Respondent is entitled to credit for any of these bills that were paid prior to the hearing date. The Petitioner reached MMI as of 12/31/13, and any treatment subsequent to that date was not reasonable or necessary within the meaning of Section 8(a).

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the findings of the Arbitrator with regard to causation and medical expenses, above, the Arbitrator finds that the Petitioner has failed to prove that the cervical surgery recommended by Dr. Raskas is reasonable and necessary in this case. As such, the Arbitrator awards no prospective medical treatment.

WITH RESPECT TO ISSUE (O), EXTENDED CHOICE OF PHYSICIAN / TWO DOCTOR RULE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings with regard to the date she reached maximum medical improvement, or MMI, this issue is moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF MCHENRY)

☐ 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

Harold Dean Brodin,

Petitioner,

17IWCC0794

vs. NO: 15 WC 35743

Centegra Health System,

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 on review and being advised of the facts and law, reverses the Decision of the Arbitrator and finds that Petitioner failed to prove he sustained a right shoulder injury on July 21, 2015. The Commission affirms the Decision of the Arbitrator with respect to Petitioner's undisputed back injury, and the Decision of the Arbitrator 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 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 July 21, 2015 Petitioner was performing his regular job duties as a maintenance worker for Respondent. As he was descending and cleaning the stairwell, he missed the last step and lost his balance. He did not fall, but he felt immediate pain in the middle and lower back. He testified that he reached for the hand rail with his right arm to straighten himself and felt a little bit of pain in his right shoulder.

Petitioner immediately reported the accident to his supervisor: "We sat down and did the accident report together, and I had told him what had happened with my back. And so we were filling that out, and I told him that my right shoulder also had some pain on it. But my main concern was the middle of my back and my lower part of my back, because that's what hurt the most." (T. 9) On its face, however, the

accident report is silent with respect to any right arm involvement in the accident or any right shoulder complaints, and the testimony of Petitioner's supervisor was not offered to corroborate Petitioner's claim that he discussed his right shoulder with his supervisor. The report states that Petitioner missed a step on the stairs and injured his lower and middle back. (RX1)

Petitioner was seen in the emergency room at Centegra Hospital on the date of accident. Petitioner agreed that he only reported a back injury. The ER records are silent with respect to any right arm involvement in the accident or right shoulder complaints. The record states: "He nearly fell (slipped walking down step). Occurred at work. No other injury." Petitioner denied any other symptoms and his physical exam was negative aside from back pain. The records show that Petitioner refused pain medication and was not in acute distress. He was diagnosed with a lumbar strain and advised to follow-up with Centegra Occupational Health.

On July 23, 2015, Petitioner presented to Centegra Occupational Health and reported having "slipped while coming downstairs when he missed a step, didn't fall but twisted mid & lower back." There is no mention of any right shoulder injury or complaints. Petitioner returned to Centegra Occupational Health on July 30, 2015 and August 5, 2015 for follow up visits and again there is no mention of the right shoulder in the records.

Petitioner was referred to physical therapy at Centegra for his back injury and was evaluated on August 10, 2015. Petitioner reported that on July 21, 2015 he was going down the stairs backward when he missed a step and reached for the railing to catch himself. He complained of constant low back pain and right shoulder soreness. On August 13, 2015, Petitioner told the physical therapist that his right shoulder pain ranged from 0 to 8/10. With respect to this new complaint, Petitioner stated "I didn't push it because my back was my primary concern." The physical therapist recommended Petitioner have his right shoulder evaluated by a physician.

It was not until August 26, 2015 that Petitioner gave a history of injuring his right shoulder to the physician at Centegra Occupational Health. He reported that his back pain improved but that he was having pain in the right shoulder. The doctor noted Petitioner's history of accident: "when the injury happened, he put his right arm forwards to prevent him from falling. Didn't have pain initially but recently noted pain to right shoulder increases with certain movements." Petitioner's physical therapy order was modified to include therapy for his right shoulder. Petitioner was subsequently examined by Dr. Gent on October 6, 2015. He reported injuring his right shoulder on July 21, 2015 when he slipped going down the stairs. He stated that he grabbed the railing with his right hand and twisted his back. He reported that his right shoulder pain increased since the accident and at the most painful it could be 10/10.

After considering all the evidence, we find that Petitioner failed to prove that he sustained a work-related injury to his right shoulder on July 21, 2015 and we reverse the Arbitrator's findings and award of benefits with respect to the right shoulder. For weeks after the accident, Petitioner failed to mention to his medical providers that he sustained a right shoulder injury or had any right shoulder complaints. There is no reasonable explanation why he would not identify the right shoulder on the

17IWCC0794

accident report or make complaints at the emergency room and follow-up visits. We are not persuaded that Petitioner's focus on his back injury caused him to fail to mention his right shoulder complaints. Dr. Gent relied solely on the history Petitioner provided to him that Petitioner immediately had right shoulder pain, and therefore we do not find his opinion on causal connection to be persuasive. Dr. Atluri had the opportunity to review more of the contemporaneous medical records and therefore had a more complete basis of fact on which to draw his conclusions and render his opinion on causal connection. We find that that the evidence supports Dr. Atluri's opinion that Petitioner's right shoulder condition is degenerative and not work-related by cause or aggravation. We reverse the Arbitrator's award of disputed temporary total disability benefits and award of medical expenses and prospective medical care with respect to the right shoulder.

We affirm the Arbitrator's findings and award with respect to the Petitioner's work-related back injury.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay any outstanding medical bills for treatment related to Petitioner's work-related back injury as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $8,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED:
DLS/plv
o-11/9/17
46

DEC 12 2017

Deborah L. Simpson

Deborah L. Simpson

David L. Gore

David L. Gore

Stephen J. Mathis

Stephen J. Mathis

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

17IWCC0794

BRODIN, HAROLD DEAN
Employee/Petitioner

Case# **15WC035743**

CENTEGRA HEALTH SYSTEM
Employer/Respondent

On 3/8/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1358 TARADASH LAW OFFICE
DANIEL E JOHNSON
908 S ROUTE 31
McHENRY, IL 60050

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT E MACIOROWSKI
105 W ADAMS ST SUITE 2200
CHICAGO, IL 60603

17IWCC0794

STATE OF ILLINOIS)
)SS.
COUNTY OF MCHENRY)

- [ ] 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)

Harold Dean Brodin
Employee/Petitioner

Case # **15** WC **35743**

v.

Centegra Health Systems
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 **Woodstock**, on **January 5, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **July 21, 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 **$38,700.48**; the average weekly wage was **$744.24**.

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

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

Respondent shall be given a credit of **$8,930.78** for TTD, **$0** for TPD, **$0** for maintenance, and **$20,505.47** for other benefits, for a total credit of **$29,436.25**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$491.20**/ week for **60 1/7** weeks, commencing **November 11, 2015** through **January 5, 2017**, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $8,930.78 for temporary total disability benefits that have been paid and $20,505.47 in long term disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services outlined in Petitioner's Exhibits 7 -15, as provided in Sections 8(a) and 8.2 of the Act. Respondent is entitled to a credit for all medical expenses it has paid.

Respondent shall authorize and pay for reasonable and necessary prospective medical treatment for Petitioner's right shoulder injury and undisputed back injury 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.

Arbitrator Anthony C. Erbacci

March 4, 2017
Date

MAR 8 - 2017

FACTS:

On July 21, 2015 the Petitioner sustained undisputed accidental injuries arising out of and in the course of his employment with the Respondent as a project worker. At the time of the injury, the Petitioner was 59 years old and he had worked for the Respondent as a project worker for 11 years. The Petitioner testified that his job duties required him to clean floors, walls, and stairs and perform routine maintenance at Centegra Hospital. The Petitioner also testified that he has been a Type II Diabetic for seventeen years and has been on medication to control his diabetic condition. He testified that he has never suffered with any diabetic neuropathic pain and that his diabetic condition never prevented him from performing his usual and customary job duties.

The Petitioner testified that on July 21, 2015 he was cleaning a stairwell when he stepped back and missed a step, causing him to fall backwards and twist at his waist. The Petitioner testified that as he fell and twisted, he experienced pain in his back and he reached out and grabbed the railing with his right arm, preventing himself from falling. The Petitioner testified that he then felt back pain and slight pain in his right shoulder.

The Petitioner testified that he immediately reported the accident to his supervisor and completed an accident report. The Petitioner testified he reported back pain and minor shoulder pain. The Accident Report was admitted into evidence as Respondent's Exhibit No. 1. The description of accident in the report is; "stepped down and missed a stair, injuring lower and middle of back." There is no mention of grabbing the rail and no mention of any shoulder injury or pain contained in the report. The pain drawing completed by the Petitioner indicated pain in his back but there was no indication of pain in the right shoulder.

The Petitioner was sent to the Emergency Department Room at Northern Illinois Medical Center where he was noted to report severe upper and lower lumbar back pain. X-rays were ordered and the Petitioner was referred to Occupational Health for further evaluation.

On July 23, 2015, Petitioner reported to Centegra Occupational Health with complaints of middle and lower back pain. The Petitioner was diagnosed with an acute lumbar sprain and placed on a five pound weight restriction. The Petitioner testified that he gave the written work restrictions to his supervisor and that the Respondent did not offer him any work within those restrictions.

On July 30, 2015, the Petitioner returned to Occupational Health with ongoing complaints of lumbar back pain. The Petitioner reported that his back pain was improving but he could not stand or sit for extended periods of time without pain. The Petitioner's work restrictions remained unchanged. The Petitioner returned to Occupational Health on August 5, 2015 and reported that his lumbar condition was unchanged, and he was referred for physical therapy.

The Petitioner reported to physical therapy on August 10, 2015, twenty days after his accident. In his initial physical therapy evaluation, the Petitioner gave a relatively consistent history of injury and reported constant low back pain and mid back pain with extension. The Petitioner also reported right shoulder soreness. When the Petitioner returned to physical therapy on August 13, 2015, he reported progressively worsening right shoulder pain ranging from 0-8/10. It was noted that the Petitioner reported that he had right shoulder pain after the injury but he didn't report the shoulder pain because

of his back issues. A right shoulder assessment was recommended for the Petitioner at that time. The Petitioner continued to complain of right shoulder pain throughout the course of his physical therapy.

On August 26, 2015, Petitioner reported to Occupational Health with complaints of lumbar back pain and right shoulder pain. It was noted that the Petitioner reported that when the injury happened, "he put his right arm forward to prevent him from falling." The Petitioner also reported that he "didn't have pain initially but recently noted pain to the right shoulder increases with motions". The Petitioner was diagnosed with a right shoulder sprain and was prescribed a right shoulder x-ray and physical therapy. The Petitioner remained on work restrictions. The x-rays were reported to reveal "no acute disease".

The Petitioner returned to Occupational Health on September 9, 2015 with ongoing lumbar back and right shoulder pain. He was instructed to continue with physical therapy and return in one month. The Petitioner was given a twenty pound lifting restriction.

On September 30, 2015, the Petitioner presented to Occupational Health and reported that his lumbar pain was improving but his right shoulder pain was not. The diagnosis and work restrictions remained unchanged. The Petitioner was prescribed additional physical therapy for his lumbar spine but was instructed to discontinue physical therapy for the right shoulder. The Petitioner was referred for an orthopedic evaluation of his right shoulder.

On October 6, 2015 the Petitioner was seen by Dr. Justin Gent. The Petitioner reported a history of injury to his right shoulder on July 21, 2015 and reported that his right shoulder pain had been getting worse "since it started". Dr. Gent's assessment was right shoulder pain after an injury that occurred at work on July 21, 2015 and a possible right rotator cuff injury. Dr. Gent performed a steroid injection and prescribed an MRI of the right shoulder.

The Petitioner returned to Dr. Gent on October 13, 2015. Dr. Gent noted that the MRI demonstrated a near full thickness articular surface tear of the supraspinatus tendon, diffuse rotator cuff tendinosis, a type II acromion, and acromioclavicular joint degenerative changes. Dr. Gent recommended the Petitioner undergo a right shoulder arthroscopy with rotator cuff repair.

On November 5, 2015, the Petitioner presented to Dr. Babak Lami for complaints of back pain since a work injury on July 21, 2015. Dr. Lami noted that the Petitioner was treating for his right shoulder with Dr. Gent who recommended surgery. Dr. Lami noted that an MRI of the Petitioner's lumbar spine showed multiple degenerative changes, which were normal for the Petitioner's age, and indicated that the Petitioner was not a candidate for surgery or injections. Dr. Lami indicated that that the Petitioner would benefit from physical therapy after completion of his right shoulder surgery and follow up treatment.

On March 10, 2016, the Petitioner presented to Dr. James Berg with back and right shoulder pain. Dr. Berg noted the Petitioner's treatment with Dr. Lami for his back and Dr. Gent for his shoulder as well as the treatment recommendations of those doctors. Dr. Berg indicated that the Petitioner had pre-existing spinal stenosis and foraminal stenosis which was aggravated and he recommended an epidural steroid injection at L5-S1. Dr. Berg also indicated that the Petitioner's shoulder pathology was preexistent and was aggravated by the twisting injury of July 21, 2015. Dr. Berg agreed with Dr. Gent's recommendation for the Petitioner's shoulder.

On December 22, 2015, the Petitioner was examined by Dr. Prasant Alturi at the request of the Respondent. Dr. Alturi opined in his report that the Petitioner's right shoulder condition could not be causally related to the July 21, 2015 injury because the Petitioner denied a right shoulder injury for weeks after the accident and did not immediately report pain in his right shoulder. Dr. Alturi opined that the Petitioner was suffering from a degenerative frozen shoulder or adhesive capsulitis condition related to his diabetic condition. In addition, Dr. Alturi opined that since the Petitioner did not immediately report pain in his right shoulder, the rotator cuff tear could not have been acute nor in any way aggravated by the July 21, 2015 accident.

Dr. Alturi's deposition was taken on July 18, 2016 and July 27, 2016. Dr. Alturi testified that he agreed with Dr. Gent that the mechanism of injury described by the Petitioner was plausible for contributing to a right shoulder injury and that it is possible to have progressively worsening of symptoms following that type of aggravation. Dr. Altrui further opined that if the Petitioner didn't tolerate therapy, even after a steroid injection, then surgery would be appropriate. Dr. Alturi acknowledged that he was not an endocrinologist, that he did not know how long the Petitioner was a diabetic, and that he was not aware of whether the Petitioner's diabetic condition was controlled or not. Dr. Alturi testified that he placed the Petitioner on a ten pound weight restriction and opined that if the Respondent did not have a light duty position available for the Petitioner, he would be completely off work.

The deposition of Dr. Justin Gent, the Petitioner's treating surgeon, was taken on June 13, 2016. Dr. Gent opined that the Petitioner suffered a work-related right shoulder injury on July 21, 2015 which rendered a previously asymptomatic degenerative condition symptomatic, and that the shoulder surgery prescribed for the Petitioner was reasonable and necessary. Dr. Gent noted that the Petitioner underwent unsuccessful conservative treatment and therefore, arthroscopic surgery was reasonable and necessary and causally related to Petitioner's July 21, 2015 work accident. Dr. Gent opined that surgery would offer the Petitioner the best opportunity to return back to his pre-injury employment.

CONCLUSIONS:

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

The Petitioner was employed by the Respondent as a project worker for 11 years prior to his undisputed work injury on July 21, 2015 and there was no evidence presented which indicated that the Petitioner had any difficulty performing the duties and activities of his job. The Petitioner testified that he never sought medical treatment for right shoulder pain prior to July 21, 2015, that following the July 21, 2015 accident he was unable to perform his usual and customary job duties, and that he has been on work restrictions since the accident. Additionally, the Petitioner testified he did not have any other injury to his right shoulder after July 21, 2015 The Petitioner's testimony in that regard was not contradicted or rebutted.

While Dr. Atluri, the Respondent's examining physician, opined that the Petitioner's shoulder condition was not causally related to the July 21, 2015 work and was a degenerative condition related to his diabetic condition, Dr. Alturi acknowledged that the mechanism of injury described by the

Petitioner was a plausible cause for aggravating a chronic rotator cuff tear and that it is possible to have progressively worsening symptoms following that type of aggravation. Dr. Alturi also acknowledged that he was unaware of the status of the Petitioner's current Diabetic condition.

Dr. Gent, the Petitioner's treating surgeon opined that the Petitioner suffered a work-related right shoulder injury on July 21, 2015 which rendered a previously asymptomatic degenerative condition symptomatic. Dr. Gent opined that the Petitioner's right shoulder condition was causally related to the accident, and that the shoulder surgery prescribed for the Petitioner was reasonable, necessary, and causally related to that accident.

While the Arbitrator notes the opinions of Dr. Atluri, the Arbitrator finds the opinions of Dr. Gent, the Petitioner's treating surgeon, to be reliable and credible and more persuasive than the opinions of Dr. Atluri. The Arbitrator finds it significant that although the Petitioner had a preexisting degenerative right shoulder condition, he was able to perform his usual and customary job duties prior to the July 21, 2015 accident without apparent difficulty or right shoulder pain. No evidence or testimony was offered which indicated that the Petitioner's right shoulder was symptomatic prior to the undisputed work injury of July 21, 2015.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that Petitioner's current condition of ill-being, including his current right shoulder condition and need for surgery, is causally related to his work accident on July 21, 2015.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, and (K.), Is Petitioner entitled to any prospective medical care, the Arbitrator finds and concludes as follows:

Based upon the Arbitrator's findings and conclusions relating to the issue of causal connection, and the acknowledgement of the reasonableness and necessity of the Petitioner's treatment made by the Petitioner's treating doctor and the Respondent's examining doctor, Dr. Alturi, the Arbitrator awards the medical expenses contained in Petitioner's exhibit #7 – 15. In addition, the Arbitrator awards the Petitioner prospective medical care for his lumbar back as proposed by Dr. Lami and the right shoulder surgery and follow up treatment proposed by Dr. Gent.

Respondent shall have credit for any amounts it paid by or through its group carrier. However, it shall indemnify and hold Petitioner harmless from any claims made by any healthcare provider for which it is receiving this credit, pursuant to Section 8(j) of the Act.

In Support of the Arbitrator's Decision relating to (L.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

There is no dispute that the Petitioner has been on work restrictions since July 21, 2015. The Respondent did not offer the Petitioner a light duty position and eventually terminated the Petitioner's employment. The Petitioner has not yet reached maximum medical improvement and is entitled to temporary disability benefits from November 11, 2015 through the date of hearing.

STATE OF ILLINOIS)
) SS
COUNTY OF JEFFERSON)

BEFORE THE ILLINOIS WORKERS'COMPENSATION COMMISSION

Frank Rice,

Petitioner,

17IWCC0795

vs. No. 15 WC 34321

State of Illinois, Vienna Correctional Center,

Respondent.

DECISION AND OPINION PURSUANT TO SECTIONS 19(H) AND 8(A)

This claim comes before the Commission on a Petition for Review under Sections 19(h) and 8(a), filed by Petitioner on September 7, 2016. No question has been raised concerning the timeliness of Petitioner's Section 19(h) Petition. Commissioner Simpson conducted a hearing in this matter on July 17, 2017. Both parties were present at the hearing and a record was made.

After considering the issues and being advised of the facts and law, the Commission denies Petitioner's Petition for Review under Section 19(h), finding that Petitioner failed to prove a material increase in his work-related disability since the date of Arbitration. Respondent did not dispute Petitioner's entitlement to further treatment and payment of medical bills under Section 8(a), only the Petitioner's request for increased permanency.

FINDINGS OF FACT

On September 23, 2015, Petitioner was performing his job duties as a Correctional Food Service Specialist when he slipped and fell near the freezer at Vienna Correctional Center. Petitioner timely filed an Application for Adjustment of Claim for work-related injuries to his left knee. Petitioner underwent left knee surgery by Dr. Paletta on November 11, 2015 and returned to his pre-injury employment.

On March 9, 2016, there was an arbitration hearing on Petitioner's claim. The only issues in dispute were temporary total disability and the nature and extent of the injury. The Arbitrator issued a Decision on July 18, 2016, finding Petitioner was entitled to compensation for the loss of 17.5% of the left leg. There was no impairment rating in evidence; the Arbitrator considered the remaining four Section 8.1b factors and gave the most weight to the reports of Dr. Paletta and Petitioner's testimony. The Arbitrator found, "Petitioner testified that surgery improved his condition, but that he still had some soreness and stiffness in the knee and difficulty with stairs. He stated he has not cut his hours at work and he still works overtime, but these double shifts reduce the effectiveness of the Ibuprofen."

17IWCC0795

On September 7, 2016 Petitioner filed a Petition for Review under Sections 19(h) and 8(a) and a hearing was held on July 11, 2017. Petitioner offered records of treatment received since arbitration. The records show that on April 13, 2016, Petitioner returned to Dr. Paletta and complained of residual patellofemoral pain. Dr. Paletta recommended a series of left knee intraarticular injections. He noted that these injections were offered to Petitioner previously on February 10, 2016. In September and October of 2016, Petitioner underwent a series of three left knee intraarticular injections at the Orthopedic Ambulatory Surgery Center of Chesterfield. On November 28, 2016, Petitioner reported that he injections did not provide significant relief. Dr. Paletta noted that Petitioner continued to work, and that "things are no worse." Dr. Paletta stated that Petitioner was still at maximum medical improvement. He noted, "It is likely he will have waxing and waning of symptoms with some good days and some bad days."

Petitioner testified that he is "still experiencing left knee pain and popping and weakness, unsteadiness in my knee." He was asked to describe how his knee is worse since arbitration: "I still have popping and unsteadiness, pain. If I'm on it for a very long time, a long period, it hurts." Petitioner testified that he has increased his over-the-counter Ibuprofen dosage since arbitration. Petitioner testified that he is "not able to do hardly anything that requires me to be up on my leg or knee for any long period of time." He continued, "Hunting, it hurts to be outside mowing and cleaning my yard. Pretty much anything."

On cross-examination, Petitioner agreed that he has continued to work full duty and he testified that he works overtime "whenever I can get it." He testified that he likes to hunt deer, ducks, and geese and that he rides his motorcycle at least once per week.

CONCLUSIONS OF LAW

After consideration of the evidence, the Commission grants the Petition under Section 8(a) and denies the Petition under Section 19(h). We find that Petitioner failed to prove a material increase in his work-related physical disability. Although Petitioner returned to Dr. Paletta with persistent complaints, Dr. Paletta specifically noted that Petitioner's medical condition was no worse. We find that Petitioner continues to experience pain and discomfort due to his work-related condition, but there is no objective evidence demonstrating worsening or advancement. We find that that Petitioner's disability has not materially changed since the arbitration award and there is no basis for increasing permanent partial disability.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition under Section 8(a) is hereby granted and that Respondent shall pay the expenses associated with Petitioner's work-related left knee condition, pursuant to Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Petition under Section 19(h) is denied.

DATED: DEC 12 2017
DLS/plv
o-11/2/17
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Deborah L. Simpson

Deborah L. Simpson

David L. Gore

David L. Gore

Stephen J. Mathis

STATE OF ILLINOIS)
) SS.
COUNTY OF)
CHAMPAIGN

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAEL SHEA,

Petitioner,

17IWCC0796

vs.

NO: 11 WC 20607

R.P.R.D DYCKMAN, INC.,

Respondent.

DECISION AND OPINION ON REMAND

This cause now comes to the Commission on remand by the Appellate Court, Fourth District Workers' Compensation Division. As background, Petitioner claimed a mental-mental work-accident/injury (PTSD) after he witnessed a fatal motor vehicle accident while working as an interstate truck driver. The Arbitrator found that Petitioner did not prove accident/causation and denied compensation. The Commission affirmed and adopted the decision of the Arbitrator. The Circuit Court of Coles County reversed the Commission and remanded the matter to the Commission to enter an order finding accident and causation and to award benefits. On remand, the Commission found accident and causation and awarded Petitioner 34&5/8 weeks of temporary total disability and 10 weeks of permanent partial disability representing loss of 5% of the person-as-a-whole.

In the current remand order, the Appellate Court found that the Circuit Court was correct in reversing the Decision of the Commission because it affirmed and adopted the Decision of the Arbitrator, who applied the incorrect legal standard. However, it also found that the Circuit Court erred in making its own factual findings rather than leaving that up to the Commission. The basis of the Appellate Court's ruling is that the Arbitrator used the incorrect legal standard because there was no indication he, and therefore we, applied the standards set out in the Appellate Court decision in *Chicago Transit Authority v. Workers' Compensation Commission*, 989 N.E.2d 608 (1st Dist. WC division 2013) rather than relying only on the previous cases of *Pathfinder v. Industrial Comm.* 62 Ill. 2d 556 (1976) and *General Motors Parts Division v. Industrial Commission,* 168 Ill. App. 3d 678 (1988).

The Appellate Court explained that *General Motors* held that the claimant had to prove "'immediate[ly] apparent psychic injury'" to establish compensability. "However, as clarified in *Chicago Transit Authority*, *** it is the emotional shock [that] must be sudden and not all resulting psychological injury. The Arbitrator's decision was, therefore, contrary to law. Further, when the Commission affirmed and adopted the arbitrator's decision without additional comment, the arbitrator's decision became that of the Commission, including the legally erroneous portion of that decision."

Findings of Facts & Conclusions of Law

1. Petitioner testified he has been married for 26 years, had three years of college education, and was previously in the active military for 21 years, primarily in aviation maintenance. On October 2, 2010, he was employed by Respondent. He was driving a semi with two trailers attached, commonly referred to as a piggyback, northbound on I-57 at about 12:30 to 12:45 A.M. The weather was clear.

2. Petitioner noticed another semi pulled over on the right side of the road at around mile marker 187. He moved into the left lane as a matter of courtesy and safety. He noticed a "lot of smoke and dust or something" in front of him. There was a stopped vehicle ahead of him "in near proximity." Petitioner began breaking immediately and swerved into the grassy median. The front of his bumper "made contact with the very left rear bumper of the car." When his truck came to a rest, the back trailer tipped over.

3. Petitioner got out of his truck and heard a woman screaming in horror. He realized "this was not good." He saw a body of a man lying on the pavement with part of his skull missing; "he was obviously dead." Petitioner testified the experience was horrible and he had never experienced something like that before. He was "in shock" and "sick." He returned to his truck and called 911. State troopers "did extensive interviews through the night." Petitioner did not get a ticket and was taken to a hospital where he was examined. He learned that another vehicle had collided with the car previously.

4. Petitioner also testified that when he was in the military he witnessed an aircraft accident which resulted in a loss of life, but he had not seen the actual dead person. Mr. Dyckman arrived a couple of hours after the accident. He eventually drove Petitioner back to St. Louis where he retrieved his car. Respondent gave Petitioner another assignment about six days later. Petitioner testified the "shock and horror still hadn't worn off" but he "really felt" that he "had to stay with it." On that assignment, he drove back and forth from St. Louis to Kansas City. Petitioner was constantly worrying and "second guessing every decision" during the trip; "it was hard, it was hell." However, he felt he had to work.

5. Petitioner was "removed from driving" immediately after he completed that route. Mr. Dyckman informed him that he was "indefinitely permanent disqualified" from driving for Respondent. He did not provide Petitioner with a reason. Petitioner wanted to continue driving trucks, but he did not think he could.

6. The biggest thing Petitioner remembered after his trip to Kansas City was the inability to sleep. It was nothing for him "to stay up all night and go to bed, sleep a couple of hours and then get back up." That problem continues from "time to time." He has become "pretty irritable, agitated." He thought he alienated a lot of his friends and family members. He has difficulty concentrating and does not "have any desire to watch any trucking programs or anything that involved, you know, misfortune, death, anything like that." Petitioner denied flashbacks of the accident. He eventually sought treatment from Dr. Lipsitz, a psychologist referred to him by his primary care provider.

7. He began seeing Dr. Lipsitz in May but discontinued in June. He saw him three or four times. Petitioner talked and talked and talked. However, after the sessions he felt worse than when he came in. Petitioner then saw Dr. Bassett for an examination pursuant to Section 12 of the Act. Dr. Bassett interviewed him for about three hours and administered tests for another three to three and a half hours. Respondent never offered Petitioner light duty or treatment for his psychological condition. Petitioner read Dr. Bassett's deposition. He did not want to take medication that had possible side-effects of sedation and loss of motor skills.

8. Petitioner sought other employment as soon as he was "released" by Respondent. Within the past couple of months, he applied at "probably at least a dozen places." He had an interview with Home Depot, but nothing came of that. He worked for a janitorial service for less than a week. He also got temporary seasonal work at Wal-Mart. In 2010 he explored "probably 50 to 75 different possibilities." That search included truck driving, but not necessarily driving a bid truck. He has not been offered any job driving non-semi-trucks. Petitioner tried to make money in photography, but realized he was losing money in the endeavor.

9. Petitioner also testified that since he was diagnosed with PTSD he would need medical clearance to operate a commercial motor vehicle. He had no such clearance from either Dr. Bassett or Dr. Lipsitz. Petitioner testified he still thinks about the incident and when he is "idle, that's nighttime, it can recur." He gets agitated and cannot sleep he'll get out of bed several times a night. He would watch TV or go on the internet to distract himself. At the time of the incident, he noticed there were human remains on the truck that was pulled off the road. Respondent has not offered him any vocational rehabilitation. Prior to the incident, Petitioner had not been diagnosed with PTSD or treated for any psychological difficulty.

10. On cross examination, Petitioner acknowledged that driver logs indicate that his assignment for Respondent after the incident was from St. Louis to Champaign. He agreed that he probably took the same route as he did on the night of the incident. While his CDL was current his medical certificate was not. He had not tried to renew his medical certificate because it would be senseless because he does not have a commercial driving job. Petitioner applied to truck-driving companies, but not necessarily for truck-driving positions. "The lady told" him that his driving record would preclude him from a warehouse driving position. When he was looking for employment he "absolutely" used Mr. Dyckman as a reference.

11. Petitioner testified he was not aware of the side-effects of medication until he read Dr. Bassett's deposition. He acknowledged that he did not ask Respondent to provide psychological treatment. He agreed that before he saw Dr. Lipsitz he consulted a lawyer about a civil action against the driver that caused the accident because he felt he "had been totally abandoned in this whole process."

12. Petitioner clarified his answer on direct that he still watches TV; he was now selective of what he watches. He'll watch network news until it repeats itself three or four times. On the night of the incident he was taken to an emergency room for a drug/alcohol test "per DOT regulation." He did not complain of any injury at that time. The accident he witnessed while in the military was a helicopter crash. Petitioner flew helicopters as well as serving as a mechanic. Petitioner was able to fly helicopters after that accident. He saw active combat in Desert Storm.

13. Petitioner's primary care provider suggested he treat with a psychologist, but he did not refer Petitioner to Dr. Lipsitz specifically. He probably discussed getting psychological treatment about two weeks prior to seeing his primary care provider. Petitioner told Mr. Dyckman he still wanted to drive trucks for Respondent after he was suspended, "until a point that [he] probably couldn't;" he needed the income. He received minimum wage in the janitorial job mostly cleaning movie theaters. He quit that job because of a disagreement with a co-worker.

14. On redirect examination, Petitioner testified when he told Mr. Dyckman that he wanted to return to work, he had not yet been diagnosed with a psychological condition. Petitioner had a physical exam when he was taken to hospital. He "imagined" that he had "questions whether [he] could continue to work with the way that route went;" "it was not an easy evening."

15. Janis Shea, Petitioner's wife, testified Petitioner's "sleeping patterns have been very sporadic" since the incident; getting up frequently. He has been very short-tempered and "his concentration is just not there." She had not noticed such behavior prior to the incident. On cross examination, she testified Petitioner had not been unemployed for an extended period of time prior to his suspension from Respondent.

16. Robert Dyckman testified he became aware Petitioner was involved in a motor vehicle accident on October 2, 2010 when Petitioner called him at about 1 A.M. He got to the scene at about 3:30 A.M. He communicated with Petitioner "quite a bit," while they were waiting for the state police to complete their investigation. He drove the semi to a Wal-Mart at the next exit and made arrangements for it to be towed to Effingham. Petitioner took the witness' car and followed them. They drove to St. Louis together. From there, Petitioner drove home in his own car.

17. He discussed the accident with Petition on the way to St. Louis; Petitioner was shaken and concerned, but he was not hysterical. He was not crying or literally physically shaking. He did not appear to be in shock. His responses were appropriate.

18. Respondent would not allow Petitioner to drive because the drug tests administered by the state would not be available for 30 to 60 days. The witness argued with Respondent to get the matter resolved, and that resulted in the assignment Petitioner was given. That run was between Springfield and Champaign. Petitioner told him that he used the same route as on the night of the incident. Petitioner thought going back to the scene of the accident and "replaying it in his mind," but that was it. It was not his decision to keep Petitioner from driving for Respondent; Respondent suspended him until all the legal matters associated with the incident were settled.

19. Petitioner never told him he was unable to work as a truck driver after the incident. He believed he first discussed a workers' compensation claim with Petitioner on May 5, 2011. Petitioner called him as a courtesy to let him know that he talked to a lawyer. The lawyer did not think a civil action would be fruitful and that he was going to see a psychological doctor and possibly file a workers' compensation claim. Petitioner did not tell him he had already seen a doctor but that it was his intention to see one.

20. On cross examination, the witness testified the run Petitioner had after the incident was from St. Louis to Champaign. Petitioner felt "weird" about going through the scene of the accident. Petitioner had been a good employee; though "there were some issues."

21. Dr. Bassett, a psychiatrist, testified by deposition on April 20, 2012. He was referred to exam Petitioner by Respondent's workers' compensation insurance carrier. He reported a history of "a person who dies and it was witnessed by the mother of the child in the vehicle," which "was seen by" Petitioner. He saw Petitioner for a total of 197 minutes, which did not include tests that were administered on Petitioner. The witness reviewed the results from the MMPI-2. They corroborated his clinical findings. He also reviewed the MCMI-III, another psychological test.

22. Dr. Bassett opined that "as a consequence of his involvement in witnessing the aftermath of this accident [Petitioner] developed a constellation of depressive, anxiety, and dissociative symptoms which meant DSM-IV-TR" called PTSD. In the opinion of the witness the condition is permanent but it is possible for symptoms to go into remission.

23. Dr. Bassett believed Petitioner's PTSD was "moderate" but permanently precludes him from working as a professional driver requiring a CDL. Patients with PTSD can suffer from panic attacks, which would cause a safety hazard for commercial truck drivers. His sleep disturbance would also interfere with his ability to drive. Dr. Bassett believed Petitioner reached maximum medical improvement when he decided not to seek additional treatment with Dr. Lipsitz.

24. On cross examination, Dr. Bassett testified he understood that Petitioner did not actually see how the victim died. He did not know whether Petitioner actually saw the actual injury, "half the head being gone." He understood that Petitioner had not actually experienced a panic attack; he should have clarified that he experienced panic attack-like symptoms *i.e.,* being hyper-alert while driving. Petitioner's condition was not so severe as to require ongoing treatment.

25. Dr. Bassett testified that the fact that Petitioner did not seek treatment until May 19, 2011 could or could not support the premise that his symptoms were not severe. Furthermore, treatment might or might not allow Petitioner to return to work as a truck driver. Some antidepressant medications are known to be helpful in treating PTSD. Petitioner was not interested in taking medication.

26. Dr. Bassett understood that Petitioner was a helicopter mechanic in Vietnam and became a pilot prior to Desert Storm. He was able to continue to fly helicopters after he witnessed helicopter crashes. However, a person's reaction to deadly situation can be different when the person is a soldier or a civilian.

27. In addition, Petitioner was in a motor vehicle accident a little less than two months after the incident. His wife was injured in that accident and required physical therapy. That experience could have contributed to his inability to drive. Petitioner told Dr. Bassett that he was "brought into the lawsuit by the estate." Petitioner also told him that he was able to make a run between St. Louis and Kansas City, but he was uncomfortable and "limped through it."

28. Dr. Bassett agreed that being anxious or hyper-alert would not necessarily preclude somebody from driving commercially. He knew that CDL licenses require a special physical examination. At times, he will issue letters that a patient is taking a stimulant or medication with sedative properties. They can be allowable if they are medically justifiable.

29. Petitioner expressed the desire to continue working and to "to get back on the horse, so to speak." If a person "is capable of it, it's a good thing." Dr. Bassett agreed that besides the sleep deprivation, there was nothing that would physically preclude Petitioner from driving a truck. Petitioner told the witness that he was looking for other trucking jobs. However, the onset of PTSD can be delayed. It would have been better for Petitioner to have tried to return to work as a driver closer to the event.

30. On redirect examination, Dr. Bassett explained his last answer that after a while "symptoms had time to set in." He did not know whether Petitioner's driving a truck would pose a safety hazard to him or the general public, but he did think it would be worse for him psychiatrically. Dr. Bassett testified that the motor vehicle accident after the incident did not cause the PTSD. Petitioner exhibited PTSD symptoms when he was making the run to Kansas City.

31. On re-cross examination, Dr. Bassett indicated that for some people the old adage "time heals all wounds" may be correct. Petitioner did report to Dr. Bassett that his sleep patterns had improved. There are treatments that are available for PTSD, if Petitioner were inclined to seek treatment. He would prescribe anti-depressants with anti-anxiety properties and refer him to a psychotherapist. Treatment may allow Petitioner to return to work as a truck driver, but he would have to be willing and able to engage in the treatment.

32. On re-redirect examination, Dr. Bassett explained his last answer to mean that Petitioner was an adult and should decide for himself whether he wanted treatment. There is no guarantee of the outcome of such treatment. In addition, anti-depressant medication has side effects such as sedation, impaired motor function, slurred speech, and habit formation. Those side effects could impair a person's ability to drive.

As noted above, the Appellate Court remanded this matter to the Commission to reanalyze the claim under the legal standards specified in *Chicago Transit Authority v. Workers' Compensation Commission,* 989 N.E.2d 608 (1st Dist. WC division 2013). The Commission notes that when we affirmed and adopted the Decision of the Arbitrator in our initial decision, we were aware of that decision of the Appellate Court. Nevertheless, the Appellate Court is absolutely correct that through our affirmance and adoption of the Decision of the Arbitrator, we did not specifically address the *CTA* case in our analysis because it was neither cited not analyzed by the Arbitrator.

In denying compensation, the Arbitrator noted that Petitioner did not seek treatment for seven months and that he held himself out as being able to continue driving a truck commercially. As the Appellate Court eloquently noted the importance of the *CTA* case is that it is the emotional shock that must be sudden and not all resulting psychological injury for a mental-mental claim to be compensable. In *CTA*, the Appellate Court affirmed the Decision of the Commission which found a CTA bus driver proved a mental-mental claim after the bus she was driving hit and killed a pedestrian. Petitioner stresses the *CTA* case stands for the proposition that immediately seeking medical attention for PTSD does not preclude the claimant from receiving compensation.

Nevertheless, the Commission finds the *CTA* case distinguishable from the case now before us. There, the driver actually caused the death of the victim, which must be considered a more traumatic experience than simply witnessing the aftermath of a deadly accident. In addition, the claimant in *CTA* reported flashbacks in which she felt she was actually re-experiencing the traumatic event, while here Petitioner noted dreams and thoughts about the event, but specifically denied flashbacks. Also notable is the fact that in *CTA*, the claimant only waited about two months before seeking treatment while the Petitioner here waited almost seven months. In addition, the *CTA* court specifically noted "based on the claimant's failure to seek treatment in a timely manner, it would also be reasonable to infer that the claimant did not suffer a severe emotional shock during the accident." Here not only did Petitioner wait seven months to seek treatment, he only sought treatment after he consulted a lawyer.

Furthermore, not only did Petitioner testify he only consulted with Dr. Lipsitz on three or four occasions, he was not interested in any medication recommended by Dr. Bassett even before he knew of any side-effects. The record indicates that apparently, Petitioner basically did not really want to undergo any treatment whatsoever. It is also noteworthy that Petitioner never submitted any medical records into evidence at arbitration to support his claim.

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Additionally, the Commission does not find the opinion testimony of Dr. Bassett particularly persuasive. First, Dr. Bassett acknowledged that a long delay in seeking treatment could indicate that his symptoms were not severe. Second, he related that Petitioner's suffered a sudden emotional shock after the accident, even though he did not know whether he actually saw the partially decapitated corpse. It is also a little questionable that he believed that while the PTSD disqualifies Petitioner from any profession requiring a CDL, Petitioner was perfectly fit for any other occupation. Dr. Bassett's apparent lack of concern about whether Petitioner receives any treatment for the condition also tends to negate his opinion that Petitioner suffered at least partially debilitating PTSD. Finally, Petitioner's ability to drive the semi on the same route a few days after he witnessed the aftermath of the fatal accident, his continued attempts to continue driving a truck after the incident, and Mr. Dychman's testimony about Petitioner's demeanor immediately after the incident, militate against the diagnosis of debilitating PTSD.

In looking at the entire record before us, the Commission finds that Petitioner failed to sustain his burden of proving he suffered a severe sudden emotional shock resulting in debilitating PTSD and depriving him of being able to pursue his profession as overland truck driver.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated August 8, 2012 is affirmed and compensation is denied.

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

DATED: DEC 12 2017

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jennifer Galeski,
Petitioner,

17IWCC0797

vs.

NO: 16 WC 5366

SOI/Chester Mental Health Center,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 24, 2017, is hereby affirmed and adopted.

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

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

DEC 12 2017

DATED:
o11/2/17
DLS/rm
046

Deborah L. Simpson

Deborah L. Simpson

David L. Gore

David L. Gore

Stephen J. Mathis

Stephen J. Mathis

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

17IWCC0797

GALESKI, JENNIFER D
Employee/Petitioner

Case# **16WC005366**

15WC039593

CHESTER MENTAL HEALTH CENTER/SOI
Employer/Respondent

On 5/24/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4852 FISHER KERKHOVER COFFEY ET AL
JORDAN GREMMELS
1300 1/2 SWANWICK PO BOX 191
CHESTER, IL 62233

0558 ASSISTANT ATTORNEY GENERAL
AARON L WRIGHT
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

MAY 24 2017

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

17IWCC0797

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(a)

JENNIFER D. GALESKI
Employee/Petitioner

v.

CHESTER MENTAL HEALTH CENTER / STATE OF IL
Employer/Respondent

Case # **16** WC **05366**

Consolidated cases: **15 WC 39593**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Herrin**, on **March 16, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

F. [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, **April 20, 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 **$36,753.54**; the average weekly wage was **$706.80**.

On the date of accident, Petitioner was **40** 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 **$ALL PAID** for TTD, **$N/A** for TPD, **$N/A** for maintenance, and **$N/A** for other benefits, for a total credit of **$ALL PAID**.

ORDER

The Arbitrator finds that the Petitioner's right shoulder condition was causally related to the 4/20/14 accident until 1/23/15, at which time an intervening injury resulted in the condition being causally related to a 1/23/15 work related accident, which is the subject of consolidated claim 15 WC 39593.

Respondent shall pay the reasonable and necessary medical services that are outlined and contained in Petitioner's Exhibit 7, as provided in Sections 8(a) and 8.2 of the Act, which were incurred between 4/20/14 and 1/22/15. Respondent shall be given a credit for any and all of the awarded 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.

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

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

Signature of Arbitrator

May 15, 2017
Date

1CArbDec19(b)

MAY 24 2017

STATEMENT OF FACTS

The parties presented for hearing for the above noted consolidated claims pursuant to Section 19(b) of the Act. The Respondent disputed the claim based on the issues of causal connection, liability for medical expenses and ongoing temporary total disability (TTD), and prospective medical treatment.

The Petitioner testified she was employed by Respondent as a Cook I at the Chester Mental Health Center (CMHC), and had been employed there for four years. On 4/20/14, she testified that she was lifting an approximate 20 pound pan of baked beans from a steamer when she felt her right shoulder pop. The Petitioner testified she immediately sought medical treatment with an orthopedist, Dr. Byrne, whom she had treated with previously, though not for the right shoulder. She testified she underwent an x-ray, was diagnosed with a right shoulder strain and underwent two weeks of physical therapy. After initially working light duty, she was released by Dr. Byrne to return to full duty work.

The incident report from Respondent, dated 4/23/14, indicates an accident history consistent with Petitioner's testimony, noting her shoulder went out and she had pain down the arm, into her collarbone and back, with weakness and reduced range of motion. (Rx6).

The Arbitrator notes no record of Dr. Byrne from April 2014 was located in the medical records submitted into evidence. There is a 4/23/14 note of Dr. Schabbing, diagnosing a right shoulder strain and restricting Petitioner's work duties. On 4/29/14, Petitioner noted some improvement but ongoing pain in the anterior shoulder and laterally at the subacromial bursa. Physical therapy was prescribed and restrictions were continued. On 5/5/14, Petitioner noted she felt a pop in her right shoulder while washing her hair, but felt like it popped into place and she felt much better. Given the resolution of pain, Dr. Schabbing released the Petitioner to full duty, noting no ongoing disability. (Px6).

Petitioner returned to Dr. Schabbing on 6/17/14, indicating she had returned to work and reported a three week history of progressively worsening right shoulder pain, with radiation to the neck and the right hand into the 4th and 5th fingers. She indicated no reinjury had occurred. Therapy was again instituted with medication and work restrictions. On 7/1/14, Dr. Schabbing noted Petitioner's therapy was not being approved, and he prescribed x-rays and referral to Dr. Byrne. (Px6).

The records of Dr. Byrne (Perry County Orthopedics and Sports Medicine) that were submitted into evidence indicate visits of 1/20, 1/27, 2/12, 2/19, 2/24, 4/7/14 for the left shoulder and bilateral knees, including pain medication and injections, as well as Orthovisc injections for the knees. (Px4).

The 7/1/14 right shoulder x-ray was reportedly normal. (Px5). On 7/23/14, Petitioner reported to Dr. Byrne bilateral shoulder pain, noting she had been trying to lift an approximate 25 pound tray and had pain since that time. Only left shoulder x-rays were obtained, and Petitioner was diagnosed with bilateral shoulder degenerative joint disease with rotator cuff tendonitis. Both shoulders were injected, Celebrex was prescribed and Petitioner was given a work restriction regarding right shoulder work that she requested. (Px4).

A 7/18/14 right shoulder MRI reportedly showed no evidence of internal derangement or bony or fibrous impingement. No tendonitis or bursal effusion was indicated. (Px4 & 5). Petitioner followed up for the bilateral shoulders on 7/28/14, and was noted to have a history of Ehlers-Danlos syndrome. She was there for review of left shoulder MRI, which showed osteoarthritic changes with a hypoplastic glenoid. Dr. Byrne indicated he

believed the majority of her left shoulder pain was due to osteoarthritis and did not recommend surgery, but offered to refer her to a shoulder specialist. Petitioner declined and was returned to work and referred to pain management "for her shoulders as well as her total body pain". (Px4).

A memo of the Respondent in evidence indicates the Petitioner worked light duty from 4/23 to 5/4/14 and again from 6/18 to 7/31/14. (Rx6).

Petitioner was evaluated for Ehlers-Danlos syndrome at Perry County Hospital on 9/30/14 on referral from Dr. Schabbing. The report states Petitioner previously saw Dr. Kim in December 2013 for fibromyalgia, noting this was being managed with mediation in pain management. Petitioner reported hypermobility since childhood. She also reported "ongoing myalgias and arthralgias secondary to fibromyalgia as well as fatigue and poor sleeping patterns." Dr. Ronholm noted hypermobility on exam mainly in Petitioner's bilateral knees, elbows and wrists. Genetic testing for Ehlers-Danlos syndrome was prescribed. (Px5).

On 11/19/14 Petitioner reported bilateral shoulder pain and Dr. Byrne noted a history of bilateral shoulder osteoarthritis. Petitioner reported she was exercising more and did not want to take Vicodin, and she requested bilateral injections, which Dr. Byrne performed. Petitioner again declined a specialist referral. (Px4).

Petitioner also saw Dr. Green at Perryville Family Care, the same facility as Dr. Schabbing. She complained of posterior and right neck pain that radiated to the upper back and right arm. There was no obvious precipitating injury. She was referred to the ER for neck pain and headache evaluation. (Px6). At Perry County Memorial on 1/13/15, Petitioner complained of headache and neck pain that extended down the spine into the right arm. The subsequent evaluation focused on the head, with no diagnosis made relative to the right arm. (Px5).

On 1/23/15, the Petitioner testified that she was putting an approximately 60 pound pan of pasta into a steam table at CMHC when she again experienced a "pop" in the shoulder and felt excruciating pain. She immediately sought treatment on site with the Respondent (see Rx3) and was directed to the Chester Memorial Hospital ER. The facility indicates Petitioner was lifting a pan of mac and cheese to a steam table when she felt a pop in her right shoulder with severe pain in the shoulder and down the right arm. X-ray reflected a very shallow glenoid fossa that was likely congenital, but was otherwise normal. Diagnosis was non-specific right shoulder injury. It was noted that she had a history of prior surgeries to the left shoulder (x2), left wrist and right knee, as well as a history of Ehlers-Danlos syndrome. She was held off work for 4 days and referred to her primary provider Dr. Schabbing. (Px2).

Documentation from Respondent regarding Petitioner's report of this accident is dated 1/24/15 and is consistent with her testimony in terms of the mechanism of injury. Symptoms of stabbing pain from the anterior to posterior shoulder radiating down the right arm to the hand were noted. Petitioner reported weakness and difficulty lifting. (Rx3).

Petitioner followed up with Dr. Schabbing on 1/27/15. She reported a work accident with right shoulder pain down the elbow and wrist with occasional numbness. Dr. Schabbing noted: "Patient has injured this shoulder before and has a complicated history of hypermobility syndrome. She did feel and heard a pop when maneuvering a heavy pan of food. She described this as a hot knife through her shoulder." She was referred to Dr. Byrne. (Px6).

On 1/28/15, Petitioner saw Dr. Byrne, but the report only notes complaints of left shoulder and bilateral knee pain. Petitioner noted a re-exacerbation of her pain, though it was unclear if this related to the shoulder or knees

or both, and indicated she was ready for a referral to a shoulder specialist. She was referred to Dr. Chamberlain in St. Louis. This report does not reflect a history of the 1/23/15 accident. (Px4).

There also is a 1/28/15 note from Dr. Turk at Chester Memorial Hospital indicating Petitioner was released to full duty. (Rx3).

Petitioner then returned to Dr. Byrne on 2/2/15, noting a new complaint of right shoulder pain. Petitioner reported she initially injured the shoulder in July 2014, and that while she improved with therapy, "she always did have some pain." She reported picking up a 50 pound tray of macaroni and cheese to shoulder height on 1/23/15 and felt a pop in the right shoulder with anterior pain that radiated down the arm and posteriorly. X-rays showed no acute findings. Dr. Byrne was concerned about a bicep tear and possible labral tear and/or subscapularis injury, and obtained a 2/12/15 right shoulder MRI arthrogram. This showed a tear of the posterior glenoid labrum, and was otherwise normal. Petitioner also underwent bilateral knee Orthovisc injections on 2/2/15.

Petitioner followed up with Dr. Byrne to review the right shoulder MRI and complained of significant pain whenever she moved the shoulder, which made examination difficult. The diagnosis was posterior labrum tear, bursitis, biceps tendonitis and scapular thoracic dyskinesia. Therapy and an injection were prescribed, with the injection performed on 2/23/15. (Px4).

Therapy for the right shoulder was instituted at Perry County on 2/25/15, and the initial evaluation reflected a consistent history of the 1/23/15 injury. She underwent 18 sessions through 4/30/15. Petitioner noted good progress per the notes, but on 4/7/15 reported she slept wrong with muscle pain in the right shoulder and upper trapezius. She also reported pain with overhead use of the arm, and by mid-April was more severe pain. At the last visit the therapist noted Dr. Byrne was prescribing right shoulder surgery. (Px5).

On 4/1/15, Petitioner reported improvement, mainly with therapy, and that she wanted to get back to her regular job. Dr. Byrne released her to work with no work over shoulder level and a 20 pound limit with the right arm. (Px4).

Petitioner returned to the Chester Memorial ER on 4/26/15 with complaints of a two day history of worsening right shoulder pain, noting she was in therapy and had been working light duty for over a month. She indicated that she had not sustained a reinjury. The triage note states she awoke Friday night with increased pain, while the physician's note states she developed pain following a therapy session. She was advised to follow up with primary care (Px2). The Petitioner returned to the Chester Memorial ER on 5/12/15 for a left thumb laceration at work. She was hospitalized for hypoxic respiratory failure in May of 2015. (Px2). On 6/18/15, Dr. Schabbing's records note a history of migraines over the years that tended to cluster when her asthma was not under control, and his records from 2014 to 2016 note multiple asthma exacerbation situations. (Px6).

At a 4/29/15 follow up, Dr. Byrne noted Petitioner complained of severe right shoulder pain and wanted to have surgery versus further ongoing conservative treatment. Dr. Byrne prescribed arthroscopic surgery, which would involve subacromial decompression and would otherwise be diagnostic for rotator cuff and/or labral tears, noting those would be debrided or repaired, if possible, if same were found. Work restrictions were continued in the meantime. (Px4).

The Petitioner was examined by Dr. Gross on 6/4/15 at Respondent's request pursuant to Section 12 of the Act. She reported lifting a 50 pound pan of macaroni and cheese onto a steam table on 1/23/15, and feeling a pop in her right shoulder with severe pain. He noted she had a right shoulder strain about a year prior versus a cuff tear. The report of Dr. Gross reflects his review of Petitioner's medical records. She was currently complaining of

pain over the anterior and posterior aspect of the right shoulder, worse with activity, and pain and popping with overhead activities. She did not complain of neck pain or pain radiating into the arm. She reported that an injection after the initial 2014 injury provided improvement and allowed her to return to full duty without significant further problems. Recent therapy and injection did not provide significant improvement. Dr. Gross noted the findings on right shoulder x-rays from 7/1/14, 2/2/15, and 6/4/15, as well as MRIs from 7/18/14 and 2/12/15. This included dysplasia of the glenoid posteriorly, no fractures and/or dislocations, and abnormalities in the anterior and posterior glenoid as well as the biceps tendon anchor. There was degeneration of the AC joint. He also noted Petitioner's history of Ehlers-Danlos syndrome. (Px1).

Dr. Gross indicated objective findings of restricted range of motion, pain with range of motion, positive signs of labral pathology and degeneration. Films indicated hypoplasia of the posterior glenoid and tearing of the anterior and posterior labrum. There was some guarding with attempts at range of motion, but no other abnormal behavior noted. Diagnosis was right shoulder osteoarthritis and labral tear. Dr. Gross opined that the hyperplasia and labrum tearing were degenerative. He further opined that there was no significant difference between the 7/1/14 and 2/12/15 MRIs, stating: "This would be consistent with her having underlying damage to her shoulder related to a congenital abnormality or Ehlers-Danlos syndrome and hypermobility of her shoulder. I do not believe that her injury has caused any significant pathology in her shoulder besides a strain of her right shoulder which may have aggravated underlying degeneration of her shoulder." He indicated treatment to date had been reasonable and necessary for her 1/23/15 shoulder injury. Dr. Gross recommended an injection, anti-inflammatory medication and physical therapy for 6 to 8 weeks, noting it appeared this protocol had helped her in the past. He recommended avoiding surgery given her underlying degeneration and Ehlers-Danlos syndrome, as there is potential for failure of any repair of connective tissue tearing. He believed Petitioner would be able to return to activities at work, but could have future problems regarding the shoulder related to degeneration and Ehlers-Danlos. (Px1).

On 6/17 and 7/20/15, Petitioner saw Dr. Byrne and reported rolling her right ankle multiple times", and that she had a significant history of Ehlers-Danlos disease. On 8/24/15 she reported that her right hip had popped out twice, and that she has chronic SI joint dysfunction issues. (Px4).

In September 2015, Petitioner returned to Dr. Byrne reporting Dr. Gross' recommendation of injection and therapy. She noted her right shoulder was worse and she had been to the ER on 9/6/15 and was prescribed muscle relaxers and pain medication. Dr. Byrne injected the right shoulder, prescribed therapy and indicated the same work restrictions he had previously – no work over the shoulder and no lifting over 20 pounds with the right upper extremity. On 10/26/15, Petitioner reported no improvement with the injection with increased pain and decreased range of motion. She noted recent hospitalization for respiratory problems. Dr. Byrne noted he did not believe he could perform surgery at his facility given Petitioner's lung function and recommended she follow up with a surgeon at a facility with a higher level of care, and she could otherwise return as needed. (Px4). Petitioner testified that she was referred to Dr. Chamberlain.

On 9/6/15, Petitioner returned to the ER with complaints of right shoulder pain after working two days of overtime. She noted no new injury, indicating that any movement of the right arm increased her shoulder and upper right arm pain. X-ray findings were the same as they were in the January 2015 films. (Px2). She again returned on 9/26/15 and 12/1/15 for flare-ups of right shoulder pain, noting no specific reinjury. (Px2). The Arbitrator notes multiple other 2015 and 2016 ER visits that are unrelated to the current case. (Px2).

Petitioner attended therapy from 9/25 to 11/6/15, at which point it was noted she would be seeing Dr. Chamberlain. The records generally note complaints of 7 to 9 out of 10 pain, with Petitioner noting increased symptoms with use of the right arm. The Arbitrator notes that towards the end of this period the Petitioner noted

that Dr. Byrne wanted her to see another physician for evaluation because there was a potential complication with surgery. What this complication was wasn't indicated. (Px3).

Petitioner initially saw surgeon Dr. Chamberlain on 11/9/15. She reported her right shoulder pain began in July 2014 when she was lifting a heavy pan at work. She improved with injection, and then had a second incident in January 2015 when lifting a 60 pound food pan, she felt a pop and pain in the right shoulder. She had no relief after that with therapy or injection and was scheduled for surgery until the Respondent requested an independent exam. She again underwent therapy and a third injection with no relief. She noted her history of Ehlers-Danlos syndrome. 11/9/15 right shoulder x-rays reflected a hypoplastic, irregular right glenoid, and was otherwise normal, and Dr. Chamberlain reviewed 2/12/15 MRI films and interpreted them as reflecting a posterior labral tear. Diagnosis was glenohumeral arthritis and biceps tendinosis in the setting of posterior labral tear. He recommended an injection into the glenohumeral joint, which was performed on 11/24/15. An updated MRI would be prescribed if she failed to improve. (Px1).

Petitioner followed up with Dr. Chamberlain on 12/15/15, and she reported 2 to 3 days of great relief with the injection, but her pain returned and she indicated she was unable to work. His diagnosis was likely right biceps tenosynovitis and refractory rotator cuff tenderness/bursitis in the setting of glenoid deformity and arthritis. Dr. Chamberlain suspected that, based on improvement with the injection, the pain was due to arthritis and possible biceps tenosynovitis. Diagnostic arthroscopy was prescribed for the right shoulder with likely biceps tenotomy, subacromial decompression and debidement of the glenohumeral joint. The doctor also restricted the Petitioner as to her right arm to 5 pounds of lift/push/pulling, and avoidance of overhead, outstretched or repetitive motion, as well as avoidance of grip/grasp/twist/pinch. (Px1).

Dr. Chamberlain saw Petitioner on 5/3, 5/23 and 6/27/16, however his notes from these dates reference the left shoulder, with Petitioner reporting activity related pain with range of motion and normal daily activities. It also noted Petitioner's left shoulder was feeling worse lately than the right. The diagnosis was early arthrosis with recurrent left rotator cuff tear in the setting of a connective tissue disorder, possibly Ehlers-Danlos syndrome, with substantial glenoid retroversion and posterior humeral subluxation. (Px1).

On 11/28/16, Dr. Chamberlain noted Petitioner was there for a right shoulder reevaluation, noting he saw her the prior year after a work injury. Petitioner stated that the injury occurred "a couple years ago" when she was lifting a 50-60 pound container of macaroni and cheese and felt a pop in the shoulder. She did not have right shoulder pain prior to that, and subsequently had persistent pain which impacted right shoulder function. The pain is mainly anterior, worse with lifting, and the pain sometimes radiates down the arm into the hand. Exam notes range of motion limited by pain and reasonable strength. X-rays showed largely unchanged (versus 11/9/15) glenoid dysplasia with mild to moderate arthrosis, and that was Dr. Chamberlain's diagnosis. They discussed that Petitioner has a complex deformity of the glenoid which complicates treatment options. He had previously recommended an MRI, and did so again. Dr. Chamberlain limited Petitioner to no overhead lifting and no lifting over 10 pounds. (Px1).

On 12/12/16, Petitioner reported increased symptoms that were radiating down the arm to the hand. Updated MRI was noted to indicate dysplasia of the glenoid with a hypertrophic posterior labrum, a small pair labral posterior cyst, and glenohumeral arthrosis, but no evidence of a rotator cuff tear. In addition to the shoulder diagnosis, Dr. Chamberlain noted Petitioner was complaining of symptoms that were likely from sources outside of the shoulder, for which he recommended a physiatry evaluation. As to her right shoulder arthritis, he recommended continued conservative management and clinical observation, noting Petitioner should try to avoid shoulder arthroplasty for as long as she could. (Px1).

Petitioner testified that she remains under restrictions from Dr. Chamberlain, including no lifting over 10 pounds and no over the shoulder lifting, and that she worked light duty in accordance with these restrictions until the Respondent no longer accommodated them. She noted if Chamberlain testified that she injured the right shoulder in July 2014, this would have been a miscommunication. She received TTD benefits up until 10/5/16. The Petitioner testified that because conservative treatment had been exhausted, Dr. Chamberlain wanted to proceed with surgery, and that she wished to undergo the surgery. She testified she is in constant pain and she cannot sleep, and that there are days when cannot dress herself and cannot brush her own hair.

The Petitioner agreed that she suffers from Ehlers-Danlos syndrome, diagnosed in approximately 2012, and is extremely hypermobile. This has caused her a lot of problems with respect to her left shoulder, including two prior left rotator cuff repairs (she thinks in 2010 and 2011), fusion of the bilateral SI joints, as well as injections. The Petitioner denied any complaints or treatment for the right shoulder prior to the 4/20/14 and 1/23/15 work injuries. On cross exam, Petitioner agreed she had already been diagnosed with Ehlers-Danlos when she started working for Respondent four years prior to the hearing date. She indicated her left shoulder problems were not due to any work injury. She hasn't applied for non-occupational disability benefits, testifying she has not looked into whether she is eligible. She has always worked in the kitchen for Respondent, indicating she initially began as a support worker there.

Board certified orthopedic surgeon Dr. Chamberlain testified via evidentiary deposition on 1/27/17. (Px1). He first saw the Petitioner on 3/16/15 regarding her left shoulder, noting complaints of pain with heavy and/or above the shoulder lifting, with a history of left rotator cuff repair and Ehlers-Danlos syndrome with hypermobile joints. There were no right shoulder complaints elicited at that time. (Px1).

As to the initial right shoulder examination on 11/9/15, Dr. Chamberlain noted Petitioner reported that her pain began after lifting heavy food at work around July 2014, and that an MRI had revealed a labral tear. She had limited strength and ability to elevate the right arm, which was likely pain related, and shoulder inflammation / impingement. Dr. Chamberlain recommended an injection into the shoulder joint, and in December the Petitioner reported she had 2 to 3 days of relief, which Chamberlain interpreted as confirming her pain was likely due to arthritis or pathology within the ball and socket joint, which included the labral tear seen on MRI and the arthritis seen on x-rays. Dr. Chamberlain discussed arthroscopic surgery to debride the inflammation to address sources of pain such as arthritis, but also noted this could have unpredictable results and "would not get rid of her arthritis problem, etc." His understanding is Petitioner opted against surgery. (Px1).

Subsequent to a May 2015 visit for the left shoulder in May 2015, the Petitioner next followed up for the right shoulder on 11/28/16. The primary finding during 11/16 exam was limited range of motion due to pain, and Dr. Chamberlain again indicated symptoms were related to arthritis and degenerative joint disease. He obtained a repeat right shoulder MRI on 12/12/16, which showed a hypertrophic posterior labrum and some tearing or a paralabral cyst in the back of the labrum, along with arthritis. He also noted she was complaining of other symptoms that were likely not coming from the shoulder, and recommended evaluation in this regard. (Px1).

Dr. Chamberlain testified that Ehlers-Danlos syndrome is related to a congenital defect or problems in the connective tissue which can manifest as multi-directional shoulder instability, where it is "loose" and can be dislocated easily (i.e. makes a person more prone to dislocation), and can at times be related to injury. Such dislocations can result in tears of the soft tissue structures. However, Dr. Chamberlain also testified that it was unclear whether such people are more susceptible to a lifting or pulling injury, as there was no evidence to suggest lifting would cause an instability event. (Px1).

Dr. Chamberlain was not aware of Petitioner having right shoulder treatment prior to her work injury. He opined that the right shoulder pain and symptoms might or could have been caused by her work injuries, mainly based on the temporal relationship of the accident to symptoms onset. The lifting incident on 1/23/15 also could have caused pain and symptoms in the shoulder. Again, while Dr. Chamberlain recommended conservative care for as long as Petitioner could tolerate, he noted that her arthritis and degenerative joint disease could ultimately require arthroplasty. He testified that, since the accident(s) caused the pain, and that surgery would be based on treating that pain, an arthroplasty would be related to her work injuries. If she underwent this shoulder replacement surgery, Dr. Chamberlain testified the Petitioner would likely require permanent lifting restrictions of no more than 40 or 45 pounds with her right arm, and at her age, there would be a strong likelihood of needing a revision surgery down the road. He couldn't recall if he gave her ongoing work restrictions, but testified he would generally recommend she not perform activities repetitively that cause her pain to linger. (Px1).

On cross exam, Dr. Chamberlain agreed both the 2/12/15 and 12/12/16 right shoulder MRIs showed a labral tear. He agreed MRI also showed a labral tear in the Petitioner's left shoulder. While he agreed that the "shape or morphology of the labral tear is present in both shoulders", the symptoms in the right shoulder occurred subsequent to an injury. Ehlers-Danlos syndrome is rare, with less than 3% of Chamberlain's patients having the condition. He agreed it is possible the Petitioner could have suffered the labral tear regardless of whether she was working or not. (Px1).

Board certified orthopedic surgeon Dr. Gross testified on 8/5/16. (Rx5). He indicated that Ehlers-Danlos syndrome is a connective tissue disease where a person can have excessive laxity of the joints, and that he has had patients with this problem. He noted a malshaped right glenoid and abnormalities of the right glenoid labrum per the films, as well as early degenerative changes of the glenohumeral joint. With regard to his diagnosis of right shoulder osteoarthritis with labral tearing, Dr. Gross opined it was not caused by the work related injury. He noted she had the previous 2014 injury to the right shoulder, and that the MRI from 2014 showed no significant difference versus 2015 films. Both showed some glenohumeral joint degeneration and abnormalities to the glenoid and glenoid labrum, which was likely congenital or related to Ehlers-Danlos disease. He also noted one of his partners had performed surgery on Petitioner's left shoulder, and that a review of the left shoulder MRI from 2011 showed the same findings that were in the right shoulder. (Rx5).

On cross-examination, Dr. Gross agreed that when he saw Petitioner she had not yet reached maximum medical improvement, and he recommended further care at that time. He did not have any additional information or records regarding the Petitioner's condition subsequent to his examination. If, hypothetically, she continued to have problems after the recommended care, he testified "she could have further treatment". He indicated she was a little young to have shoulder arthroplasty, but that any such procedure would be related to the underlying osteoarthritis. (Rx5).

Dr. Gross agreed Petitioner also had a 2014 work injury, and that he did not see any medical records indicating any pathology in the right shoulder prior to that time. He also agreed Petitioner had been able to return to full duty with conservative treatment following the 2014 accident. With regard to Ehlers-Danlos syndrome, Dr. Gross testified sufferers can have recurrent instability and dislocations of joints, which can cause them to develop degeneration over time. They can also have tendon and ligament problems due to the soft tissue involvement of those structures. He agreed that such people can have an increased risk of injury with undue stress on the joints. (Rx5).

If the Petitioner failed to improve with conservative treatment, Dr. Gross indicated she would probably be restricted from lifting at or above the shoulder level, as well as a weight limit on lifting below shoulder level. Essentially, Dr. Gross testified that the 2014 and 2015 accidents likely aggravated the Petitioner's degeneration,

but did not cause any change in pathology. He believed that the glenoid abnormalities were chronic in nature, and due to Ehlers-Danlos or other congenital problem. He believed the relevant pathology here was in the shoulder joint itself, not outside of it, which was why Dr. Byrne's subacromial injection didn't help. Dr. Gross testified: "I think she has a degenerative shoulder. And it's going to have symptoms throughout the rest of her life as she does activities." (Rx5).

The Petitioner's alleged causally related medical expenses were submitted into evidence as Px7. It appears that the vast majority of these expenses have been paid, and the parties have stipulated that the Respondent is entitled to credit for any expenses paid prior to the hearing date.

CONCLUSIONS OF LAW

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

The Arbitrator finds that the Petitioner's right shoulder condition was causally related to the 4/20/14 accident until the Petitioner sustained an intervening injury on 1/23/15 (the subject of consolidated case 15 WC 39593), at which point the right shoulder condition became causally related to the 1/23/15 accident.

In this case, the Petitioner credibly testified that she had no prior right shoulder problems before lifting a 20 pound pan of beans out of a steam table on 4/20/14. The Arbitrator finds that this involved an increased risk of injury which arose out of the employment, and the Respondent has stipulated that a compensable accident occurred.

It is clear that the Respondent's defense in this case is based on Petitioner having a preexisting condition of Ehlers-Damlos syndrome, which resulted in preexisting degeneration in the right shoulder. In such preexisting condition cases, compensability depends on the employee's ability to show that a work accident aggravated or accelerated the preexisting disease such that the current condition of ill-being can be said to have been casually-connected to the work-related injury and not simply the result of a normal degenerative process. *Sisbro, Inc. v. Industrial Comission*, 207 Ill. 2d 193, 205; 797 N.E.2d 665, 673; 2003 Ill. LEXIS 776; 278 Ill.Dec. 70, (2003). It is axiomatic in Illinois workers compensation law that employers take their employees as they find them. When a 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. Where an employee has a preexisting condition which may make her more vulnerable or prone to injury, recovery will not be denied if the claimant can prove that the employment was also a causative factor. The accident need not be the sole or primary causative factor, so long as it is a causative factor in the resulting condition of ill-being.

The documentation in Rx6 supports that the Petitioner promptly reported the accident, indicating her shoulder went out and she had pain down the arm, into her collarbone and back, with weakness and reduced range of motion. The evidence indicates Petitioner reported to Perry County Hospital in 9/14 that she has had joint laxity since she was a child, and she testified she was diagnosed with Ehlers-Danlos syndrome in 2012. Despite this, and multiple other areas of concern that appear to have been impacted by this syndrome, there is no evidence that Petitioner had any right shoulder problems or treatment prior to 4/20/14.

The Arbitrator finds that the right shoulder condition had more or less resolved following the 4/20/14 accident, though there were some ongoing complaints, and the Petitioner returned to her full duty employment until the 1/23/15 accident. At that time, she was lifting, and the Arbitrator would infer reaching, to place a 50 to 60 pound tray of food into a steam table. She testified she heard a pop in the right shoulder at that time with immediate symptoms. She also testified that the conservative protocol that helped to resolve her condition after the 4/20/14 accident did not work to resolve her condition after the 1/23/15 accident. Thus, the Arbitrator believes the preponderance of the evidence indicates the current condition is related to the 1/23/15 accident.

The testimony of Dr. Chamberlain and Dr. Gross indicates that the Petitioner's pain is likely coming from the shoulder joint itself, and is very likely related to degeneration, much of which is likely due to the Ehlers-Danlos syndrome. It is quite clear to the Arbitrator that the pathology or pathologies in the Petitioner's right shoulder are significantly due to Ehlers-Danlos syndrome, and the degeneration that occurred, at least in part, due to the syndrome. Dr. Chamberlain and Dr. Gross have indicated that the labral tear appears to be due to the glenoid problems the Petitioner has due to the disease. However, both doctors testified that the creation of symptoms, or minimally the worsening of any symptoms, was due to the work accidents. Under a *Sisbro* analysis, the Arbitrator finds that both the 4/20/14 and the 1/23/15 accidents contributed to the right shoulder condition, but that Petitioner's condition at the time of hearing was due to the 1/23/15 accident, as it produced symptoms that have not resolved. In reviewing this Supreme Court case, it is difficult for the Arbitrator to see how it could be determined in this case that the work activity, lifting a heavy pan at a steam table, did not increase the risk of injury to the Petitioner's right shoulder, and thus act as at least a causative factor in the Petitioner's present right shoulder condition. The Arbitrator believes the evidence in this case is quite clear that the Petitioner is prone to joint problems due to Ehlers-Danlos syndrome. However, these accidents, per the Petitioner's testimony and the supporting medical, appear to have triggered symptoms and exacerbated the preexisting right shoulder joint degeneration in the joint/socket, as there is no evidence she had symptoms prior to the accident dates.

Again, the Petitioner reported specific right shoulder injuries on 4/20/14 and 1/23/15. The incidents did not involve situations where there was a gradual increase in symptoms with basic lifting activities, or a sudden increase with passive activity, but rather involved specific incidents where the Petitioner was lifting and manipulating trays of food at a steam table. The Petitioner's treating physicians, including Dr. Schabbing, Dr. Bryne, and Dr. Chamberlain all related the Petitioner's right shoulder complaints to her work injuries. Dr. Gross admits the work injuries may have aggravated the Petitioners condition, even if degenerative in nature. No evidence was presented at trial which indicates the Petitioner had ever even complained of her right shoulder prior to these injuries. While the Petitioner may be more vulnerable to injury, as suggested by Dr. Gross, the Respondent has presented no evidence to suggest a cause of her complaints, aside from the work injuries suffered in 2014 and 2015, respectively. Plus, as noted, the law is clear that you take the Petitioner as you find her, which includes a predisposition to injury. The Arbitrator finds that the work accidents suffered by the Petitioner were a causative factor in her right shoulder condition of ill-being, and that the 1/23/15 accident resulted in the current condition of ill-being. It appears the incident of 1/23/15 significantly exacerbated the Petitioner's right shoulder condition, and constituted an intervening accident to the extent that the Arbitrator finds that the preponderance of the evidence indicates the Petitioner's current condition is mainly related to this accident.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Respondent shall pay the Petitioner's causally related medical expenses which are contained in Px7, and which were incurred from 4/20/14 to 1/22/15, pursuant to Sections 8(a) and 8.2 of the Act. The Arbitrator has already determined there is a causal connection between the shoulder treatment related to these bills. There is no evidence indicating that the treatment Petitioner received was unreasonable or unnecessary. Dr. Gross indicated that the treatment through his June 2015 examination was reasonable and necessary, and the subsequent conservative treatment was essentially what he recommended.

The Respondent is entitled to credit for any and all amounts paid towards the awarded expenses prior to the hearing date, and Respondent shall hold Petitioner harmless from any attempts to obtain reimbursement of the awarded medical expenses.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings regarding causation, the issue in this case is moot.

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

The Arbitrator notes that the parties have stipulated that all lost time benefits between 4/20/14 and 10/5/16 have been paid by Respondent, and Respondent is entitled to credit for same. Because the Petitioner is not seeking an award for such benefits in this matter, the Respondent's credit for these payments is only applicable to be applied to the pre-10/6/16 lost time.

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

Jennifer Galeski,

Petitioner,

17IWCC0798

vs.

NO: 15 WC 39593

SOI/Chester Mental Health Center,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 24, 2017, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision.

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

17IWCC0798

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

DATED: DEC 12 2017
o11/2/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

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

17IWCC0798

GALESKI, JENNIFER D
Employee/Petitioner

Case# **15WC039593**

16WC005366

CHESTER MENTAL HEALTH CENTER/SOI
Employer/Respondent

On 5/24/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4852 FISHER KERKHOVER COFFEY ET AL
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CHESTER, IL 62233

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1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

MAY 24 2017

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

17IWCC0798

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(a)

JENNIFER D. GALESKI
Employee/Petitioner

v.

CHESTER MENTAL HEALTH CENTER / STATE OF IL
Employer/Respondent

Case # 15 WC 39593

Consolidated cases: 16 WC 05366

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Herrin**, on **March 16, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **January 23, 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 **$32,278.78**; the average weekly wage was **$620.75**.

On the date of accident, Petitioner was **41** 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**. The Arbitrator notes that the parties stipulated that all TTD that was due and owing prior to 10/6/16 has been paid by Respondent, and is not being claimed at the time of hearing.

ORDER

The Arbitrator finds that the Petitioner's right shoulder condition is causally related to the January 23, 2015 accident.

Respondent shall pay Petitioner temporary total disability benefits of $413.83 per week for 23 weeks, commencing October 6, 2016 through March 16, 2017, as provided in Section 8(b) of the Act.

Respondent shall pay the reasonable and necessary medical services that are outlined and contained in Petitioner's Exhibit 7, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for any and all of the awarded medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

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

17IWCC0798

Signature of Arbitrator

May 15, 2017
Date

MAY 24 2017

STATEMENT OF FACTS

The parties presented for hearing for the above noted consolidated claims pursuant to Section 19(b) of the Act. The Respondent disputed the claim based on the issues of causal connection, liability for medical expenses and ongoing temporary total disability (TTD), and prospective medical treatment.

The Petitioner testified she was employed by Respondent as a Cook I at the Chester Mental Health Center (CMHC), and had been employed there for four years. On 4/20/14, she testified that she was lifting an approximate 20 pound pan of baked beans from a steamer when she felt her right shoulder pop. The Petitioner testified she immediately sought medical treatment with an orthopedist, Dr. Byrne, whom she had treated with previously, though not for the right shoulder. She testified she underwent an x-ray, was diagnosed with a right shoulder strain and underwent two weeks of physical therapy. After initially working light duty, she was released by Dr. Byrne to return to full duty work.

The incident report from Respondent, dated 4/23/14, indicates an accident history consistent with Petitioner's testimony, noting her shoulder went out and she had pain down the arm, into her collarbone and back, with weakness and reduced range of motion. (Rx6).

The Arbitrator notes no record of Dr. Byrne from April 2014 was located in the medical records submitted into evidence. There is a 4/23/14 note of Dr. Schabbing, diagnosing a right shoulder strain and restricting Petitioner's work duties. On 4/29/14, Petitioner noted some improvement but ongoing pain in the anterior shoulder and laterally at the subacromial bursa. Physical therapy was prescribed and restrictions were continued. On 5/5/14, Petitioner noted she felt a pop in her right shoulder while washing her hair, but felt like it popped into place and she felt much better. Given the resolution of pain, Dr. Schabbing released the Petitioner to full duty, noting no ongoing disability. (Px6).

Petitioner returned to Dr. Schabbing on 6/17/14, indicating she had returned to work and reported a three week history of progressively worsening right shoulder pain, with radiation to the neck and the right hand into the 4th and 5th fingers. She indicated no reinjury had occurred. Therapy was again instituted with medication and work restrictions. On 7/1/14, Dr. Schabbing noted Petitioner's therapy was not being approved, and he prescribed x-rays and referral to Dr. Byrne. (Px6).

The records of Dr. Byrne (Perry County Orthopedics and Sports Medicine) that were submitted into evidence indicate visits of 1/20, 1/27, 2/12, 2/19, 2/24, 4/7/14 for the left shoulder and bilateral knees, including pain medication and injections, as well as Orthovisc injections for the knees. (Px4).

The 7/1/14 right shoulder x-ray was reportedly normal. (Px5). On 7/23/14, Petitioner reported to Dr. Byrne bilateral shoulder pain, noting she had been trying to lift an approximate 25 pound tray and had pain since that time. Only left shoulder x-rays were obtained, and Petitioner was diagnosed with bilateral shoulder degenerative joint disease with rotator cuff tendonitis. Both shoulders were injected, Celebrex was prescribed and Petitioner was given a work restriction regarding right shoulder work that she requested. (Px4).

A 7/18/14 right shoulder MRI reportedly showed no evidence of internal derangement or bony or fibrous impingement. No tendonitis or bursal effusion was indicated. (Px4 & 5). Petitioner followed up for the bilateral shoulders on 7/28/14, and was noted to have a history of Ehlers-Danlos syndrome. She was there for review of left shoulder MRI, which showed osteoarthritic changes with a hypoplastic glenoid. Dr. Byrne indicated he believed the majority of her left shoulder pain was due to osteoarthritis and did not recommend surgery, but offered to refer her to a shoulder specialist. Petitioner declined and was returned to work and referred to pain management "for her shoulders as well as her total body pain". (Px4).

A memo of the Respondent in evidence indicates the Petitioner worked light duty from 4/23 to 5/4/14 and again from 6/18 to 7/31/14. (Rx6).

Petitioner was evaluated for Ehlers-Danlos syndrome at Perry County Hospital on 9/30/14 on referral from Dr. Schabbing. The report states Petitioner previously saw Dr. Kim in December 2013 for fibromyalgia, noting this was being managed with mediation in pain management. Petitioner reported hypermobility since childhood. She also reported "ongoing myalgias and arthralgias secondary to fibromyalgia as well as fatigue and poor sleeping patterns." Dr. Ronholm noted hypermobility on exam mainly in Petitioner's bilateral knees, elbows and wrists. Genetic testing for Ehlers-Danlos syndrome was prescribed. (Px5).

On 11/19/14 Petitioner reported bilateral shoulder pain and Dr. Byrne noted a history of bilateral shoulder osteoarthritis. Petitioner reported she was exercising more and did not want to take Vicodin, and she requested bilateral injections, which Dr. Byrne performed. Petitioner again declined a specialist referral. (Px4).

Petitioner also saw Dr. Green at Perryville Family Care, the same facility as Dr. Schabbing. She complained of posterior and right neck pain that radiated to the upper back and right arm. There was no obvious precipitating injury. She was referred to the ER for neck pain and headache evaluation. (Px6). At Perry County Memorial on 1/13/15, Petitioner complained of headache and neck pain that extended down the spine into the right arm. The subsequent evaluation focused on the head, with no diagnosis made relative to the right arm. (Px5).

On 1/23/15, the Petitioner testified that she was putting an approximately 60 pound pan of pasta into a steam table at CMHC when she again experienced a "pop" in the shoulder and felt excruciating pain. She immediately sought treatment on site with the Respondent (see Rx3) and was directed to the Chester Memorial Hospital ER. The facility indicates Petitioner was lifting a pan of mac and cheese to a steam table when she felt a pop in her right shoulder with severe pain in the shoulder and down the right arm. X-ray reflected a very shallow glenoid fossa that was likely congenital, but was otherwise normal. Diagnosis was non-specific right shoulder injury. It was noted that she had a history of prior surgeries to the left shoulder (x2), left wrist and right knee, as well as a history of Ehlers-Danlos syndrome. She was held off work for 4 days and referred to her primary provider Dr. Schabbing. (Px2).

Documentation from Respondent regarding Petitioner's report of this accident is dated 1/24/15 and is consistent with her testimony in terms of the mechanism of injury. Symptoms of stabbing pain from the anterior to posterior shoulder radiating down the right arm to the hand were noted. Petitioner reported weakness and difficulty lifting. (Rx3).

Petitioner followed up with Dr. Schabbing on 1/27/15. She reported a work accident with right shoulder pain down the elbow and wrist with occasional numbness. Dr. Schabbing noted: "Patient has injured this shoulder before and has a complicated history of hypermobility syndrome. She did feel and heard a pop when maneuvering a heavy pan of food. She described this as a hot knife through her shoulder." She was referred to Dr. Byrne. (Px6).

On 1/28/15, Petitioner saw Dr. Byrne, but the report only notes complaints of left shoulder and bilateral knee pain. Petitioner noted a re-exacerbation of her pain, though it was unclear if this related to the shoulder or knees or both, and indicated she was ready for a referral to a shoulder specialist. She was referred to Dr. Chamberlain in St. Louis. This report does not reflect a history of the 1/23/15 accident. (Px4).

There also is a 1/28/15 note from Dr. Turk at Chester Memorial Hospital indicating Petitioner was released to full duty. (Rx3).

Petitioner then returned to Dr. Byrne on 2/2/15, noting a new complaint of right shoulder pain. Petitioner reported she initially injured the shoulder in July 2014, and that while she improved with therapy, "she always did have some pain." She reported picking up a 50 pound tray of macaroni and cheese to shoulder height on 1/23/15 and felt a pop in the right shoulder with anterior pain that radiated down the arm and posteriorly. X-rays showed no acute findings. Dr. Byrne was concerned about a bicep tear and possible labral tear and/or subscapularis injury, and obtained a 2/12/15 right shoulder MRI arthrogram. This showed a tear of the posterior glenoid labrum, and was otherwise normal. Petitioner also underwent bilateral knee Orthovisc injections on 2/2/15.

Petitioner followed up with Dr. Byrne to review the right shoulder MRI and complained of significant pain whenever she moved the shoulder, which made examination difficult. The diagnosis was posterior labrum tear, bursitis, biceps tendonitis and scapular thoracic dyskinesia. Therapy and an injection were prescribed, with the injection performed on 2/23/15. (Px4).

Therapy for the right shoulder was instituted at Perry County on 2/25/15, and the initial evaluation reflected a consistent history of the 1/23/15 injury. She underwent 18 sessions through 4/30/15. Petitioner noted good progress per the notes, but on 4/7/15 reported she slept wrong with muscle pain in the right shoulder and upper trapezius. She also reported pain with overhead use of the arm, and by mid-April was more severe pain. At the last visit the therapist noted Dr. Byrne was prescribing right shoulder surgery. (Px5).

On 4/1/15, Petitioner reported improvement, mainly with therapy, and that she wanted to get back to her regular job. Dr. Byrne released her to work with no work over shoulder level and a 20 pound limit with the right arm. (Px4).

Petitioner returned to the Chester Memorial ER on 4/26/15 with complaints of a two day history of worsening right shoulder pain, noting she was in therapy and had been working light duty for over a month. She indicated that she had not sustained a reinjury. The triage note states she awoke Friday night with increased pain, while the physician's note states she developed pain following a therapy session. She was advised to follow up with primary care (Px2). The Petitioner returned to the Chester Memorial ER on 5/12/15 for a left thumb laceration at work. She was hospitalized for hypoxic respiratory failure in May of 2015. (Px2). On 6/18/15, Dr. Schabbing's records note a history of migraines over the years that tended to cluster when her asthma was not under control, and his records from 2014 to 2016 note multiple asthma exacerbation situations. (Px6).

At a 4/29/15 follow up, Dr. Byrne noted Petitioner complained of severe right shoulder pain and wanted to have surgery versus further ongoing conservative treatment. Dr. Byrne prescribed arthroscopic surgery, which would involve subacromial decompression and would otherwise be diagnostic for rotator cuff and/or labral tears, noting those would be debrided or repaired, if possible, if same were found. Work restrictions were continued in the meantime. (Px4).

The Petitioner was examined by Dr. Gross on 6/4/15 at Respondent's request pursuant to Section 12 of the Act. She reported lifting a 50 pound pan of macaroni and cheese onto a steam table on 1/23/15, and feeling a pop in her right shoulder with severe pain. He noted she had a right shoulder strain about a year prior versus a cuff tear. The report of Dr. Gross reflects his review of Petitioner's medical records. She was currently complaining of pain over the anterior and posterior aspect of the right shoulder, worse with activity, and pain and popping with overhead activities. She did not complain of neck pain or pain radiating into the arm. She reported that an injection after the initial 2014 injury provided improvement and allowed her to return to full duty without significant further problems. Recent therapy and injection did not provide significant improvement. Dr. Gross noted the findings on right shoulder x-rays from 7/1/14, 2/2/15, and 6/4/15, as well as MRIs from 7/18/14 and 2/12/15. This included dysplasia of the glenoid posteriorly, no fractures and/or dislocations, and abnormalities in the anterior and posterior glenoid as well as the biceps tendon anchor. There was degeneration of the AC joint. He also noted Petitioner's history of Ehlers-Danlos syndrome. (Px1).

Dr. Gross indicated objective findings of restricted range of motion, pain with range of motion, positive signs of labral pathology and degeneration. Films indicated hypoplasia of the posterior glenoid and tearing of the anterior and posterior labrum. There was some guarding with attempts at range of motion, but no other abnormal behavior noted. Diagnosis was right shoulder osteoarthritis and labral tear. Dr. Gross opined that the hyperplasia and labrum tearing were degenerative. He further opined that there was no significant difference between the 7/1/14 and 2/12/15 MRIs, stating: "This would be consistent with her having underlying damage to her shoulder related to a congenital abnormality or Ehlers-Danlos syndrome and hypermobility of her shoulder. I do not believe that her injury has caused any significant pathology in her shoulder besides a strain of her right shoulder which may have aggravated underlying degeneration of her shoulder." He indicated treatment to date had been reasonable and necessary for her 1/23/15 shoulder injury. Dr. Gross recommended an injection, anti-inflammatory medication and physical therapy for 6 to 8 weeks, noting it appeared this protocol had helped her in the past. He recommended avoiding surgery given her underlying degeneration and Ehlers-Danlos syndrome, as there is potential for failure of any repair of connective tissue tearing. He believed Petitioner would be able to return to activities at work, but could have future problems regarding the shoulder related to degeneration and Ehlers-Danlos. (Px1).

On 6/17 and 7/20/15, Petitioner saw Dr. Byrne and reported rolling her right ankle multiple times", and that she had a significant history of Ehlers-Danlos disease. On 8/24/15 she reported that her right hip had popped out twice, and that she has chronic SI joint dysfunction issues. (Px4).

In September 2015, Petitioner returned to Dr. Byrne reporting Dr. Gross' recommendation of injection and therapy. She noted her right shoulder was worse and she had been to the ER on 9/6/15 and was prescribed muscle relaxers and pain medication. Dr. Byrne injected the right shoulder, prescribed therapy and indicated the same work restrictions he had previously – no work over the shoulder and no lifting over 20 pounds with the right upper extremity. On 10/26/15, Petitioner reported no improvement with the injection with increased pain and decreased range of motion. She noted recent hospitalization for respiratory problems. Dr. Byrne noted he did not believe he could perform surgery at his facility given Petitioner's lung function and recommended she follow up with a surgeon at a facility with a higher level of care, and she could otherwise return as needed. (Px4). Petitioner testified that she was referred to Dr. Chamberlain.

On 9/6/15, Petitioner returned to the ER with complaints of right shoulder pain after working two days of overtime. She noted no new injury, indicating that any movement of the right arm increased her shoulder and upper right arm pain. X-ray findings were the same as they were in the January 2015 films. (Px2). She again returned on 9/26/15 and 12/1/15 for flare-ups of right shoulder pain, noting no specific reinjury. (Px2). The Arbitrator notes multiple other 2015 and 2016 ER visits that are unrelated to the current case. (Px2).

Petitioner attended therapy from 9/25 to 11/6/15, at which point it was noted she would be seeing Dr. Chamberlain. The records generally note complaints of 7 to 9 out of 10 pain, with Petitioner noting increased symptoms with use of the right arm. The Arbitrator notes that towards the end of this period the Petitioner noted that Dr. Byrne wanted her to see another physician for evaluation because there was a potential complication with surgery. What this complication was wasn't indicated. (Px3).

Petitioner initially saw surgeon Dr. Chamberlain on 11/9/15. She reported her right shoulder pain began in July 2014 when she was lifting a heavy pan at work. She improved with injection, and then had a second incident in January 2015 when lifting a 60 pound food pan, she felt a pop and pain in the right shoulder. She had no relief after that with therapy or injection and was scheduled for surgery until the Respondent requested an independent exam. She again underwent therapy and a third injection with no relief. She noted her history of Ehlers-Danlos syndrome. 11/9/15 right shoulder x-rays reflected a hypoplastic, irregular right glenoid, and was otherwise normal, and Dr. Chamberlain reviewed 2/12/15 MRI films and interpreted them as reflecting a posterior labral tear. Diagnosis was glenohumeral arthritis and biceps tendinosis in the setting of posterior labral tear. He recommended an injection into the glenohumeral joint, which was performed on 11/24/15. An updated MRI would be prescribed if she failed to improve. (Px1).

Petitioner followed up with Dr. Chamberlain on 12/15/15, and she reported 2 to 3 days of great relief with the injection, but her pain returned and she indicated she was unable to work. His diagnosis was likely right biceps tenosynovitis and refractory rotator cuff tenderness/bursitis in the setting of glenoid deformity and arthritis. Dr. Chamberlain suspected that, based on improvement with the injection, the pain was due to arthritis and possible biceps tenosynovitis. Diagnostic arthroscopy was prescribed for the right shoulder with likely biceps tenotomy, subacromial decompression and debidement of the glenohumeral joint. The doctor also restricted the Petitioner as to her right arm to 5 pounds of lift/push/pulling, and avoidance of overhead, outstretched or repetitive motion, as well as avoidance of grip/grasp/twist/pinch. (Px1).

Dr. Chamberlain saw Petitioner on 5/3, 5/23 and 6/27/16, however his notes from these dates reference the left shoulder, with Petitioner reporting activity related pain with range of motion and normal daily activities. It also noted Petitioner's left shoulder was feeling worse lately than the right. The diagnosis was early arthrosis with recurrent left rotator cuff tear in the setting of a connective tissue disorder, possibly Ehlers-Danlos syndrome, with substantial glenoid retroversion and posterior humeral subluxation. (Px1).

On 11/28/16, Dr. Chamberlain noted Petitioner was there for a right shoulder reevaluation, noting he saw her the prior year after a work injury. Petitioner stated that the injury occurred "a couple years ago" when she was lifting a 50-60 pound container of macaroni and cheese and felt a pop in the shoulder. She did not have right shoulder pain prior to that, and subsequently had persistent pain which impacted right shoulder function. The pain is mainly anterior, worse with lifting, and the pain sometimes radiates down the arm into the hand. Exam notes range of motion limited by pain and reasonable strength. X-rays showed largely unchanged (versus 11/9/15) glenoid dysplasia with mild to moderate arthrosis, and that was Dr. Chamberlain's diagnosis. They discussed that Petitioner has a complex deformity of the glenoid which complicates treatment options. He had previously

recommended an MRI, and did so again. Dr. Chamberlain limited Petitioner to no overhead lifting and no lifting over 10 pounds. (Px1).

On 12/12/16, Petitioner reported increased symptoms that were radiating down the arm to the hand. Updated MRI was noted to indicate dysplasia of the glenoid with a hypertrophic posterior labrum, a small pair labral posterior cyst, and glenohumeral arthrosis, but no evidence of a rotator cuff tear. In addition to the shoulder diagnosis, Dr. Chamberlain noted Petitioner was complaining of symptoms that were likely from sources outside of the shoulder, for which he recommended a physiatry evaluation. As to her right shoulder arthritis, he recommended continued conservative management and clinical observation, noting Petitioner should try to avoid shoulder arthroplasty for as long as she could. (Px1).

Petitioner testified that she remains under restrictions from Dr. Chamberlain, including no lifting over 10 pounds and no over the shoulder lifting, and that she worked light duty in accordance with these restrictions until the Respondent no longer accommodated them. She noted if Chamberlain testified that she injured the right shoulder in July 2014, this would have been a miscommunication. She received TTD benefits up until 10/5/16. The Petitioner testified that because conservative treatment had been exhausted, Dr. Chamberlain wanted to proceed with surgery, and that she wished to undergo the surgery. She testified she is in constant pain and she cannot sleep, and that there are days when cannot dress herself and cannot brush her own hair.

The Petitioner agreed that she suffers from Ehlers-Danlos syndrome, diagnosed in approximately 2012, and is extremely hypermobile. This has caused her a lot of problems with respect to her left shoulder, including two prior left rotator cuff repairs (she thinks in 2010 and 2011), fusion of the bilateral SI joints, as well as injections. The Petitioner denied any complaints or treatment for the right shoulder prior to the 4/20/14 and 1/23/15 work injuries. On cross exam, Petitioner agreed she had already been diagnosed with Ehlers-Danlos when she started working for Respondent four years prior to the hearing date. She indicated her left shoulder problems were not due to any work injury. She hasn't applied for non-occupational disability benefits, testifying she has not looked into whether she is eligible. She has always worked in the kitchen for Respondent, indicating she initially began as a support worker there.

Board certified orthopedic surgeon Dr. Chamberlain testified via evidentiary deposition on 1/27/17. (Px1). He first saw the Petitioner on 3/16/15 regarding her left shoulder, noting complaints of pain with heavy and/or above the shoulder lifting, with a history of left rotator cuff repair and Ehlers-Danlos syndrome with hypermobile joints. There were no right shoulder complaints elicited at that time. (Px1).

As to the initial right shoulder examination on 11/9/15, Dr. Chamberlain noted Petitioner reported that her pain began after lifting heavy food at work around July 2014, and that an MRI had revealed a labral tear. She had limited strength and ability to elevate the right arm, which was likely pain related, and shoulder inflammation / impingement. Dr. Chamberlain recommended an injection into the shoulder joint, and in December the Petitioner reported she had 2 to 3 days of relief, which Chamberlain interpreted as confirming her pain was likely due to arthritis or pathology within the ball and socket joint, which included the labral tear seen on MRI and the arthritis seen on x-rays. Dr. Chamberlain discussed arthroscopic surgery to debride the inflammation to address sources of pain such as arthritis, but also noted this could have unpredictable results and "would not get rid of her arthritis problem, etc." His understanding is Petitioner opted against surgery. (Px1).

Subsequent to a May 2015 visit for the left shoulder in May 2015, the Petitioner next followed up for the right shoulder on 11/28/16. The primary finding during 11/16 exam was limited range of motion due to pain, and Dr. Chamberlain again indicated symptoms were related to arthritis and degenerative joint disease. He obtained a repeat right shoulder MRI on 12/12/16, which showed a hypertrophic posterior labrum and some tearing or a

paralabral cyst in the back of the labrum, along with arthritis. He also noted she was complaining of other symptoms that were likely not coming from the shoulder, and recommended evaluation in this regard. (Px1).

Dr. Chamberlain testified that Ehlers-Danlos syndrome is related to a congenital defect or problems in the connective tissue which can manifest as multi-directional shoulder instability, where it is "loose" and can be dislocated easily (i.e. makes a person more prone to dislocation), and can at times be related to injury. Such dislocations can result in tears of the soft tissue structures. However, Dr. Chamberlain also testified that it was unclear whether such people are more susceptible to a lifting or pulling injury, as there was no evidence to suggest lifting would cause an instability event. (Px1).

Dr. Chamberlain was not aware of Petitioner having right shoulder treatment prior to her work injury. He opined that the right shoulder pain and symptoms might or could have been caused by her work injuries, mainly based on the temporal relationship of the accident to symptoms onset. The lifting incident on 1/23/15 also could have caused pain and symptoms in the shoulder. Again, while Dr. Chamberlain recommended conservative care for as long as Petitioner could tolerate, he noted that her arthritis and degenerative joint disease could ultimately require arthroplasty. He testified that, since the accident(s) caused the pain, and that surgery would be based on treating that pain, an arthroplasty would be related to her work injuries. If she underwent this shoulder replacement surgery, Dr. Chamberlain testified the Petitioner would likely require permanent lifting restrictions of no more than 40 or 45 pounds with her right arm, and at her age, there would be a strong likelihood of needing a revision surgery down the road. He couldn't recall if he gave her ongoing work restrictions, but testified he would generally recommend she not perform activities repetitively that cause her pain to linger. (Px1).

On cross exam, Dr. Chamberlain agreed both the 2/12/15 and 12/12/16 right shoulder MRIs showed a labral tear. He agreed MRI also showed a labral tear in the Petitioner's left shoulder. While he agreed that the "shape or morphology of the labral tear is present in both shoulders", the symptoms in the right shoulder occurred subsequent to an injury. Ehlers-Danlos syndrome is rare, with less than 3% of Chamberlain's patients having the condition. He agreed it is possible the Petitioner could have suffered the labral tear regardless of whether she was working or not. (Px1).

Board certified orthopedic surgeon Dr. Gross testified on 8/5/16. (Rx5). He indicated that Ehlers-Danlos syndrome is a connective tissue disease where a person can have excessive laxity of the joints, and that he has had patients with this problem. He noted a malshaped right glenoid and abnormalities of the right glenoid labrum per the films, as well as early degenerative changes of the glenohumeral joint. With regard to his diagnosis of right shoulder osteoarthritis with labral tearing, Dr. Gross opined it was not caused by the work related injury. He noted she had the previous 2014 injury to the right shoulder, and that the MRI from 2014 showed no significant difference versus 2015 films. Both showed some glenohumeral joint degeneration and abnormalities to the glenoid and glenoid labrum, which was likely congenital or related to Ehlers-Danlos disease. He also noted one of his partners had performed surgery on Petitioner's left shoulder, and that a review of the left shoulder MRI from 2011 showed the same findings that were in the right shoulder. (Rx5).

On cross-examination, Dr. Gross agreed that when he saw Petitioner she had not yet reached maximum medical improvement, and he recommended further care at that time. He did not have any additional information or records regarding the Petitioner's condition subsequent to his examination. If, hypothetically, she continued to have problems after the recommended care, he testified "she could have further treatment". He indicated she was a little young to have shoulder arthroplasty, but that any such procedure would be related to the underlying osteoarthritis. (Rx5).

Dr. Gross agreed Petitioner also had a 2014 work injury, and that he did not see any medical records indicating any pathology in the right shoulder prior to that time. He also agreed Petitioner had been able to return to full duty with conservative treatment following the 2014 accident. With regard to Ehlers-Danlos syndrome, Dr. Gross testified sufferers can have recurrent instability and dislocations of joints, which can cause them to develop degeneration over time. They can also have tendon and ligament problems due to the soft tissue involvement of those structures. He agreed that such people can have an increased risk of injury with undue stress on the joints. (Rx5).

If the Petitioner failed to improve with conservative treatment, Dr. Gross indicated she would probably be restricted from lifting at or above the shoulder level, as well as a weight limit on lifting below shoulder level. Essentially, Dr. Gross testified that the 2014 and 2015 accidents likely aggravated the Petitioner's degeneration, but did not cause any change in pathology. He believed that the glenoid abnormalities were chronic in nature, and due to Ehlers-Danlos or other congenital problem. He believed the relevant pathology here was in the shoulder joint itself, not outside of it, which was why Dr. Byrne's subacromial injection didn't help. Dr. Gross testified: "I think she has a degenerative shoulder. And it's going to have symptoms throughout the rest of her life as she does activities." (Rx5).

The Petitioner's alleged causally related medical expenses were submitted into evidence as Px7. It appears that the vast majority of these expenses have been paid, and the parties have stipulated that the Respondent is entitled to credit for any expenses paid prior to the hearing date.

CONCLUSIONS OF LAW

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

The Petitioner sustained her burden of proof that her right shoulder condition of ill-being is causally related to her 1/23/15 accident.

It is clear that the Respondent's defense in this case is based on Petitioner having a preexisting condition of Ehlers-Damlos syndrome, which resulted in preexisting degeneration in the right shoulder. In such preexisting condition cases, compensability depends on the employee's ability to show that a work accident aggravated or accelerated the preexisting disease such that the current condition of ill-being can be said to have been casually-connected to the work-related injury and not simply the result of a normal degenerative process. *Sisbro, Inc. v. Industrial Comission*, 207 Ill. 2d 193, 797 N.E.2d 665, 278 Ill.Dec. 70, (2003). It is axiomatic in Illinois workers compensation law that employers take their employees as they find them. When a 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. Where an employee has a preexisting condition which may make her more vulnerable or prone to injury, recovery will not be denied if the claimant can prove that the employment was also a causative factor. The accident need not be the sole or primary causative factor, so long as it is a causative factor in the resulting condition of ill-being.

Here, the parties stipulated that an accident occurred on 1/23/15. The documentation in Rx3 supports that the Petitioner promptly reported the accident, and the medical records reflect that she promptly sought treatment. The evidence indicates Petitioner reported to Perry County Hospital in 9/14 that she has had joint laxity since she was a child, and she testified she was diagnosed with Ehlers-Danlos syndrome in 2012. Despite this, and multiple

other areas of concern that appear to have been impacted by this syndrome, there is no evidence that Petitioner had any right shoulder problems or treatment prior to 4/20/14.

While there is evidence that she had a prior right shoulder injury on 4/20/14 (the subject of consolidated case 16 WC 5366), the Arbitrator finds that the right shoulder condition at that time had resolved, and the Petitioner returned to her full duty employment until the 1/23/15 accident. At that time, she was lifting, and the Arbitrator would infer reaching, to place a 50 to 60 pound tray of food into a steam table. She testified she heard a pop in the right shoulder at that time with immediate symptoms. She also testified that the conservative protocol that helped to resolve her condition after the 4/20/14 accident did not work to resolve her condition after the 1/23/15 accident.

The testimony of Dr. Chamberlain and Dr. Gross indicates that the Petitioner's pain is likely coming from the shoulder joint itself, and is very likely related to degeneration, much of which is likely due to the Ehlers-Danlos syndrome. It is quite clear to the Arbitrator that the pathology or pathologies in the Petitioner's right shoulder are significantly due to Ehlers-Danlos syndrome, and the degeneration that occurred, at least in part, due to the syndrome. Dr. Chamberlain and Dr. Gross have indicated that the labral tear appears to be due to the glenoid problems the Petitioner has due to the disease. However, both doctors testified that the creation of symptoms, or minimally the worsening of any symptoms, was due to the work accidents. Under a *Sisbro* analysis, the Arbitrator finds that both the 4/20/14 and the 1/23/15 accidents contributed to the right shoulder condition, but that Petitioner's condition at the time of hearing was due to the 1/23/15 accident, as it produced symptoms that have not resolved. In reviewing this Supreme Court case, it is difficult for the Arbitrator to see how it could be determined in this case that the work activity, lifting a heavy pan to put into a steam table, did not increase the risk of injury to the Petitioner's right shoulder, and thus act as at least a causative factor in the Petitioner's present right shoulder condition. The Arbitrator believes the evidence in this case is quite clear that the Petitioner is prone to joint problems due to Ehlers-Danlos syndrome. However, these accidents, per the Petitioner's testimony and the supporting medical, appear to have triggered symptoms and exacerbated the preexisting right shoulder joint degeneration in the joint/socket, as there is no evidence she had symptoms prior to the accident dates.

Again, the Petitioner reported specific right shoulder injuries on 4/20/14 and 1/23/15. The incidents did not involve situations where there was a gradual increase in symptoms with basic lifting activities, or a sudden increase with passive activity, but rather involved specific incidents where the Petitioner was lifting and manipulating trays of food at a steam table. The Petitioner's treating physicians, including Dr. Schabbing, Dr. Bryne, and Dr. Chamberlain all related the Petitioner's right shoulder complaints to her work injuries. Dr. Gross admits the work injuries may have aggravated the Petitioners condition, even if degenerative in nature. No evidence was presented at trial which indicates the Petitioner had ever even complained of her right shoulder prior to these injuries. While the Petitioner may be more vulnerable to injury, as suggested by Dr. Gross, the Respondent has presented no evidence to suggest a cause of her complaints, aside from the work injuries suffered in 2014 and 2015, respectively. Plus, as noted, the law is clear that you take the Petitioner as you find her, which includes a predisposition to injury. The Arbitrator finds that the work accidents suffered by the Petitioner were a causative factor in her right shoulder condition of ill-being, and that the 1/23/15 accident resulted in the current condition of ill-being. It appears the incident of 1/23/15 significantly exacerbated the Petitioner's right shoulder condition, and constituted an intervening accident to the extent that the Arbitrator finds that the preponderance of the evidence indicates the Petitioner's current condition is mainly related to this accident.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL

APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Respondent shall pay the Petitioner's medical expenses which are contained in Px7, and which were incurred from 1/23/15 to the present, pursuant to Sections 8(a) and 8.2 of the Act. The Arbitrator has already determined there is a causal connection between the shoulder treatment related to these bills. There is no evidence indicating that the treatment Petitioner received was unreasonable or unnecessary. Dr. Gross indicated that the treatment through his June 2015 examination was reasonable and necessary, and the subsequent conservative treatment was essentially what he recommended.

The Respondent is entitled to credit for any and all amounts paid towards the awarded expenses prior to the hearing date, and Respondent shall hold Petitioner harmless from any attempts to obtain reimbursement of the awarded medical expenses.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator notes that this is a difficult issue in this case. The Petitioner already has a left shoulder condition, including surgeries, that appears to have been compromised to at least some degree by the existence of Ehlers-Danlos syndrome. Dr. Gross indicates that he did not recommend surgery for Petitioner, as there is a likelihood of failure, but the Arbitrator believes that this relates to surgery involving structural repair. Dr. Byrne did not opine in this regard, but the Petitioner's therapy notes indicate she was made aware that there could be some sort of complications with surgery that led her to also understand that Byrne wanted her to be evaluated by someone else. Dr. Chamberlain also did not recommend structural repair surgery. Both he and Dr. Gross indicate that the only real surgery that could help Petitioner would be right shoulder arthroplasty, i.e. shoulder replacement surgery. Both doctors also indicate that a person should not have such a surgery at too young an age because they otherwise have a strong likelihood of needing revision surgery in the future. Dr. Gross specified that the Petitioner should wait to have such surgery until she absolutely could no longer deal with her symptoms. He also testified that it was his understanding, after discussing it with Petitioner, that she had declined such surgery. The Petitioner's testimony at trial was in opposition to this. The Arbitrator also notes that the Petitioner has multiple other health considerations that will likely be needed to be taken into account prior to any such surgery.

Significantly, Dr. Chamberlain initially was recommending arthroscopic surgery back in December 2015, and he testified that Petitioner declined. He testified that such a surgery was unpredictable, and would not resolve her arthritis. He also indicated in his more recent records and in his testimony that some of the Petitioner's symptoms could be coming from another anatomic area other than the right shoulder, and recommended physiatry evaluation regarding same. It does not appear that this has been done yet, and that any such evaluation would not be causally related to the accident.

These are all important considerations, and most importantly, the Arbitrator finds that, as of the time of the hearing, Dr. Chamberlain was not specifically recommending any particular surgery. He did indicate that arthroplasty was an option, but also indicated that the Petitioner should wait on such surgery for as long as possible. As there is no current pending recommendation for same, the Arbitrator finds that this issue is premature as of the time of trial, and declines to award such surgery. Again, the Arbitrator notes that there is a causal connection between the Petitioner's current right shoulder condition and the 1/23/15 accident, and thus if it is clearly determined by Dr. Chamberlain that arthroplasty is recommended, such surgery would be causally related as well.

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

The Arbitrator finds that the Petitioner is entitled to TTD from 10/6/16 through the 3/16/17 hearing date. Petitioner testified in unrebutted fashion that her restrictions had been accommodated by Respondent, but that this ended at some point and she only received TTD benefits until 10/5/16. Dr. Chamberlain's November 2016 note indicated ongoing work restrictions. While his December 2016 note was silent as to restrictions, and he testified he could not recall if he kept her on restrictions, he did note that she would not be able to repetitively do things that caused right shoulder pain. Dr. Gross also agreed that if Petitioner had failed to improve following the treatment he recommended, she would likely need lifting restrictions. The Arbitrator finds that the greater weight of the evidence supports that Petitioner required ongoing work restrictions as of the date of hearing.

The Arbitrator notes that the parties have stipulated that all lost time benefits between 4/20/14 and 10/5/16 have been paid by Respondent, and Respondent is entitled to credit for same. Because the Petitioner is not seeking an award for such benefits in this matter, the Respondent's credit for these payments is only applicable to be applied to the pre-10/6/16 lost time.

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

Sandra Molina,

Petitioner,

vs. NO: 04WC 06671

Cook County,

Respondent, 17IWCC0799

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 3, 2016 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that commencing January 22, 2016, Respondent pay to Petitioner the sum of $616.55 per week for life under §8(f) of the Act for the reason that the injuries sustained caused the total permanent disability of Petitioner.

IT IS FURTHER ORDERED BY THE COMMISSION commencing on the second July 15 after the entry of this Award, Petitioner may become eligible for cost-of-living adjustments, paid by the Rate Adjustment Fund, as provided in Section 8(g) of the Act.

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

17IWCC0799

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

DATED: DEC 14 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

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CJD/rlc
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

MOLINA, SANDRA
Employee/Petitioner

Case# 04WC006671

COOK COUNTY
Employer/Respondent

17IWCC0799

On 5/3/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0059 BAUM RUFFOLO & MARZAL LTD
SAMUEL J RIFFOLO
33 N LASALLE ST SUITE 1710
CHICAGO, IL 60602

0132 COOK COUNTY STATE'S ATTORNEY
ASA JEREMY SCHWARTZ
500 RICHARD J DALEY CENTER
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

Sandra Molina
Employee/Petitioner
V.
Cook County
Employer/Respondent

Case # **04WC6671**

17IWCC0799

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **April 30, 2013 and January 21, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 8, 2003**, 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 $**48,095.84**; the average weekly wage was $**924.82**.

On the date of accident, Petitioner was **51** years of age, single with **2** dependent children.

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

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

Respondent shall be given a credit of $**284,846.10** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**284,846.10**.

Respondent is entitled to a credit of $**3,157.06 pursuant to the stipulation of the parties for related medical** under Section 8(j) of the Act.

ORDER

Respondent shall be given a credit of $3,157.06 for medical benefits paid by the group carrier and Respondent shall hold the Petitioner fully harmless and indemnified from any and all claims by providers of the services for which Respondent is receiving credit, as provided in Section 8(j) of the Act and from any and all claims by the group carrier for reimbursement.

Respondent shall be given credit for $3,377.74 for medical benefits it paid directly under Section 8(a) and/or 8.2 of the Act.

Respondent shall reimburse Petitioner $3,193.99 for her out-of-pocket related medical expenses.

Respondent shall pay for all the related reasonable and necessary medical care charges in the amount of $55,808.86 pursuant to their statutory obligations as defined by Sections 8(a) and 8.2 of the Act that remain unpaid .

Respondent shall pay Petitioner temporary total disability benefits of $616.55 per week for 528 1/7th weeks commencing January 7, 2004 through January 21, 2016, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $284,846.10 for temporary total disability benefits that have been paid.

Respondent shall have a credit for all amounts paid to or in behalf of Petitioner on account of said accidental injury.

Respondent shall pay to Petitioner permanent and total disability benefits of $616.55 per week for life commencing on January 22, 2016.

Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, as paid by the Illinois Rate Adjustment Fund, as provided in Section 8(g) of the Act.

Petitioner's petition for penalties and attorney fees is denied, because the Respondent had a reasonable basis to believe that Petitioner had been released to light duty.

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

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

Milton Black

Signature of Arbitrator

May 3, 2016
Date

MAY 3 - 2016

FINDINGS AND CONCLUSIONS

1. This case was previously tried pursuant to Section 19(b) of the Act. This Arbitrator found, *inter alia*, that a work-related accident occurred on December 8, 2003, that the Petitioner sustained causally related injuries, and that the Respondent should pay temporary total disability benefits and medical benefits. The Respondent filed and then voluntarily dismissed a Review. This case was then remanded by the Commission for additional Arbitration proceedings.

2. The present Arbitration proceedings, which include the issue of permanency, commenced on April 30, 2013 and concluded at a second hearing on January 21, 2016. The delay in the two hearings was as a result, in part, of a serious and unexpected medical condition incurred by an attorney as well as a serious, unexpected, and unrelated medical condition incurred by the Petitioner.

3. The Arbitrator has again had the opportunity to observe the Petitioner as she testified. The Arbitrator finds that the Petitioner remains credible and that her continuing credible testimony is corroborated by the consistent medical evidence.

4. **The Parties have stipulated** that the Respondent shall have credit for all medical payments made or to be made.

5. **The Parties have stipulated** that the Respondent shall have credit for all compensation payments.

6. **The parties have stipulated** to waive receipt of a written decision by certified mail have agreed instead to accept receipt of the decision by e-mail.

7. **Relating to the issue of temporary total disability compensation and credit**, the Arbitrator finds:
The Petitioner has previously been found to be temporary totally disabled from January 7, 2004 through June 1, 2006. She was never returned to work by her physicians (Petitioner's Exhibits 39, 42 and 43A and 43B). Dr. Luis Redondo, Dr. David Stewart, and Dr. Ravi Kumar consistently stated that the Petitioner was permanently and totally disabled (Petitioner's Exhibits 39, 30, 31, 42 and 43A and 43B). The Petitioner was still being kept off work as of the date of the hearing on January 21, 2016, a total of 528 1/7th weeks.

The Petitioner's average weekly wage has previously been found to be $924.82. Her temporary total disability rate was found to be $616.55. The Petitioner was paid at this rate by the Respondent for 462 weeks for a total of $284,486.10. The Respondent is to have credit for said payment.

The Petitioner claims, and the Arbitrator finds, that she has been off work due to her related injuries for 528 1/7th weeks and therefore is entitled to receive $325,626.44 in temporary total disability benefits. The difference between what was claimed by the Petitioner and what was paid by the Respondent is $40,780.34 (66 1/7th weeks at $616.55).

8. **Relating to the issue of causation**, the Arbitrator finds:
In the 19(b) Arbitration Decision , it was determined that the Petitioner's then current condition of ill being from her on-the-job accident of December 8, 2003 was to both knees, her right hip, her low back and both hands.

The Petitioner testified that since then she has had no further surgeries to her injured body parts. She testified that she had been referred by Dr. Redondo to Dr. Lim, a spine surgeon colleague, also at Midwest Orthopedic Consultants, who, after testing and examination, stated that her low back symptoms and complaints were from her job injury but were not amenable to surgery.

Dr. Redondo has recommended a right hip replacement and a subsequent left hip replacement. The need for these surgeries has been caused by the altered gait consequence that the Petitioner sustained as a result of her work related injuries. Dr. Redondo prescribed, however, that the hip replacements should be delayed and ought not to commence until she was ten years post her left knee replacement procedure, due to the heightened possible consequence of infections in her knees post-surgically if her hips were replaced before then.

The Petitioner is now ten years post left knee replacement surgery, but the Petitioner described that while she is ready to have this surgery, due to a non-related surgery to remove a tumor from her heart, she is medically prohibited for the next few months from having it.

Dr. Lim, Dr. Redondo and Dr. Stewart have sent the Petitioner for pain management treatment with Dr. Kumar.

The Petitioner testified that she has had no new accidents or injuries after December 8, 2003 and no other new medical conditions that have impacted the progress or severity of her related injury consequences.

Based upon the foregoing, the Arbitrator finds that the Petitioner's current condition of ill being regarding both knees, her low back, both hands, her right hip, as well as her left hip are causally related to the accident.

9. **Relating to the issue of unpaid unreimbursed medical bills**, the Arbitrator finds:

A. The Petitioner testified that some of the medical bills that the Respondent was ordered to pay remain unpaid. The Petitioner and the Respondent have agreed, however, that those few bills that remain unpaid are unpaid solely because the care providers have failed and/or refused to submit their charges in a standard, acceptable format (on H.C.F.A. forms). The Respondent has committed to the payment of these bills if and when so submitted.

B. The parties are aware that the law relating to Respondent's obligation to pay related medical has changed in substance twice during the pendency of this claim:

1) Prior to February 1, 2006, Respondent was to pay the usual and customary charges for related, reasonable and necessary care.

2) Effective February 1, 2006 was amended so that the Respondent was to pay for related, reasonable and necessary medical care pursuant to Section 8.2 of the Illinois Workers' Compensation Act, namely:

a) pursuant to the Illinois Workers' Compensation Medical Fee Schedule, or

b) the lesser of the actual charge, if less than the Illinois Workers' Compensation Medical Fee Schedule, or

c) the lesser amount that the provider agrees to accept.

3) Effective September 1, 2011 the Act was amended so that the Illinois Workers' Compensation Medical Fee Schedule would have a reduction of the amounts to be paid to the care providers by 30%; all else in the Medical Fee Schedule remained the same.

C. The Petitioner testified that some of the related medical incurred over the years were paid by the Respondent. She testified that the Respondent did not pay some of the related medical bills and that she, therefore, put some of that group of related medical expenses through her group medical insurance, that she paid some of it out-of-pocket, and that some of it remains unpaid.

The Petitioner introduced as Petitioner's Group Exhibit 35 a Medical Bill Summary that included the medical bills summarized on it as attachments. She also introduced as Petitioner's Group Exhibit 36, related medical charge receipts that the Petitioner received for out-of-pocket payments she made on those charges incurred after the close-of-proofs hearing on the 19(b) proceeding.

In summary, these exhibits revealed the following:

1)	TOTAL RELATED CHARGES	$70,199.86
2)	OUT-OF-POCKET PAYMENTS yet to be reimbursed	
	$2,885.79	
	308.00	
	TOTAL	$3,193.79
3)	TOTAL PAID BY RESPONDENT	$3,377.74
4)	TOTAL PAID BY GROUP	$3,157.06
5)	WRITE OFFS	$7,666.20
6)	BALANCE REMAINNG UNPAID	$55,808.86

The Arbitrator finds that all of these, with the exception of those charges that have been written off by the providers, are the responsibility of the Respondent to pay for the related, reasonable and necessary medical treatment that the Petitioner has received.

10. **Relating to the issue of the nature and extent of the injuries**, the Arbitrator finds:
The Petitioner's injuries were so medically significant that she could not return to work, in accordance with the orders of Dr. Redondo and Dr. Stewart (Petitioner's Exhibit 39, Petitioner Exhibit 42, Petitioner Exhibit 43A and 43B). In his more recent office notes Dr. Stewart pronounced that the Petitioner was permanently and totally disabled.

After the 19(b) Decision the Respondent retained Dr. Rajeev Khanna (Petitioner's Exhibit 27, dated September 10, 2009) and Dr. John Cherf (Petitioner's Exhibit 14, dated October 17, 2012) to perform independent medical examinations. The Respondent also had the Petitioner visit with its own physician, Dr. J. Mankowski. These physicians focused and opined regarding the Petitioner's right leg.

The Respondent retained E.P.S. Rehabilitation on April 7, 2008 to perform a vocational assessment and formulate a plan. Mr. Edward Steffan performed the assessment and, after reading all of the related medical records, met with her on July 15, 2008. Mr. Steffan prepared a report and concluded that it is reasonable to be of the opinion that the Petitioner is not a candidate for vocational rehabilitation services and should be re-evaluated upon reaching maximum medical improvement (Petitioner's Exhibit 26). On September 9, 2008, Respondent ordered E.P.S. to stop all work and to close its file.

Ms. Susan Entenberg, a vocational rehabilitation specialist, after meeting and interviewing the Petitioner and, after reviewing all of her records, concluded that the Petitioner could not return to her prior occupation as a correctional officer, that the Petitioner was not a candidate for vocational rehabilitation, and that a stable labor market does not exist for her (Petitioner's Exhibit 24, October 29, 2008). Ms. Entenberg performed an updated assessment on January 18, 2016 (Petitioner's Exhibit 25), and she concluded essentially that her opinions had not changed.

On April 21, 2010 Petitioner underwent a functional capacity evaluation at Physical Therapy Chicago, Ltd. (Petitioner Group Exhibit 28). Mr. Peter J. McMenamin concluded that the Petitioner fell into a light level of work capacity, but he noted that she was taking medications that impact or restrict her ability to drive (including to and from a prospective job), to perform cognitively demanding work, to exercise clear judgment or to work with any potentially dangerous equipment. He further concluded that she has decreased strength in her legs, especially the knees and loss of motion following bilateral knee replacements. His report states that the functional capacity evaluation confirms that she should use a cane

for walking long distances and should avoid carrying 2 handed loads on stairs with a limitation of 14 pounds. Mr. McMenamin concluded that her her current work capacity does not match the requirements for a correctional officer.

Mr. McMenamin noted that the functional capacity evaluation should not be interpreted as a release to work but that the findings in his report were to be submitted to make a return to work determination within the overall context of the Petitioner's medical status. Additionally, Mr. McMenamin advised that the upcoming hip replacement surgery, if it is to occur, carries with it a significant period of convalescence and rehabilitation.

Based upon the foregoing, the Arbitrator finds that the Petitioner cannot return to her prior occupation as a correctional officer, the Petitioner is not a candidate for vocational rehabilitation, and that a stable labor market does not exist for her. Therefore, the Petitioner has proved that she has met the requirements for an odd lot permanent total disability.

11. **Relating to the issue of Penalties and Attorney Fees,** the Arbitrator finds:
The Petitioner filed a petition for penalties and attorney fees on April 30, 2013 (Petitioner's Exhibit 16) at the commencement of the first hearing on permanency. The Respondent, by agreement, reinstated the Petitioner's temporary total disability benefits for a time and brought the temporary total disability benefits up to date.

The Respondent stopped temporary total disability benefits again as of November 15, 2013 explaining that the cut-off was due to an independent medical examination and report of its own human resources physician, Dr. Mankowski, opining that the Petitioner could return to light duty.

Based upon the foregoing, the Arbitrator finds that the petition for penalties and attorney fees should be denied, because the Respondent had a reasonable basis to believe that Petitioner had been released to light duty.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ronald Kurecki,
Petitioner,
vs.

NO: 10WC 00422

Fullhouse Signs, and Michael Frerichs
As Ex-Officio Treasurer of the State
Employee Benefit Fund,
Respondent,

17IWCC0800

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 28, 2016 is hereby affirmed and adopted.

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

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

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

DATED: DEC 14 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

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CJD/rlc
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KURECKI, RON
Employee/Petitioner

Case# 10WC000422

FULLHOUSE SIGNS AND MICHAEL FRERICHS AS EX-OFFICIO TREASURER OF THE STATE EMPLOYEE BENEFIT FUND
Employer/Respondent

17IWCC0800

On 4/28/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.40% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0924 BLOCK, KLUKAS & MANZELLA PC
BRYAN SHELL
10 W JEFFERSON ST
JOLIET, IL 60432

0000 FULLHOUSE SIGNS
1 S EASTERN AVE
JOLIET, IL 60432

5661 ASSISTANT ATTORNEY GENERAL
MALLORY ZIMET
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

17IWCC0800

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

RON KURECKI
Employee/Petitioner

v.

Case # **10** WC **00422**

Consolidated cases: **N/A**

FULLHOUSE SIGNS and
MICHAEL FRERICHS as EX-OFFICIO TREASURER OF THE STATE EMPLOYEE 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 **Robert Falcioni**, Arbitrator of the Commission, in the city of **New Lenox, Illinois**, on **April 7, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 3, 2009**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$360.00**; the average weekly wage was **$18,720.00**.

On the date of accident, Petitioner was **42** years of age, ***married*** with **3** dependent children.

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $90,310.35, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $320.00/week for 16 weeks, commencing October 13, 2011 through February 1, 2012, as provided in Section 8(b) of the Act, which is a total of $5,120.00

Respondent shall pay Petitioner permanent partial disability benefits of $320.00/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, which is a total of $20,000.00

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

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

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

Robert E. Johnson

Signature of Arbitrator

April 27, 2016

Date

APR 28 2016

17IWCC0800

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RON KURECKI, Petitioner, v. FULLHOUSE SIGNS, and MICHAEL FRERICHS AS EX-OFFICIO TREASURER OF THE STATE EMPLOYEE BENEFIT FUND Respondents.	)	No.: 10 WC 00422 Arbitrator: Robert Falcioni

RIDER TO ABITRATOR'S DECISION

IN SUPPORT of the Arbitrator's Decision regarding A (Employer Operating Under the Act); B (Employer/Employee Relationship); C (Accident); D (Date of Accident); E (Notice); F (Causal Connection); G (AWW); H (Age); I (Marital Status); J (Medical) and K (TTD) and L (Nature and Extent), the Arbitrator makes the following findings and conclusions:

FACTS

Petitioner testified as follows, and the undisputed facts extracted from the documentary evidence introduced into the record, show the following:

At the time of trial, the Petitioner was forty-nine (49) years old, married with three dependent children. The Petitioner was employed by Respondent working in a manual labor position, where he would load/unload trucks and clean the shop area.

Respondent was in the business of producing signs made from materials such as corrugated plastic/chloroplast. The Petitioner was paid at a rate of $9.00 per hour and was hired to work forty (40) hours per week. The Petitioner

testified that he started working for Respondent a short period of time before the work injury. Petitioner was paid with several checks, but only one available as shown on Petitioner's Exhibit 24, which is dated November 20, 2009 in the amount of $122.75.

On December 3, 2009 the Petitioner was unloading a fifty-three (53) foot trailer, filled from floor to ceiling with corrugated plastic/chloroplast signs. A forklift was unavailable due to mechanical issues and the employees were forced to unload the truck without assistance of the forklift or any other mechanical device. There were four employees working, two were in the truck handing the stacks of signs down to the other two employees. The employees were instructed by the owner of Respondent to complete the unload quickly because the owner was charged extra money by the hour for any unload time lasting more than two hours. Petitioner testified that it took greater than eight hours to unload the trailer.

The Petitioner was one of two employees in the trailer. While in the trailer he would grab a stack of signs, reaching overhead at the top of the pile and down to the floor as he got further into the task. The stacks of signs weighed approximately 40-50 pounds. As the Petitioner reached up to grab a 40-50 pound stack he felt a "snap" in his right shoulder. He reported this immediately to the owner who told him to keep working and they would take care of it after the job was done. The Petitioner finished the job and went home. He was in pain that night, which continued to the next morning. The Petitioner went to work and told the owner he was still in pain. After Petitioner reported his pain complaints to the owner, he was told his services were no longer needed at the company.

After his termination, the Petitioner tried to live with the pain and see if it resolved on its own, but after five (5) days of persistent pain he sought treatment at Provena St. Joe's Emergency Room. (Pet. Ex. 2 at 14). The Petitioner reported pain after lifting heavy signs down from a truck 5 days ago at work and hurt his right shoulder, he told his boss who sent him home and pain

continued to increase. The Petitioner denied previous history of shoulder pain. The Petitioner was discharged with a referral to see Dr. Leah Urbanosky. (*Id.* at 16).

Dr. Urbanosky saw the Petitioner on January 20, 2010 where she took a history of unloading a semi by hand and felt a pain in his right shoulder. He reported the injury to the owner, but was told to go back to work. The Petitioner had trouble with any overhead lifting. After physical examination, Dr. Urbanosky diagnosed right shoulder strain with possible rotator cuff tear, possible labral tear and underlying degenerative change and recommended an MRI arthrogram. (Pet. Ex. 4 at 4-5).

The Petitioner had an MRI done, which revealed supraspinatus high grade articular surface tendon tear, infraspinatus severe tendinosis, SLAP tear with extension into the biceps tendon and biceps tendinosis and anterior-inferior glenoid labral tear. (Pet. Ex. 5 at 5).

After review of the MRI, Dr. Urbanosky opined that given the overhead nature of the injury he has some possible acute component to his rotator cuff and superior labral tearing, as well as some chronic factors contributing to his pain in his shoulder. (Pet. Ex. 4 at 7). On February 24, 2010, Dr. Urbanosky recommended physical therapy, but the Petitioner was unable to locate a facility that would accept the state medical plan and had no money to pay for treatment as he was not employed. Petitioner testified that Respondent had no insurance, which is shown in Petitioner's Exhibit 25.

The Petitioner testified that it wasn't until March 2, 2011 that he was able to find a physician to accept his insurance, when he saw Dr. Ram Aribindi at Southland Orthopedics. (Pet. Ex. 6). The Petitioner testified that he had not been working during the time frame of February 24, 2011 through March 2, 2011. The Petitioner had no other right shoulder injuries during this time period. The Petitioner also stated that during this time period his pain persisted and he attempted to seek treatment through the State of Illinois medical insurance plan, but was unable to locate a physician willing to accept the insurance, especially

with a litigation component under Workers' Compensation. Dr. Aribindi noted his medical history that he injured his right shoulder on December 3, 2009 unloading a truck load of chloroplast (plastic cardboard) and was let go from employment one day after he had reported his work injury. After review of the MRI and a physical examination, Dr. Aribindi recommended right shoulder arthroscopy. (Pet. Ex. 6 at 6-7). The Petitioner was seen again April 6, 2011 and the surgical recommendation remained the same. (*Id.* at 12).

The Petitioner was not seen by Dr. Aribindi again until October 12, 2011. The Petitioner was able to locate a position as a light duty janitor in April 2011 where he was working a light duty position, which was helping his family financially after not working the year before. The Petitioner was placed by a temp agency at Professional Medical to work a light duty janitor position, where he could use his left arm for the majority of activities and was able to work within his restrictions. The Petitioner was laid off from this position sometime in September to October 2011. The Petitioner testified that while he was working he had no right shoulder injuries and was able to control his pain by using his left dominant arm and this was a job that was within his restrictions placed on him by Dr. Aribindi, which were no overhead lifting, no lifting greater than 10-15# with his right upper extremity. (Pet. Ex. 6 at 8). As soon as he was laid off he scheduled an appointment to see Dr. Aribindi as he still had continued pain in his right shoulder.

Dr. Aribindi saw the Petitioner October 12, 2011 and the surgery on his right shoulder took place October 13, 2011. (Pet. Ex. 8).

The Petitioner started physical therapy November 8, 2011, where he filled out a patient assessment form that he was injured moving chloroplast. (Pet. Ex. 9 at 27).

The Petitioner was discharged from physical therapy January 25, 2012, where he partially met all goals, but did not meet goals 100%. (Pet. Ex. 9 at 26). The Petitioner was released to full duty work activities on February 1, 2012 by Dr. Aribindi. (Pet. Ex. 6 at 20).

The Petitioner still continues to complain of some pain in the right shoulder. He still has pain with any overhead activity. He has "cracking and popping" in the shoulder and notices pain with weather changes. The Petitioner testified that he does take over the counter medication occasionally, which he stated was a few times per week. He currently is unemployed, but had been working as a truck driver after his release from Dr. Aribindi.

After hearing all of the testimony and observing the witness, the Arbitrator finds that Petitioner was a credible witness. The Arbitrator finds that Petitioner's complaints to Doctors were consistent throughout his treatment as well as his testimony at the hearing on April 7, 2016.

In support of the Arbitrator's Decision regarding "A" (Employer operating under the Act), the Arbitrator finds as follows:

Section 1(a)(2) of The Illinois Workers' Compensation Act defines Employer as:

> 2. Every person, firm, public or private corporation, including hospitals, public service, eleemosynary, religious or charitable corporations of associations who has any person in service or under any contract for hire, express or implied, oral or written, and who is engaged in any of the enterprises or business enumerated in Section 3 of this Act, or who at or prior to the time of the accident to the employee for which compensation under this Act may be claimed, has in the manner provided in this Act elected to become subject to the provisions of this Act, and who has not, prior to such accident, effected a withdrawal of such election in the manner provided in this Act.

Further, under Section 3 of the Act, there is Automatic Coverage of the Workers' Compensation Act, particularly under Section 3(15), which states any business or enterprise in which, electric, gasoline, or other power driven equipment is used in the operation thereof. The Petitioner testified that part of the job is to operate equipment as enumerated under the Act, although the forklift was not in operation at the time of the injury, the use of such equipment is used in the operation of the business and therefore Respondent Respondent

would be subject to Automatic Coverage under the Act. The Arbitrator finds that Respondent was a private corporation involved in the use of electric, gasoline, or other power driven equipment used in the operation thereof, enumerated under Section 3 and therefore falls within the automatic coverage policy of the Illinois Workers' Compensation Act. The Arbitrator further finds that as of December 3, 2009, Respondent did not have proper Workers' Compensation insurance coverage required by the Statute as shown by Petitioners Exhibit 25, the insurance coverage search performed by the Illinois Workers' Compensation Commission, certifying that Respondent did not have coverage at the time of the injury.

In support of the Arbitrator's Decision regarding "B" (Employee-Employer relationship), the Arbitrator finds as follows:

The Arbitrator finds that an employee-employer relationship existed. Petitioner testified without rebuttal that he was hired by Respondent as an employee and was working as same at the time of the accident alleged herein.

In support of the Arbitrator's Decision regarding "C" (Arise out of / In the Scope of Employment), the Arbitrator finds as follows:

On December 3, 2009, the Petitioner was unloading a large trailer with stacks of plastic signs for Respondent. Petitioner was performing the duties as he was told, despite the task taking longer than it should have and exposing the Petitioner to exactly the type of injury sustained as he was directed to unload a high volume of plastics signs in an expedient manner as it cost the owner additional money to have the driver of the truck waiting for the unload to occur. The Petitioner was injured while reaching overhead and lifting a 40-50 pound stack of plastic, which he had done numerous times already in the previous hours of the job. The Petitioner was hired to load/unload trucks as well as clean the shop. He was injured while unloading plastic signs, which was in the scope of his employment and arose out of his employment. Accordingly, the Arbitrator finds that Petitioner proved that his accident arose out of and in the course of his employment with Respondent as alleged herein.

In support of the Arbitrator's Decision regarding "D" (Accident Date), the Arbitrator finds as follows:

The Arbitrator finds that an accident occurred on December 3, 2009. Respondent was not available for direct/cross examination to dispute the accident, despite being notified of the hearing date. Petitioner was credible in his testimony. The Application for Adjustment of Claim, Petitioner's testimony, medical records, including those of Provena St. Joe's, the initial medical history within days of the injury, are consistent with Petitioner's testimony as it relates to the date of accident.

In support of the Arbitrator's Decision regarding "E" (Notice), the Arbitrator finds as follows:

Petitioner testified that he notified the owner of the company immediately, who told him they would take care of it later. The Petitioner reported he was still in pain the next day and was terminated. The Petitioner reported to the Emergency Room physician that he told his boss, who then sent him home, which is consistent with the testimony given at trial on April 7, 2016. Respondent presented no evidence to the contrary.

The Arbitrator finds that there was timely notice given to Respondent.

In support of the Arbitrator's Decision regarding "F" (Causal Connection), the Arbitrator finds as follows:

The Arbitrator finds that causal connection is clear; the Petitioner testified that he had no prior right shoulder injuries. The Petitioner denied prior history of right shoulder pain. (Pet. Ex. 2 at 14). Both Dr. Urbanosky and Dr. Aribindi found causal connection. Dr. Urbanosky stated that there was an acute component of the injury to his rotator cuff and superior labral tearing (Pet. Ex. 4 at 7) and Dr. Aribindi diagnosed a work/injury related right shoulder labral tear and rotator cuff tear (Pet. Ex. 6 at 8).

Further, proof of prior good health and change immediately following and continuing after an injury may establish that an impaired condition was due to the injury. *Spector Freight Systems, Inc. v. Industrial Comm'n.* (1983), 93 Ill.2d

507, 67 Ill.Dec. 800, 445 N.E.2d 280. Proof of the state of the health of the employee prior to and down to the time of the injury, and the change immediately following the injury and continuing thereafter, is competent as tending to establish that the impaired condition was due to the injury. *Plano Foundry v. Industrial Commission,* 356 Ill. 186 (1934).

Not only was there causal connection established by the chian of events that followed December 3, 2009 where Petitioner had consistent right shoulder pain, treated as much as he could without insurance, but also Dr. Urbanosky opined after review of the MRI that in all likelihood, given the overhead nature of his injury, he has some possible acute component to his rotator cuff and superior labral tearing. (Pet. Ex. 4 at 7) and Dr. Aribindi offered the same causation opinion within his diagnosis. (Pet. Ex. 6 at 8).

Based on the record as a whole, the Arbitrator finds that causal connection exists between Petitioner's condition of ill-being and the work injury of December 3, 2009.

In support of the Arbitrator's Decision regarding "G" (Earnings), the Arbitrator finds as follows:

The Arbitrator finds that Petitioner's wages were as alleged on Arbitrator's Exhibit 1. $360.00 per week. The Petitioner testified that he was hired for $9.00 per hour for forty (40) hours per week. Despite having little payroll records, the only check know to exist paid Petitioner $122.75 for an unknown period of time as evidenced on Petitioner's Exhibit 24. Respondent presented no evidence or testimony to refute Petitioner's claim.

In support of the Arbitrator's Decision regarding "H" (Age), the Arbitrator finds as follows:

The Arbitrator finds at the time of trial Petitioner was 49 years old.

In support of the Arbitrator's Decision regarding "I" (Marital Status), the Arbitrator finds as follows:

The Arbitrator finds at the time of the injury Petitioner was married with three dependents.

In support of the Arbitrator's Decision regarding "J" (Medical), the Arbitrator finds as follows:

Petitioner's medical bills were admitted as Petitioner's exhibits 10-22 in the sum of $90,310.35. The Representative of the Injured Workers' Benefit Fund objected as to liability for the bills. After review of the medical records, the Arbitrator finds that Petitioner's treatment was causally connected to the accident alleged herein, and that the charges for same were reasonable and awards same, to be paid pursuant to the medical fee schedule.

In support of the Arbitrator's Decision regarding "K" (TTD), the Arbitrator finds as follows:

The Petitioner was restricted from work by Dr. Arbindi following the surgery until his full duty release February 1, 2012. Therefore, the Arbitrator awards TTD from October 13, 2011 through February 1, 2012, or a period of 16 weeks pursuant to Section 8(b) of the Act, at a rate of $320.00 per week per the minimum TTD rate in effect at the date of accident.

In support of the Arbitrator's Decision regarding "L" (Nature and Extent), the Arbitrator finds as follows:

The Petitioner testified that prior to the work injury December 3, 2009 he had no right shoulder pain. As a result of this injury, Petitioner testified that he now has trouble working overhead without pain, he has cracking and popping in the right shoulder and he occasionally takes over the counter medication, such as Aleve to help the pain. The Petitioner also testified that he notices pain and aches with changes in the weather. No AMA rating was offered by either party, the Petitioner was 49 yrs old at the time of the accident, and no evidence of impairment of earning capacity was offered. The Arbitrator considered these factors as well as the record as a whole in arriving at a decision on the issue of nature and extent.

Based on these factors, the Arbitrator finds that Petitioner has suffered 12.5% loss of use of his person as a whole under Section 8(d)(2) of the Act, which is paid at the State minimum of $320.00 per week for Petitioners with four dependents (three children and a spouse).

Arbitrator Robert Falcioni

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Malissa Montoya,

Petitioner,

vs. NO: 12 WC 17292

State of Illinois, IYC-Murphysboro, 17IWCC0801

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 28, 2016, is hereby affirmed and adopted.

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

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

DEC 14 2017

DATED:
TJT:yl
o 12/5/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MONTOYA, MELISSA
Employee/Petitioner

Case# **12WC017292**

IYC-MURPHYSBORO
Employer/Respondent

17IWCC0801

On 7/28/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.42% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1580 BECKER SCHROADER & CHAPMAN PC
MATTHEW R CHAPMAN
3673 HWY 111 PO BOX 488
GRANITE CITY, IL 62040

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

0558 ASSISTANT ATTORNEY GENERAL
FARRAH A HAGAN
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 SYSTEMS
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JUL 28 2016

HERALD A. HASSIA, Acting Secretary
Illinois Workers' Compensation Commission

17IWCC0801

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Malissa Montoya
Employee/Petitioner

v.

IYC - Murphysboro
Employer/Respondent

Case # **12** WC **017292**

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 **Herrin**, on **7-16-15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **1-10-11**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$21,900.00**; the average weekly wage was **$1,010.77**.

On the date of accident, Petitioner was **40** years of age, ***married*** with **3** children under 18.

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $93,679.33, as set forth in PX 20, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $606.46/week for 75.25 weeks, because the injuries sustained caused the 35% loss of the left leg, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $606.46/week for 10 weeks, because the injuries sustained caused the 2% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

7/15/16
Date

FINDINGS OF FACT

On January 10, 2011, Petitioner was employed as an educator in Respondent's juvenile detention facility. On that date, Petitioner suffered undisputed work-related injury when she slipped on water and fell, causing a direct impact to her left knee. After she stood up, Petitioner slipped backwards and fell again onto her buttocks. At the time of the accident, Petitioner was working full duty with no physical restrictions related to her left knee. Petitioner had never experienced any pain complaints or sought any treatment for her left knee. After the accident, Petitioner sought treatment at Herrin Hospital, where she was diagnosed with a fracture of her coccyx, as well as an injury to her left knee.

On January 14, 2011, Petitioner followed up with Dr. Latta, her family physician. (PX1). Petitioner reported pain in her left knee and her tailbone. (PX1, 1) Dr. Latta noted a "great deal of bruising, edema and pain in the left knee with any palpation/ROM." (PX1, 2) Dr. Latta's ordered an MRI and held Petitioner off of work. (PX1, 2) Dr. Latta also prescribed pain medication and a knee immobilizer. With respect to the coccyx fracture, Dr. Latta recommended a coccygeal donut pillow, which Petitioner was to use for six weeks. (PX1, 1) Dr. Latta noted that the fracture was a nonsurgical issue but can cause a lot of discomfort for many weeks or even months. (PX1, 1)

On January 19, 2011, Petitioner underwent an MRI of the left knee. (PX9) Based on Petitioner's continued complaints of pain, she was referred to Dr. Ben Houle. (PX2) On February 4, 2011, Dr. Houle noted Petitioner's history of pain and swelling over the anterior aspect of her knee since the accident. (PX2, 5) Dr. Houle noted severely limited range of motion and "very evident" crepitus in the anterior aspect of her kneecap. Dr. Houle diagnosed Petitioner with post-traumatic patellofemoral syndrome and referred her to physical therapy. Dr. Houle also held Petitioner off work. (PX2, 5)

Petitioner underwent physical therapy at St. Mary's Good Samaritan Hospital. (PX16) On March 23, 2011, Petitioner returned to Dr. Houle with no change in her symptoms. (PX2, 8) Dr. Houle changed her anti-inflammatory medication and continued physical therapy. (PX2, 8)

On April 6, 2011, Petitioner sought a second opinion from Dr. Robert Golz. (PX3) Dr. Golz diagnosed Petitioner with left patellar tendonitis and recommended continued conservative treatment. (PX3,8) Dr. Golz prescribed a steroid Dosepak and Voltaren Gel. On April 22, 2011, Dr. Golz noted that physical therapy had not helped alleviate Petitioner's symptoms. Dr. Golz noted that Petitioner had quad weakness and recommended that Petitioner continue her home exercises. (PX3,15) Dr. Golz injected Petitioner's left knee with Kenalog and Marcaine. (PX3, 15) On May 20, 2011, Petitioner reported that the intra-articular injection gave no relief. PX3, 18) Dr. Golz felt that Petitioner would be a good candidate for platelet rich plasma (PRP) injections into the patellar tendon. (PX3,18) Dr. Golz noted that approval for a PRP consultation will be sought. (PX3, 18)

On June 22, 2011, Petitioner Dr. Treg Brown for evaluation regarding PRP injections. (PX4, 1) Dr. Brown also performed an ultrasound of the patellar tendon. (PX4, 6) Dr. Brown's impression was "isolated tendonopathy versus small partial tear of patella tendon insertion onto the lateral distal pole patella." (PX4, 6) On June 29, 2011, Petitioner underwent a PRP injection. (PX4, 8) On July 27, 2011, Petitioner reported that the injection did not help her pain. Dr. Brown explained that she should not look for any significant improvement in her pain level until eight to twelve weeks post injection. Dr. Brown also recommended

physical therapy. (PX4, 10) On September 22, 2011, Petitioner's pain was unchanged. (PX4, 13) Dr. Brown noted that all non-operative measures had been exhausted and therefore recommended an open surgical exploration and debridement. (PX4, 13) On October 4, 2011, Petitioner underwent an open debridement of the left patella tendon. (PX10) Petitioner developed post-surgical left calf pain and was directed to the emergency room. (PX19, 3) A venous Doppler exam ruled out a venous thrombosis and Petitioner was discharged. (PX19) On October 25, 2011, Dr. Brown prescribed a locking knee brace to assist with recovery, ordered physical therapy, and continued Petitioner's off work restrictions. (PX4, 21) Petitioner's physical therapy took place at NovaCare Rehabilitation. (PX14) On February 7, 2012, Dr. Brown placed Petitioner in a patella tracking brace with a lateral buttress and prescribed Norco for pain. (PX4, 30)

On March 7, 2012, Petitioner reported that the brace helped with her symptoms. (PX4, 33) However, when the brace is removed, all of her symptoms return. Dr. Brown noted that Petitioner may have some patellofemoral pain that is contributing to her overall symptoms and this may be what prevented her from being able to fully recuperate and have a successful outcome following her debridement. (PX4, 34) Dr. Brown recommended an arthroscopic lateral release and evaluation of her patella, believing that there would be a good chance that this could provide her with significant relief. (PX4, 34)

On April 9, 2012, Petitioner underwent an arthroscopic patella tendon debridement and lateral release. (PX11) During the procedure, Dr. Brown noted that the patellofemoral joint had slight lateral tracking and did not fully engage at 40 degrees flexion. (PX11, 2) Dr. Brown further noted that the intracondylar notch showed a hypertrophic fat pad. Dr. Brown prescribed post-surgical physical therapy, which was done at Southern Orthopedic Associates. (PX15) On May 30, 2012, Dr. Brown noted that Petitioner had decreased strength of her quad and tenderness over the patella tendon. (PX4, 46) Dr. Brown returned Petitioner to work in a light duty capacity without prolonged standing or walking with ability to take breaks sitting. (PX4, 46)

On September 7, 2012, Petitioner underwent a Section 12 examination with Dr. Timothy Farley. (PX7) Dr. Farley diagnosed Petitioner with anterior knee pain with mild to moderate level degenerative change in the lateral patellofemoral compartment. (PX7, 4) Dr. Farley opined that there was a causal connection between Petitioner's work place injury and her current condition. (PX7, 4) Dr. Farley opined that Petitioner could potentially improve with a Fulkerson procedure, which would elevate, medialize and decompress the lateral patellar facet arthrosis. (PX7, 4) Given that Petitioner must have direct interaction with potentially violent inmates Dr. Farley suggested that a Functional Capacity Evaluation be performed before he made any specific long term recommendations. (PX7, 4)

Dr. Brown referred Petitioner to Dr. Brian Kern for the purpose of discussing the proposed Fulkerson procedure. (PX4, 54) On October 30, 2012, Dr. Kern noted Petitioner's complaints of pain, swelling, grinding, and crepitus in her left knee. (PX5, 1) Dr. Kern ordered a repeat MRI, looking for a focal articular cartilage defect of the patella and bone marrow edema in the patella or in the trochlear. (PX5, 2) The MRI took place on November 7, 2012 and revealed a small suprapatellar joint effusion with chondromalacia at the articular cartilage of the undersurface of patella laterally. (PX12) Dr. Kern reviewed the MRI findings and sent Petitioner for a Biodex test, which demonstrated that the patient put forth a good effort and had almost a 40% quadriceps deficit. (PX5, 3) Dr. Kern believed that the quadriceps deficit was a major contributor to her knee pain. Accordingly, Dr. Kern recommended additional physical therapy. (PX5, 4)

On January 24, 2013, Dr. Kern performed a corticosteroid injection on Petitioner's left knee. (PX5, 7) On March 5, 2013, Dr. Kern noted that Petitioner's pain came from two sources: 1.) pain over her patellar tendon with significant thickening of the patellar tendon on her MRI; and 2.) a small articular cartilage defect on the lateral facet of her patella, best seen on the MRI. (PX5, 8) Dr. Kern recommended a diagnostic arthroscopy to further assess her knee.

On April 22, 2013, Petitioner underwent a left knee arthroscopic patellofemoral chondroplasty, arthroscopic excision of fat pad/scar tissue; and open exploration and debridement of the patellar tendon. (PX13) Dr. Kern noted an abundance of anterolateral scar tissue with a chondral defect at the distal pole of the patella. During the procedure, Dr. Kern noted a small 3 x 3 grade II lesion on the anterior medial aspect of femoral condyle. Dr. Kern also noted a large scar nodule that was palpable and prominent, which he felt was creating mechanical symptoms.

On July 23, 2013, Dr. Kern noted that Petitioner still had pain in her knee, quad weakness, and numbness in her leg. (PX5, 13) Petitioner also reported occasional low back pain. Dr. Kern noted that low back pain with radicular symptoms could cause her leg weakness and cause the leg to give out. She was allowed to return to work on a trial basis. (PX5, 13) On November 12, 2013, Dr. Kern noted that Petitioner was continuing to complain of pain in her back over her SI joint that radiated down her leg. Petitioner also reported continued knee pain that radiates up from her knee into her thigh. Petitioner reported that she felt her back pain had been exacerbated by her return to work. Dr. Kern recommended continued therapy to work on strengthening her quadriceps. (PX5, 16) Petitioner continued to follow up with Dr. Kern. When Petitioner returned on March 27, 2014 she reported pain in her left knee as well as her left SI joint. Both complaints were exacerbated by walking or standing for extended periods of time. (PX5, 23) Dr. Kern had previously tried to get approval for an SI joint injection and pain management, but those procedures were not approved. (PX5, 23) During that physical examination, Dr. Kern noted that Petitioner was tender to palpitation over the patellar tendon as well as laterally, just lateral to the patellar tendon and along the lateral facet of the patella. Petitioner also had tenderness to palpation over the IT band and the left SI joint. Dr. Kern noted that, with regard to the knee, Petitioner was at maximum medical improvement. As for her left SI joint, Dr. Kern still believed Petitioner would benefit from SI joint injection(s). Dr. Kern recommended that Petitioner continue to work full duty. (PX5, 23)

On April 28, 2014, Petitioner saw Dr. Bradly Newcom with respect to her low back complaints. (PX6) Petitioner eventually underwent two SI joint injections for her continuing low back pain.

Dr. Kern testified via evidence deposition. Dr. Kern testified that Petitioner was referred to him for consideration of the Fulkerson osteotomy. (PX17, 7) In that procedure, the surgeon cuts the tibial tubercle and moves it over. (*Id.*) The procedure is generally indicated for patellar instability, lesions, and occasionally for cartilage defects. (*Id.*) It is a fairly morbid procedure because the bone is cut and re-positioned with hardware, which poses the risk of compartment syndrome and the risk that forces across the kneecap increase, causing additional pain. (*Id.*) The procedure is a "big deal" because it takes a long time to recover from. (*Id.*, at 10) Accordingly, Dr. Kern wanted to "be sure on the diagnosis before [going] in and [doing] that type of procedure." (*Id.*).

Dr. Kern explained that he ordered the repeat MRI because the last surgery took place six months earlier and there could be a lot of post-surgical changes. (*Id.*, at 8) In addition, Dr. Kern was investigating whether Petitioner had a lesion under her patella, patellofemoral arthritis, or a tear in her patella tendon. (*Id.*) In short, the MRI provided Dr. Kern with "a lot more detailed information." Dr. Kern testified that the MRI showed that Petitioner did have a joint effusion and cartilage damage on the lateral aspect of her kneecap. (*Id.*, at 9)

Dr. Kern explained that purpose of the diagnostic arthroscopy:

> ...to further assess the patellofemoral joint to see what we are actually dealing with, how severe is the or how severe is the common defect. What is the exact location? Does she just have some crepitus from scar tissue in that area that could easily be debrided arthroscopically, which we see all the time....[fi]rst of all the arthostomy could be therapeutic. It's also going to be diagnostic in helping determine how to treat her from going forward. In addition to that, we wanted to look closely at her patellar tendon which we thought might have some scar tissue and might be a source of pain. (*Id.*, at 12-13)

Dr. Kern further explained that the previous surgery was in April 2012 and a lot can change in the course of year. (*Id.*, at 13) In addition, before "having a major operation like a Fulkerson osteotomy, which if not done in the right indications could actually make the patient worse, you need to have full information. And if the patient does have scar tissue which was maybe resulting in the crepitus over the lateral aspect of the knee, that could easily be treated with an arthroscopic procedure and she could not need the Fulkerson procedure." (*Id.*) As such, the diagnostic arthroscopy was a more conservative approach than the procedure suggested by Dr. Farley. (*Id.*, at 14)

Dr. Kern explained that the surgery he performed allowed him to rule out the Fulkerson procedure for Petitioner. Also, Dr. Kern removed a scar nodule underneath the patella, which can cause crepitus and pain. (*Id.*, at 14) Dr. Kern noted that the scar nodule was located in an area that corresponded with Petitioner's pain complaint. (*Id.*, at 15) Dr. Kern testified that the surgery resolved Petitioner's crepitus within the knee. (*Id.*, at 16) However, as of her last visit, Petitioner was still experiencing pain in her knee. (*Id.*, at 17) Dr. Kern believed that Petitioner's condition would be unlikely to change in the future with or without additional treatment. (*Id.*, at 18)

Dr. Kern opined that the PRP injection was a reasonable, conservative treatment for suspected tendinopathies. (*Id.*, at 19) Dr. Kern opined that Petitioner's knee pain was caused by the workplace injury in this case. (*Id.*) Dr. Kern opined that all the treatment that he rendered or ordered was reasonable and necessary to treat Petitioner's condition. (*Id.*, at 20) More specifically, the April 22, 2013 surgery was therapeutic for her crepitus and diagnostic with respect to whether she was as candidate for a much more morbid operation. (*Id.*) Also, the surgery helped to determine whether she was a candidate for any type of cartilage transplant. (*Id.*) "I believe the scope ruled those procedures out and helped her avoid having a much more morbid operation, which I do not think would have helped her." (*Id.*) Dr. Kern also opined that the surgeries performed by Dr. Brown were reasonable and necessary. (*Id.*, at 31) On cross-examination, Dr. Kern testified that he could not tell whether Petitioner's low back complaints were more likely than not caused by the injury or her altered gait.

(*Id.*, at 38). Dr. Kern did opine, however, that Petitioner's back problems might or could be related to the gait alteration caused by her knee injury. (*Id.*, at 44)

Dr. Farley testified by deposition as well. Dr. Farley opined that all the treatment Petitioner received through his September 2012 Section 12 report, including Dr. Brown's two surgeries, was reasonable and necessary and causally related to the January 10, 2011 accident. (RX1, 34-35). The only exception is the PRP injection. Dr. Farley testified that he did not have a lot of data that would support that treatment modality and would not personally use that for Petitioner's condition. (*Id.*, at 34) Dr. Farley opined that Petitioner's current knee condition is causally related to the workplace accident. (*Id.*, at 39-40) Dr. Farley also opined that the Fulkerson procedure that he recommended was causally related to the workplace accident. (*Id.*, at 35-36)

After September 2012, Dr. Farley's only dispute is with Dr. Kern's surgery. Dr. Farley opined that the surgery was not reasonable and necessary because "it didn't add anything. I think we knew what the inside of her knee looked like at that point." (*Id.*, at 36) When making a surgical decision, Dr. Farley wants one of two things to happen: "I would like to either fix a patient if they have an issue or have some other sort of secondary gain from doing an intervention on a patient." (*Id.*, at 37) However, Dr. Farley did not review the November 7, 2012 MRI film or report. (*Id.*, at 38) Dr. Farley also opined that Petitioner's back issues were not related to the workplace accident. (*Id.*, at 41)

Dr. Farley was asked to provide an impairment rating for this case despite the fact that the injury predated the 2011 amendment to the Act. In his August 5, 2014 report, Dr. Farley writes: "[u]tilizing Table 16-3, it is my opinion that the patient suffered a 2% permanent partial disability at the level of the left lower extremity." In his deposition, Dr. Farley was not able to explain how he reached that rating because he did not bring the AMA guides that he used to the deposition. Dr. Farley did agree, however, that impairment and disability are two different concepts, and that the relationship between impairment and disability is complex and difficult, if not impossible, to predict. (*Id.*, at 42-43) Dr. Farley did not factor in Petitioner's continuing complaints of pain in his rating. (*Id.*, at 44) Contrary to the instructions found on page 495 of the lower extremity section, Dr. Farley did not provide a comprehensive description of the patient's current symptoms and their relationship to her daily activities. (*Id.*, at 45)

Petitioner testified that Dr. Kern's surgery alleviated the clicking and catching in her knee and the pain associated with the crepitus, but she still has pain with prolonged standing or walking. Petitioner explained that her knee swells after activity and that any amount of pressure on the kneecap causes pain. Petitioner is unable to kneel when assisting her children bathe. Petitioner is unable to run or bike due to the pain. Petitioner takes over-the-counter medication for her symptoms. Petitioner testified that her tailbone still hurts when she sits for long periods of time.

CONCLUSIONS

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

It is undisputed that Petitioner's current left knee condition is causally related to the workplace injury. It is also undisputed that Petitioner suffered a fractured coccyx as a result of the injury. With respect to Petitioner's back complaints, which did not surface until 2013, the Arbitrator finds that the back condition is not

causally related to the workplace injury. Neither Dr. Farley nor Dr. Kern provided treatment for that condition, nor could either physician testify to a reasonable degree of medical certainty that the back condition was related to the original accident or to the antalgic gait caused by the knee injury.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met her burden of establishing that the current condition of ill-being with regard to her left knee as well as her fractured coccyx are causally related to the undisputed 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?

Respondent disputes three medical services: the PRP injection, the April 22, 2013 surgery, and Dr. Newcom's treatment for low back complaints. The Arbitrator finds that the PRP injection was a reasonable and necessary conservative treatment modality based on Dr. Kern's testimony and the medical records.

The Arbitrator finds that Dr. Kern's April 22, 2013 surgery was reasonable and necessary based on the chain of events and the medical testimony. More specifically, the surgery served two reasonable purposes. The surgery was therapeutic for Petitioner's crepitus. Dr. Kern removed a scar nodule underneath the patella that corresponded with Petitioner's symptoms. After the surgery, Petitioner no longer complained of grinding or clicking in her knee. The surgery was also diagnostic in that it allowed Dr. Kern to investigate and ultimately rule out the efficacy of the Fulkerson osteotomy proposed by Respondent's Section 12 examiner. In actuality, Respondent does not dispute that Petitioner needed a third surgery. Respondent disputes the more conservative surgery performed by Dr. Kern versus the much more invasive Fulkerson procedure which involves cutting and moving bone. The surgery revealed that the Fulkerson procedure was not appropriate, thereby avoiding a much more morbid procedure that, based on the surgical findings, would have resulted in more pain for Petitioner. Dr. Kern's approach was conservative as well as reasonable and necessary to diagnose and safely treat Petitioner.

Petitioner submitted medical records totaling $93,679.33.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Respondent shall pay reasonable and necessary medical services of $93,679.33, as set forth in PX 20, as provided in Sections 8(a) and 8.2 of the Act, less any bills related to treatment of Petitioner's low back following September 7, 2012. 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?

The Arbitrator notes that 820 ILCS 305/8.1b governs determinations of permanent partial disability for injuries occurring after September 1, 2011. Accordingly, the determination in this case is not governed by the factors set forth in that Section.

Petitioner underwent three surgeries to her knee. Petitioner's testimony regarding continued pain in her left knee, which affects her activities of daily life, is corroborated by the medical evidence. Although she was

released to return to her job with no restrictions, Petitioner reported pain in her left knee after standing and walking on hard surfaces. Petitioner is unable to run or bike. In addition, Petitioner sustained a fracture of her coccyx. Petitioner had a full recovery from that injury.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds with regard to the left knee, the injuries sustained caused 35% loss of the left leg, as provided in Section 8(e) of the Act, and with regard to the fractured coccyx the injuries sustained caused the 2% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Blanca Flores,

Petitioner,

vs. NO: 05WC 45163

Chicago Board of Education,

17IWCC0802

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 medical expenses, causal connection, credit for medical payments, permanent disability, temporary disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 8, 2017 is hereby affirmed and adopted.

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

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

17IWCC0802

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: DEC 14 2017
SJM/sj
o-11/16/2017
44

Stephen J. Mathis

David L. Gore

DISSENT

I respectfully dissent from the opinion of the majority. I would find that Petitioner's back condition is not related to the accident of October 5, 2005. The medical records contemporaneous with the accident do not mention any back complaints or mechanism of injury consistent with a back injury. Petitioner's Application for Adjustment of Claim, filed approximately a week after the accident, alleges that the right arm, right wrist, and neck were affected. It is not an exaggeration to say that Petitioner's complaints spread nearly system-wide over time. Petitioner was off work and frequently treating for her neck and upper extremity complaints for over a year without making any complaints of back pain. On November 27, 2006, the first complaint of back pain appears in the records. Petitioner occasionally complained of stiffness in her thoracic spine and diffuse back pain, among other myriad and escalating complaints, but she received no treatment for low back pain until 2010. I am not persuaded by the evidence in this case that Petitioner's lumbar condition and need for the lumbar treatment that commenced over four years after the accident is causally related to the October 5, 2005 accident and therefore I must dissent.

Deborah L. Simpson

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FLORES, BLANCA
Employee/Petitioner

Case# **05WC045163**

06WC001989

CHICAGO BOARD OF EDUCATION
Employer/Respondent

17IWCC0802

On 3/8/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1980 LAW OFFICES OF STEVEN J TENZER
20 S CLARK ST
SUITE 700
CHICAGO, IL 60603

0559 CHICAGO BOARD OF EDUCATION
MICHAEL COHEN
ONE N DEARBORN ST SUITE 900
CHICAGO, IL 60603

17IWCC0802

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

Blanca Flores
Employee/Petitioner

v.

Chicago Board of Education
Employer/Respondent

Case # **05** WC **45163**

Consolidated cases: **06 WC 1989**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **August 11, 2016, September 19, 2016, and November 15, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **October 5, 2005**, 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 **$82,945.20**; the average weekly wage was **$1,595.10**.

On the date of accident, Petitioner was **47** years of age, *married* with **no** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **$596,940.76** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$596,940.76**.

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

ORDER

Respondent shall pay **$73,594.42**for medical services, as provided in Section 8(a) of the Act. Respondent shall provide payment information to Petitioner relative to any credit issue. Respondent is to pay any unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses according to the fee schedule or the negotiated rate and shall provide documentation with regard to said fee schedule or negotiated rate calculations to Petitioner. Respondent is to reimburse Petitioner directly for any out-of-pocket medical payments.

Respondent shall pay Petitioner temporary total disability benefits of **$1,063.40**/week for **566** weeks, commencing **October 6, 2005** through **August 11, 2016**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$596,940.76** for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner permanent and total disability benefits of **$1,063.40**/week for life, commencing **August 12, 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.

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

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

Milton Black

Signature of Arbitrator

March 3, 2017
Date

MAR 8 - 2017

STATEMENT OF FACTS

The petitioner testified that on the date of her accident of October 5, 2005, she was a school teacher in the fifth grade at Lowell Elementary School. She had been teaching since 1991 in the Chicago Public Schools and taught all subjects. She has two Master's Degrees, one in education and another in literature and reading. On that date, she was also volleyball coach and basketball coach at the school and she led a very physically active life. While escorting the students to lunch in the hallway, an altercation broke out between some students, which she tried to break up. In the process, her arm became intertwined with one of the student's and she was dragged down the hallway, injuring her cervical spine, lumbar spine, head (concussion), right wrist, right arm, right side and right elbow. She was in a state of shock.

After going to the principal, the first medical care she underwent was at Illinois Masonic Hospital, straight from the school. She complained of right wrist pain, right elbow tingling, neck, headaches, blurred vision and numbness. She was treated, given various tests and released. Her pain continued and she followed up with Dr. Montella on October 10, 2005. She gave him a consistent history of the incident and her complaints. He examined her, diagnosed her with a cervical herniated disc (Pet. Ex. 2, p.1) and prescribed medication, physical therapy, chiropractic care and ordered her off of work (Id. at p. 2). The petitioner visited her family doctor, Dr. Braunstein, on October 11, 2005, and provided her with a consistent history of her injuries. She testified that she complained of pain from head to toe "24/7", with radiating shock throughout her entire body, from her neck down her spine into her legs as well as her feet. Dr. Braunstein referred her for further treatment to Dr. Montella (Pet. Ex. #6, p. 6). She began chiropractic care with Dr. Sinai at Oakton Chiropractic on October 12, 2005 and physical therapy at Rehabilitation Inc. on October 24, 2005, in accordance with Dr. Montella's prescription (Pet. Ex. #2, p. 85).

The petitioner has undergone an extensive medical care. Dr. Montella has administered injections to her cervical spine (Pet. Ex. 2, pp. 36, 38, 40, 42, 43 and 44). After one injection, January 17, 2007, she fell off of the table and lost her voice for several weeks and required additional medical care for voice therapy at Illinois Masonic Hospital (Pet. Ex. #1, p. 29) and Lutheran General Hospital (Pet. Ex. #12). Due to her worsening complaints, she has been referred to various doctors for ongoing, additional treatment. Dr. Sinai referred her to a neurosurgeon, Dr. Martin Herman. He performed a C6-C7 fusion on October 1, 2007 (Pet. Ex. #13, p. 11). When she continued to have worsening complaints Dr. Herman referred the petitioner to Dr. Barry Ring. He diagnosed her with cervical disc syndrome, treated her and performed multiple injections, a radio frequency ablation and has prescribed a dorsal column stimulator (Pet. Ex. #14, pp. 1, 4, 11, 16, 25, 34 and 43).

Dr. Braunstein referred the petitioner to Dr. Ira Melnicoff, who took a consistent history of injury, examined her and diagnosed her with reflex sympathetic dystrophy and fibromyalgia (Pet. Ex. #15, p. 3). He prescribed medications and referred her to a pain clinic (Id. at p. 7). The petitioner continued with additional pain care through Dr. Zaki Anwar at the Pain Management Institute through a referral from Dr. Sinai. He gave her multiple diagnoses: cervicogenic headaches; failed cervical spinal fusion surgery; cervical disc herniation; occipital neuralgia; cervical radiculitis; cervical strain; myofascial pain syndrome; lumbar strain; status post work-related injury of the cervical spine on October 5, 2005 with no relief with multiple epidural steroid injections under fluoroscopy; cervical spine fusion surgery on C5-C6 and hardware with Dr. Herman on October 1, 2007 with worsening and changing symptoms after the surgery; and temporary, short-term relief with chiropractic treatments, but do help the patient with Dr. Todd (Pet. Ex. #16, p. 3). He prescribed opioid management, continued chiropractic care, a psychological evaluation and a trial spinal cord stimulator (Id. at p. 9, 21). He also found causal connection between the petitioner's current condition and her initial injury (Id. at p. 22). On May 13, 2010, Dr. Anwar implanted the trial spinal cord stimulator (Pet. Ex. #17, p. 14). It did not work and was withdrawn. He then performed additional lumbar and cervical injections (Id. at pp. 23, 27 and 39). In addition to finding causal connection, he indicated that she was permanently disabled and unable to perform any type of work (Id. at p. 41).

On September 11, 2011, the petitioner underwent a functional capacity evaluation. The findings were considered valid and placed her at the sedentary level of physical work (Pet. Ex. #19).

The petitioner continued to treat with Dr. Herman, who eventually prescribed an L4-L5 medial facetectomy to decompress the nerve (Pet. Ex. #20, p. 6), but she has yet to undergo the procedure because it has never been

approved by the workers' compensation carrier. She continues to treat with her family physician, Dr. Braunstein, who continues to prescribe her medication (Pet. Ex. #7a).

The petitioner received a letter sent on March 26, 2009 informing her that she was "vacated" from her position at Lowell Elementary School, effective March 27, 2009 (Pet. Ex. #25).

The petitioner was seen by Dr. Merrie Viscarra at the request of the Chicago Board of Education's Pension Board on June 12, 2012. Dr. Viscarra was of the opinion that the petitioner was "wholly and permanently disabled to return to her position as a school teacher" (Pet. Ex. #21, p. 3). The petitioner was also seen at the Pension Board's request by Dr. Prerna Khanna on July 30, 2012. Dr. Khanna's opinion that the petitioner was "wholly and permanently incapacitated from her occupation as a teacher" (Pet. Ex. #22, p. 6).

Edward Pagella, a certified rehabilitation counselor, was retained by the petitioner to perform a vocational evaluation. He provided a report on September 10, 2014 indicating that that no stable occupation or labor market exists for the petitioner (Pet. Ex. #23, p. 3 and Pet. Ex. #24).

At the request of the respondent, the petitioner was examined by Dr. J. S. Player, on July 18, 2006 and June 22, 2009. On both occasions, he was of the opinion that the petitioner was in no further need of any medical care and that there was no causal connection between her work accident and her condition (Resp. Exs. #1 and 2).

Ms. Flores testified that she had no prior neck or back complaints and had no prior treatment. She has been off of work since her accident, has been receiving TTD, and has not been able to return to work since due to the pain that she is experiencing. She is limited in her activities of daily living due to her medical condition.

CONCLUSIONS OF LAW

CAUSAL CONNECTION

The Petitioner testified that she was injured while trying to break up a fight between two students on October 5, 2005. She had multiple injuries as a result, for which she never had any prior treatment. She gave consistent histories throughout her entire treatment with all of her treating doctors. Her testimony is not contradicted and is found to be credible. Dr. Montella found a causal connection between her injuries and her condition on

numerous occasions. He based his opinion upon objective medical evidence. Dr. Sinai also found a causal connection between her work incident and her injuries. She was referred to the neurosurgeon, Dr. Martin Herman, who found a causal connection. Dr. Barry Ring, the pain doctor, also found causal connection during the course of his treatment. Dr. Melnicoff diagnosed her with fibromyalgia, post traumatic headaches, reflex sympathetic dystrophy then complex regional pain syndrome also found a causal connection. Dr. Zaki Anwar, who performed the trial spinal cord stimulator, as well found a causal connection between her complaints and her medical condition. The two doctors hired by the Pension Board to examine the petitioner found that her condition was related to her work incident (Pet. Exs. #21 and 22).

Respondent had Ms. Flores examined on two separate occasions by Dr. J. S. Player, and he found no causal connection between her work accident and any medical condition. His opinion is not credible and is far outweighed by all of the other physicians who were consistent in their histories, diagnoses and causal connection between her accident and her condition.

Based upon the foregoing, the Arbitrator finds that the petitioner's current condition of ill being is causally related to her accident.

MEDICAL

All of the medical care incurred by the Petitioner is deemed to be reasonable and necessary. The unpaid medical bills in the amount of $73,594.42, as itemized in Pet. Ex. #26, are found to be reasonable and necessary. The necessity of the medical treatment is supported by the treating physicians. Throughout her entire course of treatment, Dr. Montella provided notes regarding her history, examination findings and recommended treatment. He prescribed chiropractic care and physical therapy. Dr. Herman indicated the need for her cervical spine surgery. Dr. Ring described the need for the numerous injections post op as well as the radio frequency ablation that he performed. Dr. Anwar discussed the ongoing need for the chiropractic and physical therapy care in his treating records as well. Both reports of Dr. Player indicate that the medical care of Ms. Flores was not reasonable or necessary, but his opinions are contrary to every other physician. His opinions are given no weight and are not found to be credible.

TTD

The Arbitrator finds that the petitioner has been unable to work. This is supported by her treating doctors' notes indicating that she is unable to work. Dr. Montella took her off of work. He specifically wrote that she was unable to return to work. Dr. Sinai took her off of work due to her work. Dr. Herman kept her off of work. Dr. Ring prescribed her off of work. Upon her last visit with Dr. Braunstein on March 17, 2016, Dr. Braunstein noted that she is still disabled after her initial injury of 2005 when attacked by a student). Both doctors seen at the request of the Pension Board were of the opinion that her medical condition caused by her work accident precluded her from returning to work.

NATURE AND EXTENT

The Arbitrator finds that the petitioner is permanently and totally disabled. In support of that finding is an extensive amount of evidence, as has been discussed. Dr. Montella specifically stated: "she is permanently and totally disabled" (Pet. Ex. #5, p. 2). After treating Ms. Flores for a number of years and performing numerous injections, Dr. Zaki Anwar indicated that her condition has become permanent and that "In my opinion, the patient has reached permanent disability at this point, and is unable to do any kind of work with her current condition" (Pet. Ex. #17, p.41). Upon examining Ms. Flores, Dr. Merrie Viscarra found that Ms. Flores "is wholly and permanently disabled to return to her position as a school teacher" (Pet. Ex. #21, p. 3). Upon examining Ms. Flores and reviewing additional treating medical records, it was the professional opinion of Dr. Prerna Khanna that she "is wholly and permanently incapacitated from her occupation as a teacher" (Pet. Ex. #22, p. 6). Edward Pagella stated that it is his "professional opinion as a Vocational Expert and Certified Rehabilitation Counselor with over 25 years' experience that no stable occupation or labor market exists for Ms. Flores" (Id.). Again, the opinions of Dr. Player are contrary to the overwhelming weight of the evidence in favor of total and permanent disability and they are given no weight. The opinions of Dr. Player are found not to be credible. The condition of the petitioner is found to be permanent and total and she is to receive her weekly benefits for life. As a result, the Rate Adjustment Fund applies to her benefits paid.

DISMISSAL OF SECOND CASE (06 WC 1989)

There were two case filings for the same accident (05 WC 45163 and 06 WC 1989), both by separate attorneys. Law Offices of Steven J. Tenzer, Ltd. has worked out fee agreements with both attorneys and has moved to have the second case (06 WC 1989) dismissed and have the Arbitrator write his findings on the first case (05 WC 45163). On motion of Law Offices of Steven J. Tenzer, Ltd. to dismiss the second case (06 WC 1989) and have the Arbitrator render his findings on the first case (05 WC 45163), said motion is granted.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

AUBREY KELLY,

Petitioner,

vs. NO: 15 WC 26284

17IWCC0803

MARATHON CAR WASH &
ILLINOIS STATE TREASURER as
Ex-Officio CUSTODIAN of the
INJURED WORKERS' BENEFIT FUND,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of employee-employer relationship, accident, medical, prospective medical, causal connection, and temporary total disability (TTD), being advised of the facts and applicable law, reverses the Decision of the Arbitrator and finds that Aubrey Kelly established that he was an employee of the Respondent, Marathon Car Wash.

The Commission finds that Aubrey Kelly was involved in a work-related accident on July 5, 2015 and that his current condition of ill-being is causally related to said accident. As a result, the Commission awards Kelly prospective medical treatment as recommended by Dr. Jain and all reasonable and necessary medical expenses. The Commission further finds that Kelly's AWW was $336.00 and he is entitled to 63-6/7 weeks of TTD at $224.00 per week. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings and arguments submitted by the parties.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission makes the following findings:

1. Aubrey Kelly testified that he began working for Respondent in April 2015. He was introduced to Marvis Wilson, the manager of Marathon Car Wash, through his uncle, Martin Williams. Kelly testified that Marvis Wilson interviewed him for the job and his uncle, his brother Edcedric Williams, and another guy "Unc" were present during the interview. Kelly testified that he asked for the job and Marvis stated that he would try him out. T.19. Kelly started working that day and was supposed to work from 8:00 a.m. to 8:00 p.m., 6 to 7 days a week. T.21. The schedule was set by Marvis. Kelly testified that he was told by Marvis that he would get on the payroll every week and receive tips daily. T.20.

2. Kelly testified that he was given a t-shirt that the other employees wore. He was trained by his Uncle Martin. He was to wipe down or vacuum the cars. *Id.* Marathon provided the towels and tire shine. T.22. Kelly testified there were 7 to 10 other employees. He would put his name on a list, which determined who cleaned the next car at the car wash. T.26. The list was provided by Marathon.

3. Kelly testified that between April and July, he received about $100.00 per week in tips, but never received payroll. T.26.

4. Per the NCCI certificate, Respondent, Marathon Car Wash, did not have workers' compensation insurance on July 5, 2015. PX.1.

5. On July 5, 2015, Kelly put his name on the list and proceeded to clean a car. As a car exited the wash, Kelly entered the car when the car rapidly accelerated and rammed the back of another car. T.30. Kelly's head and knee hit the steering wheel. T.31. He got out of the car and his brother and "Unc" came over. Police were called and a report was made.

6. Per the police report, the driver of unit 2 (the car exiting the wash) was an employee of the car wash and was moving the car when it accelerated rapidly for unknown reasons and struck the rear of another vehicle. Unit 2 was the striking vehicle being driven by an employee of Marathon Car Wash. RX.1.

7. On cross-examination by Marathon, Kelly testified that he did not fill out any paperwork for the interview and did not receive a W2 or 1099. He never received a check or cash from the respondent. T.58. He received cash tips from the customer directly, which he did not

have to report to Marathon. T.59. Kelly reported to Marathon that he was not receiving his check and was told that he had to work every day to receive a check. He worked 11 weeks without a check. T.61. He stated that he never discussed an hourly or weekly rate of pay. T.87. Kelly testified that on days it rained, he would call in to make sure he did not have to come in to work. T.88.

8. On cross-examination by the State, Kelly stated that he only worked for the car wash. T.68. If he could not make it into work, he had to call the manager. T.68. He would not get paid if he did not come into work every day. T.69. He was never told how much he would get paid. T.70. He thinks he would have been fired had he left early. T.71. He was not aware of anyone being fired. T.72. He would put his name on a list and they would go on to the next name if he did not want that car. T.79. He stated that he did not have to punch in and only had to put his name on the list. T.84. He did not have to sign out when he left. T.85.

9. Marvis Wilson is a manager at the car wash and stated Kelly was not an employee. T.7. He did not interview or offer petitioner a job. T.10. He stated that the guys can come and go as they work for tips only. T.12. Marathon does not collect the tips. T.13. They provide training for the guys. T.14. They only provide services for tips and no other function. *Id.* They have two full-time and 4 to 5 part-time employees. He has two guys that get paid about $4.00 per hour. T.15. He stated that petitioner's t-shirt was likely from one of Petitioner's family members. T.16.

10. On cross-examination by petitioner's attorney, Wilson stated that Joseph Jerbin is the owner. T.17. Wilson never met Kelly prior to the July 5 accident. He stated that Kelly's uncle is an employee and was paid with cash. T.18.

11. On cross-examination by the State, Wilson stated that he gets a 1099 from his employer and gets paid a percentage of the car wash earnings. T.28. He learned after the accident that the respondent did not have workers' compensation insurance. T.32. He stated that the guys that work for tips have t-shirts. T.33. He stated that Kelly could not come and go as he pleased as he never saw him before. T.35. He never saw petitioner wiping down cars. T.36. He stated some guys who work for tips can come and go with notification to him. T.37. Wilson testified that Kelly did not fill out an employment application. *Id.*

12. Edcedric Williams is Aubrey Kelly's brother. T.40. He was hired by Marvis and was given a t-shirt. T.42. Williams was present when his brother started working for Respondent in April 2015. His Uncle introduced them to Marvis. In April 2015, his brother, his uncle Martin, Marvis and himself were at Marathon and they had a conversation about what Kelly had to do. He stated that Marvis hired Kelly. T.49. He stated Kelly's schedule was 8 a.m. to 8 p.m. T.49. Marvis was present on the day of the accident. Edcedric testified that he did not have to complete an employment application when he was hired. T.52.

13. On cross-examination by Marathon, Edcedric testified that he would call the station on rainy days to see if there was work. T.54. He only received tips. T.55. He was told that he would be put on the payroll if he came in to work every day. *Id.* Despite coming into work every day, he was never put on the payroll. He continued to work as he needed the money. T.56.

14. On cross-examination by the State, Edcedric stopped working for Respondent when it went out of business. He worked 7 days a week, 12 hours a day. T.61. He could leave for lunch when he wanted, but had to let the manager know first. *Id.* He was allowed to not show up for work as he had a good relationship with the owners. T.62.

15. Following the accident, Kelly was transported via ambulance to Franciscan Health Olympia Fields on July 5, 2015. The insurance information indicated Kelly was unemployed while the coverage information indicated he was employed by Marathon Car Wash. Kelly had a Medicaid Card. Per the report, Kelly reported that there was a police stick pressing down on the gas pedal causing the car he was about to wipe off to rapidly drive forward. The clinical impression was cervical strain and a knee contusion. PX.12.

16. Kelly underwent an initial consultation with Dr. Krishna Chunduri on July 17, 2015. Kelly complained of neck and low back pain with bilateral lower extremity pain and left lower extremity weakness. He was taken off work. PX.3.

17. Petitioner underwent an MRI of the cervical spine on July 24, 2015 that revealed grade 1 retrolisthesis of C4 over C5, hypertrophy of the facet joint and uncinate process at C3-C4 and C5-C6, spinal canal and neural foramina were patent at all cervical spine levels, and the remainder of the cervical spine was normal. PX.3.

18. A lumbar MRI was also performed that revealed a 1 to 2 mm diffused disc protrusion compressing the thecal sac at L3-L4 and L4-L5. There was spinal canal stenosis. The disc material and facet hypertrophy was causing bilateral neuroforminal narrowing that effaced the left and right existing nerve roots at those levels. At L5-S1, there was a 1 to 2 mm diffused disc protrusion compression the thecal sac and osteophyte complexes at the lateral aspect. There was disc material and facet hypertrophy causing bilateral neuroforminal narrowing that effaced the left and right L5 nerve roots. PX.3.

19. Kelly underwent an MRI of the left knee on July 29, 2015 that revealed a medial collateral ligament sprain and small knee joint effusion. PX.5a.

20. Kelly was seen by Dr. Chunduri on August 10, 2015 for neck and low back pain. His neck pain was 6 out of 10 and 10 out of 10 in the low back. A course of conservative treatment with physical therapy was recommended and he was to follow-up once he completed 3 to 4 weeks of therapy. Injections were recommended. PX.3.

21. Kelly was seen by Dr. Jamie VanDenElzen of Advances Spine and Rehab Center on August 13, 2015. It was noted that Kelly had severe disability to his lower back as he scored an 82 on the Revised Oswestry Lower Back Disability Index. The diagnoses were a sprain of the cervical ligaments; strain of the muscle, fascia, and tendon at the neck; sprain of the lumbar ligaments; muscle spasms of the back; and, knee pain. Kelly continued therapy through November 10, 2015. PX.3.

22. Kelly was seen by Dr. Neeraj Jain of Pinnacle Pain Management on August 26, 2015 for an initial evaluation. Kelly reported that his neck pain had resolved and his knee pain was much improved, but his low back pain remained very severe. He reported a great deal of difficulty sleeping and doing his normal activity. He had not worked since the accident. Examination revealed that Kelly could toe walk with reports of severe low back pain and could only walk a few steps due to pain. He could flex and extend to 20 degrees with reports of severe pain. He had full range of motion of the cervical spine. He had pain with palpation of the paravertebral muscles of the lumbar spine. The MRI of the left knee revealed a medial collateral ligament sprain/strain. Dr. Jain recommended continued therapy with continued use of Norco. Dr. Jain opined that Kelly's condition was directly related to the accident. He was continued off work. PX.5a.

23. Dr. Jain performed a bilateral L4-L5 and L5-SI transforaminal epidural steroid injection with nerve root block on November 3, 2015 and January 12, 2016. PX.5a.

24. During his follow-up visit with Dr. Jain on February 10, 2016, Kelly reported excellent relief of his low back pain for two weeks following his injections, but then the pain quickly returned. He now had 50 percent relief but the pain was still severe. Examination revealed reduced range of motion of the lumbar spine. He could flex to 60 degrees and extend to 10 degrees with pain. He had no pain to palpation of the lumbar spine. They recommended a third epidural injection and to restart physical therapy. He was to remain off work. The diagnoses remained lumbar discogenic pain, lumbar facet syndrome, and lumbosacral radiculopathy. PX.5a.

25. Petitioner underwent a third injection on March 18, 2016.

26. During his follow-up visit with Dr. Jain on April 6, 2016, Kelly reported 40 percent relief that only lasted two weeks. Kelly had recurrent pain with complaints of numbness and tingling in his bilateral buttocks and posterior thighs. His pain increased to 10 out of 10 with 8 being the average. His examination remained unchanged. Dr. Jain recommended another injection and they discussed a diagnostic branch block to prognosticate the efficacy of longer lasting radiofrequency ablation. He was to continue therapy and continued off work. PX.5a.

27. Kelly was last seen by Dr. Jain on September 8, 2016 with continued lumbar pain that was 7 out of 10 and radiated down into his bilateral buttocks and upper thighs. He had been

discharged from therapy. Dr. Jain recommended an L3-SI discogram to pinpoint the pain generator followed by a CT scan. He was to continue with his medication including Flexeril, Norco, Ibuprofen and a topical cream. He was to also continue using his LSO brace and TENS unit. He was not allowed to return to work. PX.5a.

28. Kelly stated that Marvis and an owner of the company told him to stop going to court and they would take care of all the bills. T.45. Petitioner stated that he is currently in constant pain and his back and knee hurt. T.51.

An employment relationship is a prerequisite for an award of benefits under the Act, *Roberson v. Industrial Comm'n,* 225 Ill. 2d 159, 174, 866 N.E.2d 191, 310 Ill. Dec. 380 (2007) quoting *O'Brien v. Industrial Comm'n,* 48 Ill. 2d 304, 307, 269 N.E.2d 471 (1971). In assessing whether an individual is an employee, Illinois courts have articulated a number of factors, including the right to control the manner in which the work is done, the nature of the work performed by the alleged employee in relation to the general business of the employer, the method of compensation, the right to discharge, and the label the parties place upon their relationship. *Roberson,* 225 Ill. 2d at 175; *Ware v. Industrial Comm'n,* 318 Ill. App. 3d 1117, 1122, 743 N.E.2d 579, 252 Ill. Dec. 711 (2000); *Area Transportation Co. v. Industrial Comm'n,* 123 Ill. App. 3d 1096, 1100, 465 N.E.2d 533, 80 Ill. Dec. 421 (1984). Also relevant is whether the purported employer dictates the worker's schedule, whether income and social security taxes are withheld from the worker's paycheck, and whether the purported employer supplies the worker with materials and equipment. *Roberson,* 225 Ill. 2d at 175; *Ware,* 318 Ill. App. 3d at 1122; *Area Transportation Co.,* 123 Ill. App. 3d at 1100. While no single factor is determinative and the significance of the factors will change depending on the work involved, the right to control and the nature of the work performed by the alleged employee in relation to the general business of the employer are often regarded as the two most important factors. *Roberson,* 225 Ill. 2d at 175; *Ware,* 318 Ill. App. 3d at 1122.

Regarding the nature of the work performed, the Supreme Court has noted that "because the theory of workmen's compensation legislation is that the cost of industrial accidents should be borne by the consumer as a part of the cost of the product, this court has held that a worker whose services form a regular part of the cost of the product, and whose work does not constitute a separate business which allows a distinct channel through which the cost of an accident may flow, is presumptively within the area of intended protection of the compensation act." *Ware,* 318 Ill. App. 3d at 1124, quoting *Ragler Motor Sales v. Industrial Comm'n,* 93 Ill. 2d 66, 71, 442 N.E.2d 903, 66 Ill. Dec. 342 (1982).

The question whether an employer-employee relationship existed at the time of an accident is one of fact. *Ware,* 318 Ill. App. 3d at 1122. Where elements of both an employer-employee relationship and independent contractor status are present, the Commission is empowered to draw the inferences either way. *Area Transportation Co.,* 123 Ill. App. 3d at 1099.

The evidence supports that Kelly was an employee of Marathon Car Wash. Marathon trained its employees how to clean cars, provided its workers with rags, tire shine, and the vacuums to clean cars, and controlled how the work was to be performed. Marathon also had the right to fire its workers if they did not show up for work and required its workers to call to see if they had to come in to work.

Furthermore, Marathon required its workers to work 12 hours a day, 7 days a week. If they failed to work the required 7 days a week, 12 hours a day, they would not be put on the payroll. While Petitioner did not know his hourly rate of pay, the testimony establishes that some of the employees earned tips and some of the employees earned $4.00 per hour. There was no evidence that Marathon withheld taxes. Marathon required its workers to work 84 hours a week before they would be put on the payroll. Any deviation from the 84-hour work week resulted in the employees not getting paid and Marathon receiving the benefit of free labor. The Commission finds that this supports an employment relationship.

In further support of an employment relationship, the job duties performed by the workers were an essential part of Marathon's business. The workers were required to clean the inside of the cars and wipe down the exterior of the cars following the wash; functions the Commission finds important to a car wash operation.

The Commission has serious misgivings regarding Marvis Wilson's testimony relative to the employment relationship and gives no weight to his testimony that the workers were independent contractors and that he did not provide Kelly with a company t-shirt.

The Commission finds Marathon exerted sufficient control over its workers through its coercive and unscrupulous business practices, thereby creating an employment relationship.

Turning to the issues of accident and causal connection, the Commission finds that Kelly sustained an accident arising out of and in the course of his employment on July 5, 2015 and established that his current condition of ill-being is causally related to the accident. The Respondent offered no evidence to rebut those issues.

Pursuant to Section 10 of the Act:

> The compensation shall be computed on the basis of the '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. Where by reason of the shortness of the time during which the employee has been in the employment of his employer or of the casual nature or terms of the employment, it is impractical to compute the average weekly wages as above defined, regard shall be had to the average weekly amount which during the 52 weeks previous to the injury, illness or disablement was being or would have been earned by a person in the same grade employed at the same work for each of such 52 weeks for the same number of hours per week by the same employer. 820 ILCS 305/10

The Commission finds that the proper basis to calculate Kelly's AWW is through the fourth method listed above. Marvis Wilson testified that Marathon has two full-time and 4 to 5 part-time employees who earn $4.00 per hour. The testimony establishes that Kelly was required to work 7 days a week, 12 hours a day resulting in an 84-hour work week. The Commission finds that an employee in the same position as Kelly earned $4.00 per hour and had to work 84 hours a week. Therefore, Kelly's AWW is $336.00 resulting in a weekly TTD rate of $224.00. The Commission finds Kelly is entitled to 63-6/7 weeks of TTD (July 5, 2015 through September 27, 2016, the date of hearing). The records demonstrate that Petitioner was taken off work following the accident and has not been released by his doctor. The respondent failed to offer evidence establishing that petitioner was capable of working.

The Commission further awards all reasonable and necessary medical expenses, and prospective medical treatment as recommended by Dr. Jain.

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

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $224.00 per week for a period of 63-6/7 weeks, July 5, 2015 through September 27, 2016, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize and pay for prospective medical treatment as recommended by Dr. Jain.

17IWCC0803

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses under §8(a) of the Act and subject to the medical fee schedule.

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 $14,400.00. 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: DEC 15 2017

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
O: 11/7/17
052

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

KELLY, AUBREY
Employee/Petitioner

Case# **15WC026284**

MARATHON CAR WASH & MICHAEL FRERICHS
ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

17IWCC0803

On 12/20/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.64% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

1920 BRISKMAN BRISKMAN & GREENBERG
RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

0000 MARATHON CAR WASH
21043 S CICERO AVE
MATTESON, IL 60443

5204 ASSISTANT ATTORNEY GENERAL
CHRISTOPHER FLETCHER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

17IWCC0803

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Aubrey Kelly
Employee/Petitioner

v.

Case # **15** WC **26284**

Consolidated cases: **N/A**

Marathon Car Wash
& Michael Frerichs, Illinois State Treasurer,
as *ex-officio* custodian of the Injured Workers' Benefit Fund
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the city of **Chicago**, on **9/27/16 and 10/21/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **July 5, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondent.

On 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 an average weekly wage of **$100.00**.

On the date of accident, Petitioner was **27** years of age, ***single*** with **0** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

ORDER

The Arbitrator finds as a matter of law and fact he was not an employee of the Respondent in the case at bar. Therefore, the Arbitrator makes no award in the other issues in the case.

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

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

#01 George Andros
Signature of Arbitrator

December 20.2016
Date

DEC 20 2016

STATE OF ILLINOIS)
)
COUNTY OF Cook)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Aubrey Kelly,
Employee/Petitioner

Case # 15 WC 26284

v.

Chicago, IL

Marathon Car Wash & Michael Frerichs, Illinois State Treasurer, as *ex-officio* custodian of the Injured Workers' Benefit Fund,
Employers/Respondents

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

I. FINDINGS OF FACT

This action was pursued under the Illinois Workers' Compensation Act (the "Act") by the Petitioner seeking Section 19(b) relief from Marathon Car Wash and the Injured Workers' Benefit Fund regarding Petitioner's work-related accident on July 5, 2015. Marathon Car Wash was represented by counsel at trial. The Illinois Attorney General filed an appearance on behalf of the Illinois State Treasurer, as *ex-officio* custodian of the Injured Workers' Benefit Fund. Petitioner's Exhibits 1 - 12 were admitted into evidence. Respondent-employer's Exhibit 1 was also admitted into evidence.

Petitioner testified he worked at Marathon Car Wash for a "couple of months." Petitioner claimed his uncle introduced him to the owner, Marvis. Petitioner's uncle is Martin Williams. Petitioner claimed his uncle accompanied him to interview at the car wash on Cicero Avenue in Matteson, Illinois. Petitioner testified his uncle was there for the interview with Marvis and another manager they called "Unc.". Petitioner also testified his brother Edcedric Williams was also there and worked for the car wash.

Petitioner testified during the interview he told Marvis he works hard, is a fast learner, and is highly motivated. Petitioner claimed to ask for a job and Marvis said he would try him out. Petitioner was then given a t-shirt for the Marathon Car Wash.

Petitioner testified Marvis told him the job duties at the car wash. Petitioner claimed he was told payroll would be every week and tips would be every day. Petitioner testified he was told he could start working the same day he was interviewed. Petitioner testified salary for the job was to be in two forms: he would be paid payroll and then also paid tips.

Petitioner claimed the schedule was 8 a.m. to 8 p.m. for 6 days a week and sometimes 7 days, if required. Items for the job like towels and tire shine were provided by Marathon Car Wash. Petitioner claimed all the employees have the same company t-shirt, about 7 to 10 individuals, and no customers were given the t-shirt.

Petitioner claimed in April, May, June, and the first 5 days of July he continued to work at the car wash and perform his duties. Petitioner testified, "They have a list of names on the list and that's how I knew which car to do." Petitioner claimed the list was provided by Marathon. Petitioner received tips up until July and never received his promised payroll. Petitioner's tips were all in cash.

Concerning the date of the accident, Petitioner testified he placed his name on the list. Petitioner waited for a car to come from the car wash bay. Petitioner testified, "I initially opened the door to get in the car and I couldn't get it into drive. I finally got it in drive and it shot off and accelerated quickly." Petitioner was then in an auto accident, smashing into the car ahead of him. Petitioner's forehead hit the steering wheel. Petitioner's back and neck went forward and back fast and his right knee hit under the steering wheel.

After the accident, Petitioner was sitting on the ground and his brother Edcedric, who was working at Marathon also, came over to him. Petitioner reported the accident to Marvis and Unc. Petitioner was in pain and he was told to lie down. Petitioner testified the police came and there was a police report. Petitioner went to the ER at St. James in Olympia Fields. Petitioner later went to Illinois Orthopedic Network for treatment.

Petitioner explained he had three epidural injections and the last visit with Dr. Jane was in September of 2015. Petitioner was recommended to have a discogram, but Petitioner has no way to pay for it. Petitioner testified he received disability notes from two of his doctors. Petitioner testified shortly before his trial he saw Marvis at the car wash and Marvis came over to him. Petitioner claimed another man was there, the owner of Marathon and they started a conversation with Petitioner. Petitioner testified they told him to stop coming to Court and "forget all this lawyer stuff," and that they had a care package for him. The other individual told Petitioner he would sue Petitioner. This intimidation occurred the day before trial in this case.

Petitioner went on to testify he was approached by his uncle Martin Williams and then he saw Marvis and they attempted to talk to him about the case before the trial started.

Concerning his current condition, Petitioner testified he has pain in his neck and back and his activities of daily living are affected, such as cooking and cleaning.

On cross-examination, Petitioner testified he previously worked at QFS Staffing prior to working at Marathon Car Wash, where he did industrial work. Petitioner claimed he did have an interview at Marathon. He was not provided a W-2 or 1099 and was not provided an employment application. Petitioner claimed he was told he would be paid weekly and he never received payroll. Petitioner testified he would have "maybe $100 in tips" a week and he received those tips from owners of vehicles he serviced. Petitioner did not pay Marathon any portion of

his tips and did not have to give an accounting to Marathon of the different vehicles he serviced. On days it was raining, Petitioner called into the car wash to make sure he did not have to go in.

Marvis Wilson was also called as a witness in Respondent-employer's case-in-chief. Mr. Wilson testified he is one of the managers at Marathon Car Wash. Mr. Wilson testified Petitioner was not an employee on July 5, 2015. Mr. Wilson has employees at Marathon named Damon Shaw, Martel Williams, and a couple more individuals.

Mr. Wilson claimed he pulled up to work after the accident took place and saw the Petitioner was sitting on the ground. Mr. Wilson testified, "I'm not sure what he was doing at the car wash that date." Mr. Wilson testified he never offered Petitioner a job. Mr. Wilson testified no one else, to the best of his knowledge, offered him a job. Mr. Wilson testified arrangements for the individuals that work for tips "come and go as they please." Mr. Wilson said, "Well they let us know if they want to work for tips. They're not full time or anything like that." Mr. Wilson said the arrangement is between the car owner and that individual working for tips.

Mr. Wilson testified Marathon provides training for people that work for tips and those individuals do not perform any other duties for the business. Mr. Wilson claimed there are two individuals that are full-time employees and roughly four or five part-time employees.

On cross-examination, Mr. Wilson testified Joseph Jerbin is an owner of Marathon and he has a couple Partners, but Mr. Wilson did not know their names. Mr. Wilson claimed "never in his life" did he meet Petitioner before the day of the accident. Mr. Wilson claimed he has hired other employees and gave them an application, set their schedules, and explained their job duties. Mr. Wilson claimed perhaps Petitioner got his Marathon t-shirt from another family member because he knows Petitioner's brother had a Marathon t-shirt.

Edcedric Williams testified next in Petitioners rebuttal case. Edcedric is the brother of Petitioner. Edcedric testified Marvis Wilson is the boss at the car wash. Edcedric was working at the carwash in the past. Edcedric worked at the car wash for two years drying cars. Edcedric was also paid in tips. He claimed to work from 8 a.m. to 8 p.m. and that he was hired by Marvis Wilson and given a Marathon t-shirt. Edcedric was nearby when Petitioner had a conversation with Mr. Wilson but Edcedric did not know what was said during that conversation. Edcedric claims Mr. Wilson hired his brother and "showed him the ropes of what to do." Edcedric did not complete a written job application.

At the time of the accident, Edcedric testified Mr. Wilson was in the car wash lobby with him. Petitioner testified he never received any money other than tips, but was told that if he came to work every day he would be put on the payroll.

On cross-examination by the State Treasurer, Edcedric admitted if he wanted to take a Friday off work, he could just take it off. Edcedric further admitted he could just come back to work after a day off because of his good relationship with Marathon.

II. CONCLUSIONS OF LAW

f. Did Petitioner prove an Employer-Employee Relationship?

The law in Illinois provides no easily defined test for determining whether an employer-employee relationship exists. Rather, such a relationship, if one exists, must be inferred from the conduct of the parties, where the right to control work being the primary factor in determining an employment relationship. There are multiple factors to consider in assessing the nature of the relationship between the parties. *Ware v. Industrial Comm'n,* 318 Ill.App.3d 1117, 1122 (1st Dist.2000). Among these are: 1) Whether the employer may control the manner in which the person performs the work; 2) Whether the employer dictates the person's schedule; 3) Whether

the employer pays the person hourly; 4) Whether the employer withholds income and Social Security taxes from the person's compensation; 5) Whether the employer may discharge the person at will; 6) Whether the employer supplies the person with the needed instrumentalities; and 7) Whether the employer's general business encompasses the person's work. *Roberson v. Industrial Comm'n*, 225 Ill.2d 159, 175 (2000). Other relevant factors include: 8) The label the parties place on the relationship; and 9) Whether the parties' relationship was "long, continuous, and exclusive." *Ware*, 318 Ill.App.3d at 1122, 1126. "The single most important factor determining whether a party is an employee or an independent contractor is the right to control the manner in which in one's work is done...an independent contractor is one who undertakes to produce a given result, without being controlled as to the method by which he attains the result." *Bryant v. Fox*, 162 Ill.App.3d 46, (1st Dist. 1987). This Arbitrator recognizes no single factor is determinative and the question depends on the totality of the circumstances.

In the case at bar, applying the above factors, the Arbitrator finds as a matter of law and fact the Petitioner is no an employee under the Act.

Petitioner has failed to meet his burden to prove an employer-employee relationship. It is clear Petitioner dictated how he was going to complete the work he did on vehicles he serviced and Marathon exercised no control over Petitioner in this regard. If he did a good job for the customer, he would be tipped. That does not mean he was an employee of Marathon Car Wash. The Arbitrator is further persuaded by the fact no taxes of any kind was taken out of Petitioner's tips and no W-2 nor 1099 was issued. That Petitioner was promised to be put on the payroll was just that, a thin promise.

Finally, this Arbitrator is very persuaded by the testimony of Edcedric Williams when he testified on cross-examination that he could take a day off work if he wanted and there would

essentially be no consequences, as he could just return to the car wash on another day because of his good relationship with the owners. It seems too clear that Edcedric and Petitioner could come and go as they pleased to pick up cash in the form of tips from work they did on a customer's vehicle. That they would provide no accounting for work they did on each car is further proof Marathon was not controlling them.

This Arbitrator questions the credibility of Marvis Wilson and his testimony that he "never in his life" met Petitioner before the date of the accident and that he had no idea why Petitioner was at the car wash that day. Despite Mr. Wilson's serious credibility problems, the totality of the evidence dictates that the relationship Petitioner had with Marathon was not an employer-employee relationship. Therefore, Petitioner has failed to meet the burden to prove an essential element of his case and benefits to Petitioner under the Workers' Compensation Act are denied.

Given the above, the other issues are moot.

*_#01 George Andros_*

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERTO MORALES aka
NELSON CENTENO,

Petitioner,

vs. NO: 14 WC 29803

COUNTYWIDE LANDSCAPING INC.,

17IWCC0804

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioenr herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, prospective medical, notice, and temporary total disability (TTD), and being advised of the facts and applicable law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. Petitioner's claim for compensation is denied.

After reviewing the record, the Commission is compelled to comment on the disingenuous conduct of the Petitioner. The Commission has come to learn that Roberto Morales had unlawfully assumed the identity of a person named Nelson Centeno, as he admitted in *Roberto Morales v. Countywide Landscaping Inc.*, 14 WC 29803. Roberto Morales previously filed a claim under the name Nelson Centeno, *See Nelson Centeno v. Minute Men Staffing,* 10 WC 44071.

During the arbitration hearing in *Morales*, 14 WC 29803, the Petitioner, then identified himself as Roberto Morales, and on cross-examination admitted that he also used the name Nelson Centeno. Morales further admitted that he stopped using that name, Nelson Centeno, after he was confronted by a police officer and accused of identity theft. From that point forward, Morales indicated that he used his true name, Roberto Morales, the named Petitioner in the case at bar.

17IWCC0804

During the pendency of the *Centeno* claim, and under the name Nelson Centeno, the petitioner denied that he had used the name Roberto Morales, denied that he had filed another claim involving a low back injury, under any other name, and denied that he had in fact returned to work for Countywide Landscaping. This is a component of the conduct that the Commission finds so egregious that it causes the Commission to now question the credibility of this Petitioner in all aspects of both cases.

Because of his admissions in *Roberto Morales,* case (14 WC 29803), the two cases are so inextricably intertwined that the transcript in *Morales* and the transcript in *Centeno* must be considered together. The Commission, therefore, amends the Application for Adjustment of Claim filed in the Nelson Centeno case and the Application for Adjustment of Claim filed in the Roberto Morales case, *sua sponte*, to reflect the name Nelson Centeno aka Roberto Morales on Case 10 WC 44071 and Roberto Morales aka Nelson Centeno under case 14 WC 29803. The Commission further attaches to its Decision the Arbitrator's Decision in *Centeno* and considers the transcript from *Centeno,* case (10 WC 44071), as Commission's Exhibit 1, so that a reviewing court has a full understanding of the dishonest nature of the Petitioner, Roberto Morales aka Nelson Centeno.

As Nelson Centeno, the Petitioner alleged that he sustained a back and ankle injury in 2010. A hearing under Section 19(b) of the Act was held in September 2012, and as Centeno he was awarded benefits including a discogram and fusion as recommended by Dr. Thomas McNally, together with $97,230.00 in unpaid medical expenses. On Review of the first 19(b) Decision, the Commission reduced the medical bills to $66,781.33. That Decision, 13 IWCC 914, was appealed to the Appellate Court. Before the Appellate Court's Decision was issued, Petitioner, as Centeno filed a second 19(b) Petition and a hearing was held in December 2015. Petitioner, as Centeno sought TTD benefits from September 2012 through the December 2015 hearing, penalties for the non-payment of the medical bills, and enforcement of the prospective medical that was awarded in the first 19(b) hearing, held in 2012.

During the December 2015 hearing, the Petitioner, as Centeno, testified that he had not worked since 2010 and specifically denied working at Countywide Landscaping. Petitioner, as Centeno testified that he wanted to proceed with the fusion as recommended by Dr. McNally. Respondent was about to call Detective John Zurick as a witness. Detective Zurick works for the West Chicago Police Department and the record demonstrates that he had arrested Roberto Morales for identity theft. The identity that Morales had stolen was that of Nelson Centeno. At the request of Petitioner's counsel, Michael Lulay, the hearing was continued to January 25, 2016, at which time the Petitioner, Centeno aka Morales failed to appear, as was previously agreed.

During the continued hearing on January 25, 2016, Detective Zurick confirmed that he investigated a report of identity theft involving the name Nelson Centeno aka Roberto Morales. Through his investigation in February 2014, Detective Zurick learned that Centeno aka Morales was employed at Countywide Landscaping in Elburn, Illinois. Detective Zurick personally spoke with Centeno aka Morales at Countywide Landscaping. Detective Zurick testified that Centeno

17IWCC0804

aka Morales admitted to purchasing the name Nelson Centeno and a Social Security card with a fraudulent number. Centeno aka Morales admitted that his name was Roberto Morales.

Detective Zurick was present at the first hearing and noted that the gentleman at the first hearing – who was not present at the continued hearing – was known as Roberto Morales aka Nelson Centeno, and the same person that he had arrested for identity theft.

During the pendency of the *Centeno* case, Roberto Morales filed an Application for Adjustment of Claim in September 2014 alleging a back injury in August 2014 while moving an outdoor grill. That claim, case number 14 WC 29803, was filed against Countywide Landscaping and heard in April 2016. The claim was denied.

During the hearing in *Morales*, Morales testified on cross-examination that he was no longer pursuing the *Centeno* case (10 WC 44071). Petitioner, as Morales, testified that he last treated with Dr. McNally under the alias Nelson Centeno on August 4, 2015. He did not inform Dr. McNally of the August 7, 2014 accident, as alleged in *Morales*. Dr. McNally had recommended that Centeno undergo an L5-SI discogram and lumbar fusion.

While operating under the alias of Morales, petitioner began treating with Dr. Ronald Michael of the Illinois NeuroSpine Institute and denied a prior history of a low back injury. Dr. Michael performed an L5-SI discogram and posterolateral discectomy on October 12, 2015 and an L5-SI biacuplasty on November 9, 2015.

The respondent in *Morales*, obtained a Section 12 opinion from Dr. Wellington Hsu of Northwestern University relative to Roberto Morales on March 11, 2015. Dr. Hsu did not believe a lumbar fusion was appropriate and opined that Morales was at MMI and could work full-duty and without restrictions. He noted that Morales had 4 out of 4 positive Waddell signs.

The Commission affirms the Arbitrator's denial of benefits in this case. The Petitioner, Roberto Morales aka Nelson Centeno, effectively admits to having perpetrated a fraud upon the Commission and then prays that the Commission award benefits against the Respondent. Not since the Petitioner in *Walker v. Illinois Medi-Car, Inc.*, 2015 Ill. Wrk. Comp. LEXIS 1257. 15 IWCC 629 *Aff'd* 2017 IL App (2d) 160368WC-U, has the Commission seen a more prolific liar. Roberto Morales aka Nelson Centeno under any *nom de plume* cannot be believed and has no credibility. His conduct in these matters cannot be countenanced.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.
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: DEC 15 2017

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MORALES, ROBERTO
Employee/Petitioner

Case# **14WC029803**

COUNTY WIDE LANDSCAPING INC
Employer/Respondent

17IWCC0804

On 6/20/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.40% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0226 GOLDSTEIN BENDER & ROMANOFF
DAVID Z FEUER
ONE N LASALLE ST 26TH FL
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY
BRIAN T RATERMAN
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

17IWCC0804

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ROBERTO MORALES
Employee/Petitioner

v.

COUNTY WIDE LANDSCAPING, INC
Employer/Respondent

Case # **14** WC **29803**

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 **Arbitrator Hegarty**, Arbitrator of the Commission, in the city of **Geneva**, on **April 18 and April 19, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **August 7, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$27,896.00**; the average weekly wage was **$621.24**.

On the date of accident, Petitioner was **39** years of age, ***married*** with **3** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

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

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

ORDER

Because Petitioner has failed to prove by a preponderance of the evidence that he sustained accidental injuries arising out of and in the course of his employment with Respondent, all benefits are denied.

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

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

Jason C. Wyatt

Signature of Arbitrator

6/16/16
Date

JUN 20 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERTO MORALES,	)	
	)	
Petitioner,	)	
	)	No.: 14 WC 29803
vs.	)	
	)	
COUNTYWIDE LANDSCAPING, INC,	)	
	)	
Respondent.	)	

Petitioner testified that on August 7, 2014 he was working for the Respondent repairing bricks and installing a large grill. As he and a co-worker unloaded the grill and placed it on a cart, his back snapped causing immediate pain. According to his testimony, he continued working until 5:00 p.m. and later called Respondent's representative, Sebastian, to inform him of his work injury. Approximately 5 days after his alleged accident, Petitioner told his boss, Brian Larsen, that he had suffered an accident at work and needed medical treatment. Petitioner testified that Mr. Larsen told Petitioner that he did not care.

Petitioner testified that on August 13, 2014 he was seen at Central DuPage Hospital for low back pain and received injections and an IV. (PX. 1) Petitioner testified that he was next seen by Dr. Ravi Barnabas of Herron Medical Center and was prescribed medication, physical therapy and referred to Dr. Abdellatif for injections. (PX. 2). Petitioner then testified that he had three injections at Pro Clinics. (PX. 4(a) and 4(b)). Petitioner testified that he did not feel better after the injections and he was referred to a surgeon. Petitioner further testified that he saw Dr. Mark Sokolowski on January 21, 2015 where he was examined and surgery was recommended, which Petitioner testified was a lumbar fusion. (PX. 5). Petitioner further testified that he was then referred to Dr. Ronald Michael who performed two surgeries. (PX 3). Specifically, Petitioner testified that Dr. Michael performed a discectomy on October 12, 2015 and then performed an L5-S1 biacuplasty on November 9, 2015. (*Id.*). Petitioner stated that Dr. Michael recommended additional physical therapy after the surgeries. (*Id.*). Finally, Petitioner testified that Dr. Michael is currently prescribing medications and has not released him from his care. Petitioner further testified that Dr. Michael recommended a lumbar fusion. Petitioner stated that he has a lot of low back pain and wants the fusion surgery.

Petitioner testified that he worked for 5-6 months after August 7, 2014 in a factory that manufactured glass but had to quit before the October, 2015 surgery and that he has not worked since.

On cross-examination, Petitioner admitted the following:

- That he had a prior low back injury for which he sought treatment using the alias "Nelson Centeno."
- That he purchased a driver's license and social security card from someone in West Chicago, Illinois. (Rx 5).
- That the Michigan drivers' license and social security card of "Nelson Centeno" shown as

Respondent's Exhibit 5, were indeed his. (*Id.*).

- That as Nelson Centeno he hurt his left ankle and low back when he lifted something heavy while working for a concrete company named "Minute Men" in 2010 and that he filed an Application for Adjustment of Claim for this accident under his alias name captioned *Nelson Centeno v. Minute Men*, Case No. 10 WC 44071. (RX. 12).

- That he sought treatment following his 2010 "Nelson Centeno" claim that included left ankle surgery and low back treatment. Dr. Howard Freedberg removed fixation hardware with a scar revision and repair of the deltoid ligament on June 3, 2011. (RX. 11, pg. 260-261).

- That two months prior to his alleged accident case in the case at bar, he treated with Dr. Thomas McNally at Suburban Orthopedics as Nelson Centeno for his low back, and that Dr. McNally referred him to a general surgeon for an opinion regarding the feasibility of an anterior approach for lumbar inter-body fusion. (*Id.*).

- That he was seeking medical and TTD benefits under two names, for the same time periods.

On continued cross-examination, Petitioner denied that he was still pursuing benefits as Nelson Centeno for his 2010 accident. Petitioner testified that he had dropped his "Nelson Centeno" case and was only seeking benefits against Countywide Landscaping as Roberto Morales. Petitioner testified that he has not recently testified in any hearings as Nelson Centeno and could not even recall how long it had been since he did testify in his 2010 claim. Petitioner was then presented and reviewed a trial transcript captioned *Nelson Centeno v. Minute Men*, 10 WC 44071, for testimony given on December 21, 2015. (RX. 14, pg. 1). Petitioner was read testimony given by Nelson Centeno on December 21, 2015, in which he stated that he saw Dr. McNally on June 3, 2014 and was prescribed a fusion surgery and instructed to stay off of work (RX. 14, pg. 27). Petitioner ultimately admitted that it was indeed him testifying in this hearing.

Petitioner testified that on August 7, 2014, he was Roberto Morales, which was his real name, because he changed his name from Nelson Centeno when he was investigated by a police officer and told to stop using the name Nelson Centeno.

On December 21, 2015 Petitioner, as Nelson Centeno, made the following admissions at a hearing before another Arbitrator:

- That he honored his physician's prescription to not return to any work duties since December, 2011. (RX. 14, pg. 26).

- That he had not worked since October 7, 2010 because of his back, ankle and leg condition. (*Id.* at pg. 57).

- That he sought temporary total disability benefits from Minute Men from September 7,

2012 through December 21, 2015. (*Id.* at pg. 62).

- That he never heard of a man named Roberto Morales. (*Id.* at pg. 65). When shown Respondent's Exhibit No. 5, a filed Application for Adjustment of Claim captioned *Roberto Morales v. Countywide Landscaping*, Case No. 14 WC 29803, Petitioner testified that he did not know who that Petitioner was. (*Id.* at pg. 76, 78, containing RX. 5). Petitioner further testified that he never treated with Dr. Abdellatif or Dr. Sokolowski. (*Id.* at pg. 84).

Testimony of Respondent's Witness(es)

Respondent's witness, Sebastian Mancera, testified that he has been employed as a foreman by Respondent, Countywide Landscaping for approximately 4 years. Mr. Mancera testified that he had been employed by Respondent a total of 10 years. Mr. Mancera stated that he recognized the Petitioner in the room and called him Nelson Centeno at work. Mr. Mancera stated that he also knew the Petitioner as Roberto. Mr. Mancera testified that he was working on August 7, 2014 at a resident's home to repair a patio and to perform various other landscaping functions. (RX. 20). Mr. Mancera testified that he was the foreman for this job and in his crew included Adrian Gonzalez, Petitioner, and another individual. Mr. Mancera testified that he remembered that there was a grill at this home that was moved on August 7, 2014 so his crew could work around it. Mr. Mancera testified that he assisted in the move and it was lifted under human power by four (4) men. Mr. Mancera testified that Petitioner was one of these men. Mr. Mancera testified that he and his men moved the grill a distance of approximately 50 to 100 feet from where it was installed on the resident's patio to another location on the side of their home. Mr. Mancera testified that the grill was placed on the ground and was never placed onto anything, including a pallet. Mr. Mancera testified that during the process of moving the grill, he observed that Petitioner appeared normal with no verbal or visual signs of injury. Mr. Mancera testified that the Petitioner did not tell him that he had hurt his back in moving the grill that day. Mr. Mancera further testified that the grill was not moved by anybody on his crew after it was initially relocated.

Mr. Mancera testified that the Petitioner demolished a stone fire pit after assisting in moving the grill. Mr. Mancera testified that demolishing a stone fire pit required that the Petitioner use a hammer and chisel to knock out the glue that held the stone bricks together. Mr. Mancera testified that after the adhesive was removed, Petitioner then lifted the bricks and moved them elsewhere. Mr. Mancera described the particular stone fire pit that the Petitioner was dismantling as a round fire pit with approximately 18 stones per row with three rows completing the fire pit. (RX. 18). Mr. Mancera testified that each stone weighed approximately 20-30 pounds. (*Id*). Mr. Mancera testified that after dismantling the fire pit, Petitioner did not make any complaints to him of low back pain. Mr. Mancera did testify that Petitioner sent him text messages on August 8, 2014 stating that he hurt his low back moving the grill the previous day. Mr. Mancera finally testified that on August 8, 2014 his entire crew, including Petitioner, was previously scheduled off of work.

Brian Larsen testified that he has owned Countywide Landscaping since 2002. Mr. Larsen testified that the last time he spoke with the Petitioner was the Monday following August 7, 2014 when Petitioner came into his office requesting workers' compensation information and stated

he needed to see a doctor. Mr. Larsen testified that the Petitioner did not tell him that he injured his low back on August 7, 2014 lifting a grill.

Roberto Morales' Medical History

On August 13, 2014, Petitioner sought treatment for his alleged injury at Central DuPage Hospital where he denied any prior low back injury. (PX. 1).

Petitioner sought medical treatment at Herron Medical Clinic with Dr. Ravi Barnabas on August 21, 2014. (PX. 2). Dr. Barnabas recommended physical therapy three times a week for 6 weeks (*Id.*).

A lumbar MRI was performed at Lake Shore Open MRI and CT on October 21, 2014, which the radiologist interpreted to show L5-S1 mild retrolisthesis with a posterior disc herniation. (*Id.*).

Petitioner attended approximately 83 visits of physical therapy at 4 Pro Physical Therapy from October 28, 2014 through December 22, 2015. (PX. 4(a)).

Petitioner saw Dr. Ossama Abdellatif of Chicagoland Advanced Pain and Headaches Clinic on November 6, 2014 and denied any prior low back injuries. (PX. 4(b)).

Petitioner received a lumbar sacral block, an epidural steroid injection at L4-5 and a trigger point injection on November 14, 2014 from Dr. Abdellatif. (*Id.*) Petitioner then received trigger point injections into multiple mid and low back locations on November 20, 2014 by Dr. Abdellatif. (*Id.*) On December 5, 2014, Dr. Abdellatif performed lumbar trigger point injections, an L4-5 epidural steroid injection, and radiofrequency ablation at L3-4, L4-5, L5-S1, and at S1. (*Id.*) Petitioner received trigger point injections again in the mid and low back on December 11, 2014 from Dr. Abdellatif. (*Id.*) On December 13, 2014, Dr. Abdellatif performed additional trigger point injections into the lumbar region, an L4-5 epidural steroid injection, bilateral radiofrequency ablation at L3-4, L4-5, and L5-S1 and S1. (*Id.*)

On January 22, 2015, Petitioner saw Dr. Sokolowski who recommended an L5-S1 lumbar fusion by either anterior or posterior approach. (PX. 5). Petitioner reported that he had no prior back injuries. (*Id.*)

Dr. Abdellatif performed an additional epidural steroid injection at L4-5 and L5-S1 on February 25, 2015. (PX. 4B).

Petitioner saw Dr. Ronald Michael of the Illinois NeuroSpine Institute on August 31, 2015. (PX. 3). Petitioner denied a history of prior low back injury. (*Id.*)

On October 12, 2015, Dr. Michael performed an L5-S1 discogram and posterolateral discectomy with Elliquence instrumentation and intradiscal electrothermal therapy with Elliquence wand at Lakeshore Surgery Center. (*Id.*)

On November 9, 2015, Dr. Michael performed an L5-S1 biacuplasty on Petitioner at Lakeshore

Surgery Center. (*Id.*)

"Nelson Centeno's" Medical History

On December 22, 2011, Petitioner as "Nelson Centeno" was seen by Dr. McNally and diagnosed with an L5-S1 disc herniation and disc displacement that was aggravated and accelerated by the work-related accident on October 7, 2010. (RX. 11, pg. 74). Dr. McNally recommended a lumbar discogram at L5-S1 with 1 to 2 control levels to determine if the L5-S1 level reproduced Petitioner's back pain. (*Id.*) Dr. McNally opined that if there was concordant pain at the L5-S1 level, then an L5-S1 fusion surgery was appropriate. (*Id.*).

Petitioner returned to Dr. McNally on April 3, 2014 and reported the lumbar discogram was not performed but that he continued to have lower back pain that radiated forward to the left leg with numbness and tingling at the left knee. (*Id.* at pg. 26). Dr. McNally again recommended a lumbar discogram prior to an L5-S1 fusion. (*Id.* at pg. 28).

On June 3, 2014, Petitioner returned to Dr. McNally with low back pain most pronounced in the center of his back that was worse than his left leg pain. (*Id.* at pg. 11). He rated his pain 8/10. (*Id.*) Dr. McNally recommended a lumbar fusion, and Petitioner stated he was interested in this fusion surgery (*Id.*). Dr. McNally referred to a general surgeon for feasibility of an anterior or posterior approach of the fusion. (*Id.* at pg. 11-15). Dr. McNally indicated Petitioner was medically unable to work. (*Id.* at pg. 10). Petitioner testified that this June appointment was his last with Dr. McNally, as he was no longer pursuing treatment at Nelson Centeno and had "dropped his case."

Petitioner returned to Dr. McNally on August 4, 2015 and reported he never saw the general surgeon regarding an anterior approach to the lumbar fusion and continued to have low back pain, numbness and tingling in the anterior aspect of his left leg rated 8/10. (RX. 14, containing PX. 85). Petitioner reported that he last worked on October 7, 2010 and did not report to Dr. McNally an accident on August 7, 2014. (*Id.*). Dr. McNally again recommended a lumbar fusion and referred him to general surgery. (*Id.*). Dr. McNally further referred Petitioner to Dr. Eugene Lipov for a discogram of L5-S1 and one control level. (*Id.*).

Testimony of Section 12 Physician, Dr. Wellington Hsu

The Section 12 physician, Dr. Wellington K. Hsu, M.D., testified via evidence deposition on September 28, 2015. (RX. 2). Dr. Hsu initially examined the Petitioner at the request of the Respondent on March 11, 2015 and completed a report of his examination and findings. (RX. 3, generally). Dr. Hsu testified that he reviewed medical records for Petitioner both as Roberto Morales and "Nelson Centeno" for treatment incurred by Petitioner through the date of his examination. (RX 2, 9-13). Dr. Hsu further testified that he reviewed the images of an MRI of the lumbar spine performed of the Petitioner as Roberto Morales on October 21, 2014. (*Id.* at 12). Dr. Hsu testified that the MRI images showed L5-S1 degenerative disc disease that he classified as moderate. (*Id.*). Dr. Hsu stated he saw no evidence of any nerve root compression or spinal stenosis. (*Id.* at 12).

Dr. Hsu testified that he took a history from the Petitioner of his alleged accident on August 7, 2014 and further inquired into the Petitioner's past medical history. (*Id.* at 13). Dr. Hsu testified that the Petitioner reported to him that he did use the name Nelson Centeno and admitted to left ankle surgery; however, Dr. Hsu testified that the Petitioner denied ever having any history of back pain prior to the injury and also denied ever seeing a surgeon for low back pain prior to August 7, 2014. (*Id.* at 13-14).

Dr. Hsu further testified that he performed a physical examination of the Petitioner. (*Id.* at 14). He testified that he found positive Waddell's sign with axial compression, supersensitivity, hip rotation and distraction. (*Id.* at 15). Dr. Hsu stated that he was suspicious that Petitioner did not give full effort on the lumbar spine range of motion because he performed tasks outside the examination room that were different from inside. (*Id.* at 15-16). Dr. Hsu said specifically he observed Petitioner walk, bend and twist in a way outside of the room that was not reflective of the Petitioner's behavior inside the examination room. (*Id.* at 15-16).

Dr. Hsu testified that Petitioner sustained a lumbar strain during the work-related injury as reported on August 7, 2014 that had resolved. (*Id.* at 18). Dr. Hsu testified that Petitioner's complaints at the time of the IME exam were related to his pre-existing spondylosis that was not caused or aggravated by the alleged incident on August 7, 2014. (*Id.*). Dr. Hsu testified that a lumbar strain should have resolved within 6 weeks after the injury and any treatment beyond 6 weeks was excessive and not related to the alleged August 7, 2014 incident. (*Id.* at 19). Dr. Hsu specifically stated that the epidural steroid injections and the facet joint injections were excessive. (*Id.*).

Dr. Hsu finally testified that the L5-S1 lumbar fusion that was being recommended only by Dr. Sokolowski at the time of the exam would not be appropriate based on the evidence that suggested fusions for degenerative disc disease and patients like Petitioner had poor outcomes. (*Id.* at 20). He further testified that if the Petitioner underwent the proposed lumbar fusion nonetheless, the underlying condition that could necessitate it would be lumbar spondylosis that was unrelated to the alleged incident of August 7, 2014. (*Id.* at 20).

Ultimately, Dr. Hsu testified that Petitioner could work without restrictions as it related to a lumbar strain Petitioner had reached maximum medical improvement within 6 weeks of August 7, 2014. (*Id.* at 21-22).

"Nelson Centeno" Case History with the IWCC

On September 7, 2012, Petitioner proceeded to hearing, under his alias, Nelson Centeno pursuant to Section 19(b)/8(a) of the Act before a different Arbitrator. (*Nelson Centeno v. Minute Men*, 10 WC 44071 (RX 13, pgs. 3-4). In a Decision entered on January 3, 2013, the Arbitrator found that Petitioner sustained accidental work related injuries on October 7, 2010 specifically finding causal connection for a "a bi-malleolar fracture of his left ankle, a strain of his left knee, a lumbar sprain, L5-S1 disc herniation and that the trauma caused his condition of previously asymptomatic degenerative lumbar spine to become symptomatic." **The Arbitrator awarded TTD commencing October 8, 2010 through hearing on September 6,**

2012, a total of 100-1/7 weeks. The Arbitrator also found that Petitioner was married with 3 dependents and applied the minimum average weekly wage of $319.00. The Arbitrator awarded Petitioner **$97,230 in unpaid medical expenses.** The Arbitrator further awarded **"all the medical care prescribed by Dr. McNally, including the discogram and the fusion surgery,** should Dr. McNally still recommended after the discogram, and any treatment that is reasonable and necessary to recover from the surgery." (Id.).

The Arbitrator's Decision of January 3, 2013 was reviewed by both parties. The Commission issued a Decision and Opinion on Review dated October 30, 2013. The Commission modified the Arbitrator's Decision on the issue of medical expenses awarded reducing the $97,230 award to $66,781.33 awarded to Petitioner in unpaid medical expenses. The Commission reduced the Arbitrator's medical expense award finding that certain chiropractic charges beyond the initial six treatments were neither reasonable nor necessary. All remaining findings of the Arbitrator were affirmed and adopted by the Commission.

Both Petitioner and Respondent sought appeal of the Commission Decision to the Circuit Court of Kane County. On May 12, 2015, the Kane County Circuit Court issued a Judgment Order finding that, after a de novo review of the parties' stipulations on the issues of number of dependents and minimum average weekly wage, Petitioner had 5 dependents and that the applicable minimum average weekly wage was $330.00. The Circuit Court found "As the stipulations provide the correct amount of the benefit to be used, the Court will enter the appropriate order without the need to remand to the Commission to do so." The Circuit Court further wrote, "In reviewing the balance of the factual findings, the Court finds that the Commission is not against the manifest weight of the evidence and accordingly must be affirmed." The Circuit Court ordered "The decision of the Commission regarding TTD is reversed as to the amount of the benefit only." The Court further ordered "The Employer/Respondent shall pay the Employee/Petitioner temporary total disability benefits of $330 per week for 100-1/7 weeks commencing October 8, 2010 through September 7, 2012 as provided in Section 8(b) of the Illinois Workers Compensation Act. In all other aspects of the decision of the Defendant Illinois Workers Compensation dated October 30, 2013 is affirmed. Affirmed in part and reversed in part." Again, the Commission Decision was not remanded as the Circuit Court on its own order changed the number of dependents and the minimum average weekly wage without the need for remand.

On June 4, 2015, Petitioner filed a Notice of Appeal asking the Appellate Court to reverse the portion of the Circuit Court order affirming "the decision of the Workers' Compensation Commission to the degree that the Workers' Compensation Commission calculated the award of medical bills and failed to award ... fees and penalties." To date, no Decision has been issued by the Appellate Court on Petitioner's appeal. The Arbitrator notes that the current issues on appeal to the Appellate Court brought by Petitioner concern only the reduction in the chiropractic bill taken by the Commission and affirmed by the Circuit Court as well as the denial of Petitioner's request for fees and penalties at the first trial. The Arbitrator notes that Respondent did not seek appeal of any portion of the Circuit Court's Order. To date, no Decision has been issued by the Appellate Court on Petitioner's appeal.

On December 21, 2015, the parties appeared before another Illinois Workers' Compensation Arbitrator on Petitioner's second 19(b)/8(a) petition as his alias, Nelson Centeno. Petitioner

testified via interpreter. Bifurcation was granted and proofs were closed before on January 25, 2016. Petitioner requested TTD for the period of September 7, 2012 to the hearing date, unpaid medical expenses incurred subsequent to the first hearing in 2012, prospective medical treatment prescribed AFTER the first award and penalties and fees on the previously awarded unpaid medical bills in the amount of $66,781.32, unpaid TTD underpayment of $1,101.57 resulting from the Circuit Court Order, and delayed payment of $17,389.20 in TTD previously awarded by the Commission affirmed by the Circuit Court and not paid until February 11, 2015. (T. 8-13.).

On March 21, 2016, an Arbitration Decision and Addendum was issued in the above matter. The Arbitrator noted the issue pending only related to whether a causal connection existed between Petitioner's current condition of ill-being subsequent to the first trial. Ultimately, the Arbitrator found Petitioner had failed in that respect and denied all claimed benefits.

CONCLUSIONS OF LAW

In support of the Arbitrator's Decision with respect to (C), accident, the Arbitrator finds as follows:

Arbitrator's Exhibit #1 (IWCC Request for Hearing) states Petitioner is seeking TTD benefits from August 7, 2014 through April 18, 2016 for a total of 88-3/7 weeks of benefits at the rate of $414.16 per week. Petitioner, through his attorney, confirmed that the Request for Hearing accurately represented the issues in dispute.

With respect to Petitioner's credibility, the Arbitrator notes the countless false statements contained in the body of this Addendum. Petitioner simply cannot be recognized as a source of reliable information:

When he testified as Nelson Centeno (10 WC 44071) on December 21, 2015 (where he was claiming entitlement to TTD benefits for the period between September 7, 2012 through January 25, 2016) Petitioner stated he has been incapable of any work and had not worked since his accident in October of 2010.

In the same hearing on December 21, 2015, Petitioner testified that prior to his employment with the Respondent, Minute Men, he worked for the Respondent in the instant case, Countrywide Landscaping, but had not worked at Countrywide at any time after his injury with Respondent in 2010. Petitioner further denied a low back injury on August 7, 2014 and denied filing an Application for Adjustment of Claim as Robert Morales; and even denied ever hearing of Roberto Morales.

During his visit with Dr. McNally on August 4, 2015, Petitioner failed to report that he injured his low back on August 7, 2014. Petitioner also reported to Dr. McNally that he had not worked since October 7, 2010.

Petitioner initially testified in the instant proceedings that he had not sought any medical care as Nelson Centeno for his low back at any time recent to August 7, 2014 but later admitted that he

visited Dr. Thomas McNally on June 3, 2014 when Dr. McNally recommended a lumbar fusion.

Petitioner continued to testify that he was no longer pursuing benefits as Nelson Centeno as he had "dropped the case" and specifically testified that he has not testified as "Nelson Centeno" in recent memory; Petitioner later admitted to testifying as "Nelson Centeno" before another Arbitrator on December 21, 2015 after being presented with the transcript of the proceedings.

Ultimately, Petitioner admitted that he sought temporary total disability and medical benefits as both "Nelson Centeno" and Roberto Morales for the same time periods.

With respect to his alleged mechanism of injury, the Arbitrator notes inconsistencies in the histories between many of Petitioner's treatment providers. When confronted with such inconsistencies at the arbitration hearing, Petitioner conceded that the providers accurately recorded the history he reported.

The Arbitrator notes the testimony of Sebastian Mancera who credibly testified that he, the Petitioner and additional co-workers moved a grill on August 7, 2014 and that Petitioner did not display or verbalize any signs of injury during or after this process. Mr. Mancera further testified that Petitioner demolished a round stone fire pit by hand after moving the grill without any reports of pain. Such evidence further refutes Petitioner's claim that he suffered immediate low back pain when he moved the grill.

In reviewing all of the evidence as a whole, Petitioner's direct testimony was credibly refuted by evidence presented on cross-examination and by Respondent's witnesses. The Arbitrator concludes that Petitioner, and his testimony relative to an alleged accident on August 7, 2014 is simply not credible. Accordingly, the Arbitrator finds that Petitioner, Roberto Morales, has failed to sustain his burden with respect to this issue.

Even if the Arbitrator were to find that the Petitioner had suffered a compensable work-related accident on August 7, 2014, the Arbitrator finds that Petitioner failed to prove that his admitted pre-existing low back condition was aggravated or exacerbated by the work-related trauma on August 7, 2014. Petitioner presented no testimony or medical evidence from a treating physician that opined that his low back condition was aggravated or exacerbated by the August 7th work trauma. In fact, Petitioner denied that he had any pre-existing low back history when questioned by his physicians; therefore, his treating physicians had no viable evidence to opine as to causation.

Based on the record as a whole, the Arbitrator finds that the Petitioner failed to prove by a preponderance of the evidence that he sustained accidental injuries arising out of and in the course of his employment with Respondent on August 7, 2014.

Accordingly, all remaining contested issues are moot. All benefits are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

NELSON CENTENO a/k/a
ROBERTO MORALES,

Petitioner,

vs.

NO: 10 WC 44071

MINUTE MEN STAFFING,

17IWCC0805

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical, prospecitve medical, wage rate, jurisdiction, temporary total disability (TTD), penalties, and "failure to enforce prior award, etc. Responent's ex-parte communication with Arbitrator by failing to serve Petitioner with proposed decisions," and being advised of the facts and applicable law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Indus. Comm'n*, 78 Ill. 2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980).

After reviewing the record, the Commission is compelled to comment on the disingenuous actions of the Petitioner, Nelson Centeno a/k/a Roberto Morales. Centeno filed a second claim under the name Roberto Morales (14 WC 29803). During the arbitration hearing on that claim, Petitioner Morales admitted that he used the stolen identity of Nelson Centeno. Because of this admission, these two cases are so inextricably intertwined that the transcript in *Morales* and the transcript in *Centeno* must be considered together. The Commission, therefore, amends the

Application for Adjustment of Claim filed in the Nelson Centeno case and the Application for Adjustment of Claim filed in the Roberto Morales case, *sua sponte*, to reflect the name Nelson Centeno a/k/a Roberto Morales. The Commission further attaches to its Decision the Arbitrator's Decision and considers the transcript from the Roberto Morales case (14 WC 29803) as Commission's Exhibit 1, so that a reviewing court has a full understanding of the dishonest nature of the Petitioner, Nelson Centeno a/k/a Roberto Morales.

In the case at bar, Nelson Centeno alleged that he sustained a back and ankle injury in 2010. A hearing under Section 19(b) of the Act was held in September 2012, and the Petitioner, as Centeno was awarded benefits including a discogram and fusion as recommended by Dr. Thomas McNally and $97,230.00 in unpaid medical expenses. The Commission reduced the medical bills to $66,781.33. The case was appealed to the Appellate Court. Before the Appellate Court Decision was issued, Centeno filed a second 19(b) Petition and a hearing was held in December 2015. Centeno sought TTD benefits from September 2012 through the December 2015 hearing, penalties for the non-payment of the medical bills, and enforcement of the prospective medical that was awarded in the first 19(b) hearing, which was held in 2012.

During the December 2015 hearing, Centeno testified that he has not worked since 2010 and specifically denied working at Countywide Landscaping. Centeno testified that he wanted to proceed with the fusion as recommended by Dr. McNally. Respondent was about to call Detective John Zurick as a witness. Detective Zurick works for the West Chicago Police Department and ultimately testified that he arrested Nelson Centeno for identity theft. At the request of Petitioner's counsel, Michael Lulay, the hearing was continued to January 25, 2016. Centeno failed to appear at the continued hearing, as previously agreed.

During the continued hearing on January 25, 2016, Detective Zurick confirmed that he investigated a report of identity theft involving the name Nelson Centeno a/k/a Roberto Morales. Through his investigation in February 2014, Detective Zurick learned that Centeno was employed at Countywide Landscaping in Elburn, Illinois. Detective Zurick personally spoke with Centeno at Countywide Landscaping. Detective Zurick testified that Centeno admitted to purchasing the name Nelson Centeno and a Social Security card with a fraudulent number. Centeno admitted that his real name was Roberto Morales.

Detective Zurick was present at the first hearing and noted that the gentleman at the first hearing – who was not present at the continued hearing – was known as Roberto Morales a/k/a Nelson Centeno.

During the pendency of the Centeno case, Roberto Morales filed an Application for Adjustment of Claim in September 2014 alleging a back injury in August 2014 while moving a grill. That claim under case number 14 WC 29803 was filed against Countywide Landscaping. That claim was heard in April 2016 and the claim was denied.

During the hearing on the claim against Countywide, Morales stated that he was no longer pursuing the Centeno case. Morales testified that he last treated with Dr. McNally under the alias Centeno on August 4, 2015 and he did not inform Dr. McNally of the August 7, 2014 accident. Dr. McNally had recommended that Centeno undergo an L5-SI discogram and lumbar fusion. The Commission and the Appellate Court had ratified the treatment prescribed by Dr. McNally.

While operating under the name/alias of Morales, petitioner sought treatment with Dr. Ronald Michael of the Illinois NeuroSpine Institute and denied a prior history of a low back injury. Dr. Michael performed an L5-SI discogram and posterolateral discectomy on October 12, 2015 and an L5-SI biacuplasty on November 9, 2015.

The respondent in the Countywide Landscaping case, obtained a Section 12 opinion from Dr. Wellington Hsu of Northwestern University in relation to Roberto Morales on March 11, 2015. Dr. Hsu did not believe a lumbar fusion was appropriate and opined that Morales was at MMI and could work full duty and without restrictions. He noted that Morales had 4 out of 4 positive Waddell signs.

The Commission scheduled oral arguments in both cases on the same day. An attorney from Michael Lulay's office sought enforcement of the first 19(b) decision along with TTD benefits and penalties for non-payment of the medical expenses. However, pursuant to *Millennium Knickerbocker Hotel v. Guzman*, 2017 IL App (1st) 161027WC, P3, 76 N.E.3d 825, 829, 2017 Ill. App. LEXIS 258, 412 Ill. Dec. 759, 763, the proper venue to seek enforcement of a final award of the Commission is in the circuit court pursuant to 19(g) of the Act.

The evidence establishes that Morales underwent an L5-SI discogram and posterolateral discectomy, and an L5-SI biacuplasty in 2015, at the hands of Dr. Ronald Michael. Dr. McNally was not made aware of this treatment. Dr. Hsu's opinion that Morales was at MMI, could work full-duty without restrictions, and was not in need of a lumbar fusion is equally applicable to Nelson Centeno as they are one in the same person. Therefore, the Commission would not, if it had the power to do so, order Respondent to authorize the fusion as Nelson Centeno a/k/a Roberto Morales is at MMI.

The Commission also affirms the Arbitrator's denial of penalties and TTD benefits. The Petitioner admits to perpetrating a fraud on the Commission and then asks the Commission to award penalties and TTD benefits. The evidence establishes that during the period Centeno allegedly did not work and, for which he is seeking benefits, he was working for County Wide Landscaping under the alias Roberto Morales. The Commission will not award TTD benefits or penalties unless compelled to do so by a reviewing court.

Not since the Petitioner in *Walker v. Illinois Medi-Car, Inc.*, 2015 Ill. Wrk. Comp. LEXIS 1257. 15 IWCC 629 *Aff'd* 2017 IL App (2d) 160368WC-U, has the Commission seen a more prolific liar. Nelson Centeno aka Roberto Morales under any *nom de plume* cannot be believed and has no credibility. His conduct in these matters cannot be countenanced.

17IWCC0805

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 23, 2016 is hereby affirmed and adopted.

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

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

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

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

DATED: DEC 15 2017

MJB/tdm
O: 10-24-17
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

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

CENTENO, NELSON
Employee/Petitioner

Case# **10WC044071**

MINUTE MEN STAFFING
Employer/Respondent

17IWCC0805

On 3/23/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.44% 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:

4220 LULAY LAW OFFICES
MICHAEL B LULAY
2323 NAPERVILLE RD SUITE 220
NAPERVILLE, IL 60563

1401 SCOPELITIS GARVIN LIGHT ET AL
VICTOR P SHANE
30 W MONROE ST SUITE 600
CHICAGO, IL 60603

STATE OF ILLINOIS)
)
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
19(b) ARBITRATION DECISION

NELSON CENTENO
Employee/Petitioner

v.

MINUTE MEN STAFFING
Employer/Respondent

Case # 10 WC 44071

17IWCC0805

An *Application for Adjustment 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 Doherty**, arbitrator of the Commission, in the city of **Elgin and Ottawa**, on **Decemer 21, 2015 and January 25, 2016**. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was the respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☐ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to the respondent?

F. ☒ Is the petitioner's present condition of ill-being causally related to the injury?

G. ☒ What were the petitioner's earnings?

H. ☐ What was the petitioner's age at the time of the accident?

I. ☐ What was the petitioner's marital status at the time of the accident?

J. ☒ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☒ What amount of compensation is due for temporary total disability?

L. ☒ Should penalties or fees be imposed upon the respondent?

M. ☒ Is the respondent due any credit?

N. ☒ Other **Prospecitve medical**

FINDINGS

- On **October 7, 2010**, the respondent **Minute Men Staffing** operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship *did* exist between the petitioner and respondent.
- On this date, the petitioner sustained injuries that arose out of and in the course of employment.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $ 20,800; the average weekly wage was subject to the minimum rate of $330.00 SEE DECISION .
- At the time of injury, the petitioner was **33** years of age. SEE DECISION for dependents.
- Necessary medical services have not been provided by the respondent. SEE DECISION
- To date, $ **18,140.00** has been paid by the respondent for TTD and/or maintenance benefits. **Respondent has paid an additional $17,389.20 in TTD benefits since the date of the last hearing of 9/7/12. Respondent shall receive credit for amounts paid. SEE DECISION**

ORDER

- Based on the findings regarding causal connection through 9/7/12 only, no further benefits are awarded Petitioner. SEE DECISION
- The respondent shall pay $ **0** for medical services, as provided in Section 8(a) of the Act.
- The respondent shall pay $ **0** in penalties, as provided in Section 19(k) of the Act.
- The respondent shall pay $ **0** in penalties, as provided in Section 19(l) of the Act.
- The respondent shall pay $ **0** in attorneys' fees, as provided in Section 16 of the Act.
- In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of temporary total disability, medical benefits, or compensation for a permanent disability, if any.

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

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

Carolyn M. Doherty

Signature of arbitrator

3/21/16
Date

ICArbDec19(b) p. 2

MAR 23 2016

FINDINGS OF FACT

BACKGROUND

Petitioner originally presented for a 19(b)/8(a) trial before a different Arbitrator in on September 7, 2012. In a Decision entered on January 3, 2013, the Arbitrator found that Petitioner sustained accidental work related injuries on October 7, 2010 specifically finding causal connection for a "a bi-malleolar fracture of his left ankle, a strain of his left knee, a lumbar sprain, L5-S1 disc herniation and that the trauma caused his condition of previously asymptomatic degenerative lumbar spine to become symptomatic." The Arbitrator awarded TTD commencing October 8, 2010 through hearing on September 6, 2012, a total of 100-1/7 weeks. The Arbitrator also found that Petitioner was married with 3 dependents and applied the minimum average weekly wage of $319.00. The Arbitrator awarded Petitioner $97,230 in unpaid medical expenses. The Arbitrator further awarded "all the medical care prescribed by Dr. McNally, including the discogram and the fusion surgery, shoulder Dr. McNally still deem it recommended after the discogram, and any treatment that is reasonable and necessary to recover from the surgery." PX 75.

The Arbitrator's Decision of January 3, 2013 was reviewed by both parties. The Commission issued a Decision and Opinion on Review dated October 30, 2013. PX 75. The Commission modified the Arbitrator's Decision on the issue of medical expenses awarded reducing the $97,230 award to $66,781.33 awarded to Petitioner in unpaid medical expenses. The Commission reduced the Arbitrator's medical expense award finding that certain chiropractic charges beyond the initial six treatments were neither reasonable nor necessary. PX 75. All remaining findings of the Arbitrator were affirmed and adopted by the Commission. PX 75.

Both Petitioner and Respondent sought appeal of the Commission Decision to the Circuit Court of Kane County. On May 12, 2015, the Kane County Circuit Court issued a Judgment Order finding that, after a de novo review of the parties' stipulations on the issues of number of dependents and minimum average weekly wage, Petitioner had 5 dependents and that the applicable minimum average weekly wage was $330.00. PX 80. The Circuit Court found "As the stipulations provide the correct amount of the benefit to be used, the Court will enter the appropriate order without the need to remand to the Commission to do so." PX 80. The Circuit Court further wrote, "In reviewing the balance of the factual findings, the Court finds that the Commission is not against the manifest weight of the evidence and accordingly must be affirmed." PX 80. The Circuit Court ordered "The decision of the Commission regarding TTD is reversed as to the amount of the benefit only." The Court further ordered "The Employer/Respondent shall pay the Employee/Petitioner temporary total disability benefits of $330 per week for 100-1/7 weeks commencing 10/8/10 through 9/7/12 as provided in Section 8(b) of the Illinois Workers Compensation Act. In all other aspects of the decision of the Defendant Illinois Workers Compensation dated October 30, 2013 is affirmed. Affirmed in part and reversed in part." Again, the Commission Decision was not remanded as the Circuit Court on its own order changed the number of dependents and the minimum average weekly wage without the need for remand. PX 80.

On June 4, 2015, Petitioner filed a Notice of Appeal asking the Appellate Court to reverse the portion of the Circuit Court order affirming "the decision of the Workers' Compensation Commission to the degree that the Workers' Compensation Commission calculated the award of medical bills and failed to award ... fees and penalties." PX 81. To date, no Decision has been issued by the Appellate Court on Petitioner's appeal. The Arbitrator notes that the current issues on appeal to the Appellate Court brought by Petitioner concern only the reduction in the chiropractic bill taken by the Commission and affirmed by the Circuit Court as well as the denial of Petitioner's request for fees and penalties at the first trial. The Arbitrator notes that Respondent did not seek appeal of any portion of the Circuit Court's Order. At the time of the current 19(b) trial, Respondent

had not authorized the surgery or medical treatment previously ordered by the Arbitrator and affirmed by both the Commission and the Circuit Court.

On December 21, 2015, the parties appeared before this Arbitrator on Petitioner's second 19(b)/8(a) requesting TTD for the period of 9/7/12 to the present, unpaid medical expenses incurred subsequent to the first hearing in 2012, any prospective medical treatment to be shown at trial which was prescribed AFTER the first award and is substantially different from the first award, and/or PPD. At the 12/21/15 hearing, it was made clear on the record that no issues pertaining to the first 19(b) hearing and decided by both the Commission and the Circuit Court would be revisited by the Arbitrator. Further, it was made clear that all relief requested from the Arbitrator in connection with the current 19(b) would involve the consideration of facts and evidence dated subsequent to the first 19(b) hearing in September 2012. T. 6-13. The Arbitrator further noted Petitioner's current request for penalties and fees on the previously awarded unpaid medical bills in the amount of $66,781.32, unpaid TTD underpayment of $1,101.57 resulting from the Circuit Court Order, and delayed payment of $17,389.20 in TTD previously awarded by the Commission affirmed by the Circuit Court and not paid until February 11, 2015. T. 8-13. ARB EX 1.

Finally, the Arbitrator notes that PX 1-PX 65 admitted at this trial are all exhibits admitted at the first 2012 19(b) hearing and are contained in the Commission file and are made part of the current record. PX 66-85 also admitted at the current 19(b) trial are physically part of the instant record. ARB EX 1. 1/25/16 transcript T. 97-98.

FINDINGS OF FACT

The instant trial started before this Arbitrator on 12/21/15. Petitioner testified via interpreter. Bifurcation was granted as noted below and proofs were closed before this Arbitrator on 1/25/16.

Petitioner testified that he currently resides at 425 Harrison St. in West Chicago. T. 14. He suffered a work related injury on 10/7/10 while working for Respondent Minute Man. On that date, he slipped and fell striking his lower back and left ankle. Dr. Freedberg treated Petitioner's left ankle. Petitioner underwent two surgeries to his left ankle, the second of which was to remove a metal rod from the ankle. T. 17. Dr. Freedberg released Petitioner from care for his ankle injury on 2/27/12, prior to the first hearing on 9/7/12.

Petitioner was treated simultaneously by Dr. Freedberg's partner, Dr. McNally for his low back. Petitioner saw Dr. McNally on 11/11/11 for his low back prior to the first trial on 9/7/12. T. 21. At that time, Petitioner presented with complaints of numbness and tingling into his left leg and calf. Low back discogram followed by fusion surgery was prescribed by Dr. McNally on 12/22/11. The discogram and surgery was awarded by the first Arbitrator but have not been authorized by Respondent. Dr. McNally also took Petitioner off work. T. 23.

Petitioner did not see Dr. McNally again for any treatment following the 12/22/11 visit (prior to the first hearing on 9/7/12) until April 3, 2014. PX 68. With his last visit to Dr. McNally being in December 2011, the gap in treatment is approximately 2.4 years. T. 24. Petitioner testified that his low back felt substantially the same as it did when he last saw Dr. McNally in 2011 and that his ankle felt the same as the last time he saw Dr. Freedberg in 2012. T. 25. Petitioner testified that in April 2014, Dr. McNally recommended a closed MRI of the low back, an EMG, medications and continued off work. T. 25.

Petitioner underwent a lumbar MRI on April 23, 2014 and an EMG on 5/6/14. The 4/23/14 MRI showed "degenerative changes at L5-S1 with bilateral degenerative foraminal and lateral recess narrowing as was present on previous lumbar spine MRI study of 5/11/11. Central disc protrusion present at this level on the old

scan does not reproduce on the current study." PX 68. The EMG revealed multilevel lumbosacral radiculopathy, more prominent at level L3-4 on the left and bilateral L4-5 and L5-S1 levels." PX 68. Petitioner returned to Dr. McNally on 6/3/14 and Dr. McNally discussed different surgical options with Petitioner including the Krames option, and decompression versus fusion surgeries. Dr. McNally referred Petitioner to a general surgeon specifically to discuss the feasibility of anterior approach for anterior lumbar interbody fusion. Dr. McNally also discussed non surgical options. He also continued Petitioner off work. PX 68.

Petitioner did attend Respondent's Section 12 exam with Dr. Ghanayem on June 1, 2015. Dr. McNally recorded the impression of Dr. Ghanayem noting "Impression: "My impression is that Mr. Centeno has subjective complaints of back pain that are in excess of what would be expected from his radiographic findings on his two MRI scans of 2011 and 2014. He also exhibits multiple nonorganic physical exam findings consistent with symptom magnification. Assuming just for a moment that he had a central disc protrusion at L5-S1, as seen on 2011 MRI scan, it appears that by report that this protrusion has resolved by 2014. In addition, his subjective complaints of back pain are in excess of what would be expected from a central disc protrusion. Therefore, relative to his work injury with regard to his spine, he has reached MMI and can return back to work at full duty and unrestricted duty. If he did, indeed, sustain a central disc protrusion (nonoperative), a brief course of physical therapy and injection would have been medically reasonable. The total in duration of disability for that would have been three to four months in total. In regards to his ankle; I would offer no particular opinion. With regard to his lumbar spine, he can return to work at full duty and has no residual permanence given to multiple nonorganic physical exam findings seen in today's evaluation." (Pet. Ex. 68).

Petitioner returned to see Dr. McNally on 8/4/15. Dr. McNally again referred Petitioner to see a general surgeon to discuss "an opinion regarding feasibility of anterior approach for anterior lumbar interbody fusion first referenced 6/3/14". PX 68. Petitioner testified that he tried to see a surgeon, Dr. James Kane, to discuss the option but was unable to see Dr. Kane in that the treatment was not authorized by Respondent. T. 28. Dr. McNally again prescribed the same Krames low back surgery option and again referred Petitioner to a general surgeon to discuss. He continued the pain medications and off work recommendations. T. 30. Dr. McNally also prescribed another "update" EMG and MRI and referred Petitioner to Dr. Lipov for the discogram with a one level control. Dr. McNally also discussed non-surgical options with Petitioner as well. PX 68. At the time of trial, Petitioner had not received the recommended updated EMG and MRI nor had he received the discogram. T. 32. Petitioner testified that he would like to proceed with the fusion surgery which was previously awarded by the Commission and again recommended as an option by Dr. McNally in August 2015.

Petitioner testified that he currently has 8/10 pain in his low back "basically all the time." T. 37. He takes ibuprofen and performs stretching exercises at home. T. 38. He performs minimal daily activities. T. 40. The children currently living with him help with household chores. T. 43. Petitioner testified that he is not currently working and continues to be off work per Dr. McNally. T. 43-54.

On cross-exam, Petitioner testified again that he has been incapable of any work since his accident in October 2010 because of the pain in his back and that he has not applied for any work because of the pain in his back. T. 57-59. Petitioner again testified that he is requesting TTD for the period commencing after the last trial on 9/7/12 through the current date in that he has been incapable of work for that period. T. 62. Petitioner testified that he saw Dr. McNally in April and June 2014 and then again 14 months later in August 2015. He testified that he did not work or apply for work during this period of time. T. 64.

Petitioner testified that prior to his employment with Respondent he worked for Countrywide Landscaping. T. 66. He testified that he has not worked at Countrywide at any time after his injury with Respondent in 2010. Petitioner again testified that his current address is 425 Harrison Street and that he does not recall living at 1223

N. Kings Court in West Chicago. T. 70. RX 3 was admitted and is a W-2 Wage and Tax Statement from 2013 issued by the employer Countrywide Landscaping Inc to Nelson Centeno at the address of 1223 N. Kings Court in West Chicago. RX 3 shows wages of $16,164.00 earned in 2013. Petitioner listed social security number on the W2 for 2013 is the same social security number he testified to at trial. T. 65. RX 3. Petitioner denied receiving the W2 form at RX 3. T. 71.

Petitioner agreed that he was the person depicted in two Michigan drivers licenses at RX 4. T. 72-73. Petitioner denied ever having gone by any other names and specifically denied ever hearing of the name Roberto Morales. T. 75. RX 5 is an Application for Adjustment of Claim filed by Roberto Morales against the employer Countrywide Landscaping for an accident alleged on 8/7/14. The listed home address is 425 Harrison St. in West Chicago. T. 77. Petitioner testified that his home at 425 Harrison St. is a duplex and he does not know if a person named Roberto Morales lives in the top floor of the duplex. T. 77. Petitioner denied filing the Application at RX 5. T. 77.

RX 6 is a photo of a permanent residence card for Roberto Morales and a social security card for Roberto Morales with a different social security number than testified to by Petitioner. Petitioner also denied the picture on the card was his. T. 82. Petitioner further testified that he did not recall being arrested by the West Chicago Police in 2014. T. 86. Petitioner was then excused upon completion of cross examination.

Respondent then prepared to start its case and was preparing to call its first witness, Detective John Zurick from the West Chicago Police Department. Prior to the start of Detective Zurick's testimony, Petitioner's attorney requested bifurcation of the case based on a breakdown in his relationship with his client which he alleged caused an ethical problem possibly effecting his continued representation of Petitioner. T. 108-111. Petitioner's counsel was asked whether he was requesting a withdrawal and he responded that he needed a bifurcation to allow him time to assess his continued representation of Petitioner. T. 111. Bifurcation was granted over Respondent's objection. T. 111-122.

Prior to the bifurcated hearing date of 1/25/16, Petitioner's counsel advised the Arbitrator and Respondent's counsel that he would continue to represent Petitioner at the bifurcated trial and that he filed a motion to withdraw his 19(b) Petition which he would present at the start of the bifurcated trial. The Arbitrator denied this motion to withdraw the 19(b) Petition and the bifurcated hearing was held on 1/25/16. Petitioner was not present at the hearing. Petitioner's counsel participated subject to his position that there was no matter pending before the Arbitrator based on his withdrawal of the 19(b) despite the denial of his motion to withdraw the 19(b) by the Arbitrator.

Respondent called Detective John Zurick from the West Chicago Police Department. He testified that he was assigned to investigate a complaint against Nelson Centeno. The Detective personally met with Nelson Centeno in the course of his investigation at Countrywide Landscaping. T. 38. He further testified that in looking at Petitioner's Michigan drivers license pictures at RX 4 the photos depicted the same man he approached as Nelson Centeno at Countrywide Landscaping. T. 42. His investigation eventually led to charges filed against Nelson Centeno. T. 51.

Respondent next called Rhonda Sitterly to testify in her capacity as the office manager at Countrywide Landscaping. T. 61. The witness testified that Petitioner Nelson Centeno worked at Countrywide Landscaping for various periods of time ranging from 2006 through 2014. T. 66. RX 9. She further testified that she had a conversation with Nelson Centeno in 2014 during which he asked her to change his name on the payroll to Roberto Morales. T. 67. The witness further testified that the handwritten note on RX 6 reading "was Nelson

Centeno" was in fact written by the witness. T. 67-70. RX 6 is the residency card and social security card of Roberto Morales given to the witness in 2014. T. 67-70, 81.

CONCLUSIONS OF LAW

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

The Arbitrator initially notes that Respondent submitted a proposed decision to the Arbitrator addressing the issues at trial. Petitioner did not submit a proposed decision.

G. What were Petitioner's earnings?

To the extent Respondent disputed the issue of Petitioner's earnings at this hearing, the Arbitrator notes that the use of the minimum rate of $330 was established by the Circuit Court and will not be changed by the Arbitrator. The Arbitrator further notes that no evidence was presented at trial on the issue of number of dependents, earnings or AWW to support Respondent's dispute of the issue reflected on the stip sheet at ARB EX 1.

F. Is Petitioner's condition of ill-being causally related to the injury? O. Prospective Medical J. Were the medical services provided to Petitioner reasonable and necessary?

The Arbitrator initially notes that causal connection for Petitioner's injuries, including his lower back injury and need for surgery, was addressed by the first Arbitrator, and affirmed by the Commission and the Circuit Court. Causal connection was not appealed to the Appellate Court. The only issue pending before the Appellate Court is the amount of the chiropractic bill incurred by Petitioner.

The issue pending before the current Arbitrator is causal connection for Petitioner's current condition of ill-being subsequent to the first trial. In connection with that issue the Arbitrator notes that Petitioner sought no new or additional treatment subsequent to the first trial for his left ankle or leg. In connection with his lower back, the Arbitrator notes that Petitioner sought treatment in December 2011 with Dr. McNally (prior to the first trial) and then did not seek any treatment for his low back again until April 2014, a gap of approximately 2.4 years. The Arbitrator finds this gap in treatment detrimental to Petitioner's claim of continued causal connection for his low back condition currently at issue and is not persuaded to find otherwise based on Petitioner's claimed inability to obtain payment for the treatment. Furthermore, the Arbitrator notes that Dr. McNally's opinion on the need for treatment did not substantially change from his opinions rendered at the first hearing. Accordingly, giving deference to the findings made at the 2012 19(b) hearing affirmed by the Commission and the Circuit Court, the Arbitrator finds causal connection for Petitioner's condition of ill-being through September 7, 2012. The Arbitrator makes no finding of continued causal connection or medical expenses incurred thereafter based on the significant gap in treatment between 2011 and 2014. The Arbitrator makes no new findings on the issue of prospective medical care based on the substantially similar treatment options presented by Dr. McNally in 2011 and 2014.

K. Temporary Benefits / TTD M. Is Respondent due any credit?

Based on the Arbitrator's findings on the issue of causal connection through September 7, 2012 only based on the significant gap in treatment between 2011 and 2014, the Arbitrator further finds that Petitioner was temporarily and totally disabled through September 7, 2012 only. In finding no further period of temporary total disability the Arbitrator further notes that substantial evidence was presented which places great doubt on

Petitioner's claimed inability to work during his currently claimed period of TTD commencing 9/7/12 through the present.

To the extent Respondent has paid any additional TTD not ordered at the first 19(b) hearing and subsequent to September 2012, Respondent is entitled to a credit for those amounts paid.

L. Should penalties or fees be imposed upon Respondent?

Based on the record in its entirety, the Arbitrator finds that Respondent's conduct in the delayed or failed payment of TTD ordered in the first 19(b) trial was neither so unreasonable nor vexatious so as to justify the imposition of the requested penalties and fees. With regard to the portion of Petitioner's penalty and fee Petitioner stemming from the failure to pay previously awarded medical expenses, the Arbitrator finds that such a request is not ripe for determination until the resolution of the pending Appeal regarding the chiropractic bill awarded at the first 19(b) hearing and until such time as a total amount of medical expenses to be awarded Petitioner from the first 19(b) hearing can be determined.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JUDY JAKUSZEWSKI,

Petitioner,

vs.

NO: 09 WC 07746

WALGREEN'S,

17IWCC0806

Respondent.

DECISION AND OPINION ON REVIEW

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

Petitioner has been employed by Respondent as a registered pharmacist since 1989. On July 12, 2008 Petitioner sustained an undisputed accident when she slipped and fell on a wet floor while assisting a customer, landing on her buttocks and left shoulder. At the time of the work accident, July 12, 2008, Petitioner earned $109,512.00 and the average weekly wage was $2,106.00. Petitioner was assigned to a store near her home and allowed to work a set overnight (graveyard) shift due to her seniority. Respondent scheduled Petitioner and other registered pharmacists working retail to work eight to twelve hour shifts. Registered pharmacists were expected to work 80 hours over a two-week period.

Petitioner was off work immediately following the accident and began treatment with a chiropractor and later with several orthopedic specialists. An incomplete fracture of the left sacrum and sacral S3 segment with extension to the S1 region was diagnosed by MRI. Petitioner continued treatment for lumbar, hip and left shoulder pain with several practitioners, including Dr. Froese, Dr. Mayer and Dr. Chenelle. Petitioner underwent treatment with Dr. Bare for left shoulder and upper extremity complaints.

Respondent obtained Section 12 evaluations with Dr. Zoellick on September 15, 2008, March 15, 2010 and December 3, 2010. He found Petitioner was not at MMI and recommended work restrictions. Dr. Zoellick expressed the opinion that Petitioner's shoulder injuries were not causally connected to her work injury.

Petitioner returned to her regular work duties commencing March 23, 2009 through December 3, 2010. Petitioner developed increasing pain with work. On December 3, 2010 Petitioner was referred to Dr. Andreshak and started treatment with Dr. Chenelle for persistent and increasing lower back complaints, and with Dr. Bare for left shoulder complaints. Petitioner was taken off work effective December 3, 2010 by Dr. Chenelle.

At the request of both Petitioner and Respondent, Dr. Alexander Ghanayem became involved in the case for a "third party" medical opinion. He first examined Petitioner on August 12, 2013 and recommended work restrictions including a 15 pound-frequent, 20 pound-occasional work status, and the use of a barstool and a doughnut cushion as needed for sitting.

On August 31, 2015, Petitioner was offered a job by Respondent as a floating pharmacist. Starting wage in this position was $58 per hour. This position resulted in a loss of seniority due to Petitioner's extended medical absence. The position also required that Petitioner "float" and provide coverage to retail stores within the district as required by Respondent. Had Petitioner stayed in her pre-accident seniority status her hourly wage would have been $63.25.

At hearing Petitioner testified that she could lift 15 pounds. This position fell within the work restrictions placed by Dr. Ghanayem in August 2013. Petitioner was required to complete re-training and re-certification prior to returning to work on October 29, 2015.

While Petitioner's return to work was pending she received new restrictions from Dr. Chenelle, limiting her to 20 hours work per week. Additionally, Petitioner received new restrictions from Dr. Bare on December 18, 2015 (twenty- two months following her most recent appointment with Dr. Bare) that limited her to two-pounds lifting and a 20 hour work week.

The parties agreed to send Petitioner back to Dr. Ghanayem on March 14, 2016, for a second examination. Dr. Ghanayem again noted that Petitioner had residual complaints of pain in her back and sacroiliac region. Dr. Ghanayem commented that Petitioner has "been adequately treated, both from a rehab standpoint and injections." Dr. Ghanayem restated his work

restrictions as expressed in August 2013, specifically, 15 pound (frequent) to 20 pound (occasional) lifting, with "no reason why she cannot work a standard 8 hour day in the context of a 40 hour work week." The Commission adopts the opinions of Dr. Ghanayem.

The Commission finds Petitioner was at MMI as of March 14, 2016 and modifies the Arbitrator's award of temporary partial disability/ interim wage differential benefits as follows:

10/29/2015 through 11/4/2015	($63.25 x 40 - $58 x 36) x 2/3 =	$294.67
11/5/2015 through 11/11/2015	($63.25 x 40 - $58 x 36) x 2/3 =	$294.67
11/12/2015 through 11/18/2015	($63.25 x 40 - $58 x 28) x 2/3 =	$604.00
11/19/2015 through 11/25/2015	($63.25 x 40 - $58 x 44) x 2/3 =	$0
11/26/2015 through 12/2/2015	($63.25 x 40 - $58 x 16) x 2/3 =	$1,068.00
12/3/2015 through 12/9/2015	($63.25 x 40 - $58 x 48) x 2/3 =	$0
12/10/2015 through 12/16/2015	($63.25 x 40 - $58 x 32) x 2/3 =	$449.33
12/17/2015 through 12/23/2015	($63.25 x 40 - $58 x 29) x 2/3 =	$565.33
12/24/2015 through 12/30/2015	Not scheduled to work	$1,178.48
12/31/2015 through 1/6/2016	Not scheduled to work	$1,178.48
1/7/2016 through 1/13/2016	Not scheduled to work	$1,178.48
1/14/2016 through 1/20/16	Not scheduled to work	$1,178.48
1/21/2016 through 1/27/2016	($63.25 x 40 - $58 x 24) x 2/3 =	$758.67
1/28/2016 through 2/3/2016	($63.25 x 40 - $58 x 24) x 2/3 =	$758.67
2/4/2016 through 2/10/2016	($63.25 x 40 - $58 x 23) x 2/3 =	$797.33
2/11/2016 through 2/17/2016	($63.25 x 40 - $58 x 24) x 2/3 =	$758.67
2/18/2016 through 2/24/2016	Not scheduled to work	$1,178.48
2/25/2016 through 3/2/2016	Not scheduled to work	$1,178.48
3/3/2016 through 3/9/2016	($63.25 x 40 - $58 x 6) x 2/3 =	$1,454.67
3/10/2016 through 3/16/2016	($63.25 x 40 - $58 x 8) x 2/3 =	$1,377.33
3/17/2016 through 3/23/2016	($63.25 x 40 - $58 x 24) x 2/3 =	$758.67
3/24/2016 through 3/30/2016	($63.25 x 40 - $58 x 23) x 2/3 =	$797.33
3/31/2016 through 4/6/2016	($63.25 x 40 - $58 x 23) x 2/3 =	$797.33
4/7/2016 through 4/13/2016	($63.25 x 40 - $58 x 24) x 2/3 =	$758.67
4/14/2016 through 4/20/2016	($63.25 x 40 - $58 x 24) x 2/3 =	$758.67
4/21/2016 through 4/27/2016	($63.25 x 40 - $58 x 24) x 2/3 =	$758.67
4/28/2016 through 5/4/2016	($63.25 x 40 - $58 x 15) x 2/3 =	$1,106.67
5/5/2016 through 5/11/2016	($63.25 x 40 - $58 x 23) x 2/3 =	$797.33
5/12/2016 through 5/18/2016	($63.25 x 40 - $58 x 15) x 2/3 =	$1,106.67
5/19/2016 through 5/25/2016	($63.25 x 40 - $58 x 24) x 2/3 =	$758.67
5/26/2016 through 6/1/2016	($63.25 x 40 - $58 x 15) x 2/3 =	$1,106.67
6/2/2016 through 6/8/2016	($63.25 x 40 - $58 x 16) x 2/3 =	$1,068.00
6/9/2016 through 6/15/2016	($63.25 x 40 - $58 x 18) x 2/3 =	$990.67
6/16/2016 through 6/22/2016	($63.25 x 40 - $58 x 16) x 2/3 =	$1,068.00
6/23/2016 through 6/29/2016	($63.25 x 40 - $58 x 13) x 2/3 =	$1,184.00

6/30/2016 through 7/6/2016 ($63.25 x 40 - $58 x 14) x 2/3 = $1,145.33

Since Petitioner has returned to her usual and customary line of employment, albeit with diminished seniority and pay, the Commission denies vocational rehabilitation and maintenance benefits. The Commission defers the issue of further wage differential benefits, if any, as the matter was tried pursuant to Section 19 (b) and permanent disability was not at issue during the arbitration hearing.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,178.48 per week for a period of 288 1/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §8(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary partial disability and interim wage differential benefits as set forth above.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's awards of vocational rehabilitation and maintenance are hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $13,943.49 for medical expenses under §8(a) and 8.2 of the Act.

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

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

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

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.

17IWCC0806

DATED:
o: 10/19/17
SM/msb
44

DEC 18 2017

Stephen Mathis

David L. Gore

L. Elizabeth Coppoletti, special concurrence and dissent.

I agree with the ultimate conclusion and reasoning reached by the majority, but I dissent as to the award of temporary partial disability benefits beyond March 14, 2016. As Petitioner reached MMI as of March 14, 2016, her condition stabilized and temporary benefits are no longer awardable. See *e.g. Archer Daniels Midland Company v. The Industrial Commission*, 138 Ill. 2d 107, 118, 561 N.E.2d 623 (1990) ("Once an injured employee's physical condition stabilizes, he is no longer eligible for TTD benefits, although he may be entitled to permanent partial total disability compensation under section 8(d) or permanent total disability under section 8(f)…"). Petitioner's failure to return to work was her choice, but such choice was not supported by the medical evidence specifically the opinions of Dr. Ghanayem. Although I believe in the ultimate disposition in this case, I believe no further temporary partial disability benefits are due beyond March 14, 2016.

L. Elizabeth Coppoletti

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

JAKUSZEWSKI, JUDY
Employee/Petitioner

Case# **09WC007746**

17IWCC0806

WALGREENS
Employer/Respondent

On 3/15/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.91% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2208 CAPRON & AVGERINOS PC
DANIEL F CAPRON
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

2389 GILDEA COGHLAN & REGAN LTD
EDWARD A COGHLAN
901 W BURLINGTON AVE SUITE 500
WESTERN SPRINGS, IL 60558

17IWCC0806

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPAGE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Judy Jakuszewski
Employee/Petitioner

v.

Walgreens
Employer/Respondent

Case # **09** WC **07746**

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 **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Wheaton**, on **September 27, 2016 and November 3, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **July 12, 2008**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$109,512.00**; the average weekly wage was **$2,106.00**.

On the date of accident, Petitioner was **44** 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 **$314,712.67** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$314,712.67**.

ORDER

Maintenance

Respondent shall pay Petitioner maintenance benefits of $1,178.48/week for 17 2/7 weeks, commencing July 6, 2016 through November 3, 2016, as provided in Section 8(a) of the Act.

Medical benefits

Respondent shall pay reasonable and necessary medical services of $13,943.49, as provided in Sections 8(a) and 8.2 of the Act.

Temporary Partial Disability

Respondent shall pay Petitioner temporary partial disability benefits of $943.69/week for 35 6/7 weeks, commencing October 29, 2015 through July 5, 2016, as provided in Section 8(a) of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $1,178.48/week for 288 1/7 weeks, commencing July 13, 2008 through March 22, 2009 and from December 3, 2010 through October 28, 2015, as provided in Section 8(b) of the Act.

Vocational Rehab

Respondent is ordered to provide vocational rehabilitation services to Petitioner pursuant to Section 8(a) of the Act.

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

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

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

Jason C. Kingsley

Signature of Arbitrator

3-7-17
Date

ICArbDec19(b)

MAR 15 2017

17IWCC0806

ILLINOIS WORKERS' COMPENSATION COMMISSION

JUDY JAKUSZEWSKI,	)	
	)	
Petitioner,	)	
	)	
v.	)	No. 09 WC 07746
	)	
WALGREENS,	)	
	)	
Respondent.	)	

ADDENDUM TO THE DECISION OF THE ARBITRATOR

I. Findings of Fact.

Petitioner began working for Respondent in 1982 as a part-time pharmacist's assistant while she was still in school. Upon receiving her pharmacy degree in 1989, she was promoted to a full-time pharmacist.

It is undisputed that on July 12, 2008, she slipped and fell on a recently mopped floor, falling onto her left buttock and shoulder. She was immediately taken to the emergency room of Central DuPage Hospital where x-rays of her lower back and coccyx were normal. (PX 2, p. 43)

On July 16, 2008, Petitioner saw Dr. Kathleen McMahon, a chiropractor, who began treating her lower back, initially through August 8, 2008. (PX 1, p. 1-3)

On July 17, 2008, Petitioner was seen at the occupational health department of Central DuPage Hospital where she was diagnosed with a back strain and contused coccyx. (PX 2, p. 35) Petitioner also complained of left elbow pain at that time. (PX 2, p. 34) She was given a prescription for medication and a work restriction. (PX 2, p. 36, 37) On August 4, 2008, she was given a prescription for physical therapy. (PX 2, p. 23)

Petitioner underwent an MRI of her lumbar spine on August 12, 2008 which revealed degenerative facet changes with mild, diffuse bulges. (PX 2, p. 15) When Petitioner's symptoms persisted, she was referred to Dr. Beth Froese, a physiatrist at what was then known as Orthopedic Associates of DuPage, now known as Northwestern Medicine Orthopedics. (PX 1, p. 1)

Prior to seeing Dr. Froese, Petitioner was examined on September 15, 2008 at the request of Respondent pursuant to Section 12 of the Act by Dr. David Zoellick. He diagnosed Petitioner with a contusion and strain of her lower back and coccyx. He recommended an MRI of Petitioner's tailbone. (RX 2, p. 12)

On September 16, 2008, Petitioner first saw Dr. Froese who recommended an MRI of her pelvis. (PX 3, p. 92) This test was performed on September 26, 2008 and revealed that Petitioner had a

fractured coccyx. (PX 3, p. 129) Upon receiving the MRI results, Dr. Froese prescribed four weeks of rest. (PX 3, p. 89) On November 6, 2008, Dr. Froese prescribed physical therapy. (PX 3, p. 87) She administered an ischial bursal injection on December 4, 2008 (PX 3, p. 84) and an SI injection on January 8, 2009. (PX 3, p. 81)

Dr. Froese referred Petitioner to Dr. Steven Mayer who administered a bilateral SI joint injection on February 19, 2009. (PX 3, p. 132)

On March 19, 2009, Dr. Froese recommended another SI joint injection, but this was not authorized by Respondent. (PX 3, p. 74, 78)

On May 19, 2009, Dr. Froese administered an epidural steroid injection into Petitioner's left ischial bursa. (PX 3, p. 75)

On June 18, 2009, Petitioner was examined by Dr. Matthew Ross, a neurosurgeon, on referral from Dr. Froese. He felt that Petitioner's symptoms were multifactoral and he recommended an injection of anesthetic for both diagnostic and therapeutic purposes and indicated that a discogram might also be needed. (PX 8) Dr. Froese agreed with this approach and on July 2, 2009, she referred Petitioner to Dr. James Wilson, a pain management specialist. (PX 3, p. 73)

On March 15, 2010, Petitioner was re-examined at the request of Respondent pursuant to Section 12 of the Act by Dr. David Zoellick. He felt that an epidural steroid injection might be beneficial. (RX 2, p. 18)

Petitioner underwent an MRI of her pelvis and lumbar spine on October 7, 2010. These studies did not reveal any new pathology. (PX 3, p. 126-128) Dr. Zoellick reviewed the films and felt that Petitioner should refrain from undergoing the steroid injection and instead allow the fractured coccyx more time to heal. (RX 2, p.

On December 10, 2010, Petitioner was seen by Dr. John Andreshak for a surgical consult on referral from Dr. Wilson. He diagnosed mechanical low back pain stemming from her lower lumbar spine. In order to better determine whether surgery would help, Dr. Andreshak prescribed a discogram. (PX 3, p. 69-71)

On December 27, 2010, Petitioner was seen by Dr. Andrew Chenelle, a neurosurgeon, on referral from Dr. McMahon. (PX 5, p. 3) He diagnosed Petitioner with a fractured coccyx, left sacroilitis and slight lumbar discogenic pain for which he administered an SI joint injection. (PX 5, p. 5)

On January 31, 2011, Petitioner told Dr. Chenelle that the injection had "helped a bit." (PX 5, p. 7)

On April 6, 2011, Dr. Chenelle recommended a bilateral SI joint injection under fluoroscopic guidance and he referred her to Dr. Aaron Bare to evaluate her left shoulder pain. (PX 5, p. 12) The SI joint injection was administered on April 15, 2011. (PX 5, p. 15)

On April 11, 2011, Petitioner was seen by Dr. Aaron Bare, an orthopedic surgeon. She complained of left shoulder pain since falling at work in 2008, with increased symptoms since October, 2010. Dr. Bare diagnosed adhesive capsulitis, injected Petitioner's shoulder with cortisone and prescribed an MRI. (PX 3, p. 66, 67) Petitioner testified that she had a difficult time obtaining authorization for this test.

On May 25, 2011, Dr. Chenelle injected Petitioner's low back with lidocaine. (PX 5, p. 22) When Petitioner returned to him on August 1, 2011, he characterized her back pain as a "chronic problem" and he urged her to see Dr. Eugene Lipov, a pain management physician, for a second opinion. (PX 5, p. 28-30)

On October 21, 2011, Dr. Chenelle noted that Petitioner had undergone an ischeal bursa injection by Dr. Wilson with some improvement. He recommended that she see Dr. Bare for her frozen shoulder and Dr. Lipov for a facet rhizotomy. (PX 5, p. 31)

Petitioner returned to Dr. Bare on December 16, 2011. The condition of her left shoulder was unchanged from the preceding April. Dr. Bare reiterated his recommendation for an MRI. (PX 3, p. 84-85) This test was performed on January 5, 2012. It showed no tears, mild tendinopathy and possible impingement. (PX 3, p. 125) On January 27, 2012, Dr. Bare recommended that Petitioner continue with physical therapy. (PX 3, p. 82)

On April 11, 2012, Dr. Chenelle reiterated his recommendation that Petitioner see Dr. Lipov and get physical therapy for her SI joint pain. (PX 5, p. 36)

On June 8, 2012, Dr. Bare felt that Petitioner had essentially reached MMI for her left shoulder condition. He prescribed an FCE. (PX 3, p. 54) This test was performed on June 22 and 25, 2012. Although there were some inconsistencies, the FCE revealed that Petitioner was functioning at the low range of the medium exertional capacity which would match her job duties as a pharmacist. (PX 3, p. 162-163)

On June 29, 2012, Petitioner was able to see Dr. Eugene Lipov on referral from Dr. Chenelle. He recommended a medial branch injection with fluoroscopic guidance. (PX 7, p. 11) This treatment was administered on September 4, 2012. (PX 7, p. 13) In the meantime, Dr. Bare determined on August 17, 2012 that Petitioner had attained MMI and was cleared for full duty relative to her left shoulder injury. (PX 3, p. 52)

On October 22, 2012, Petitioner returned to Dr. Chenelle who recommended that she follow up with Dr. Lipov for another SI joint injection. (PX 5, p. 38) One day later, Dr. Lipov prescribed the injection. (PX 7, p. 20)

Petitioner returned to Dr. Bare on December 13, 2012 complaining of continuing left shoulder pain. Since Petitioner was already in physical therapy for her lower back, Dr. Bare recommended that this treatment be extended to include her left shoulder. He noted that her symptoms "would probably be permanent to a certain degree." (PX 3, p. 48-49)

On January 28, 2013, Dr. Chenelle clarified that Petitioner's symptoms stemmed from her SI joint and not from her lumbar spine. He recommended that she undergo additional SI joint injections. (PX 5, p. 41)

On February 6, 2013, Dr. Bare administered a cortisone injection to Petitioner's left shoulder and prescribed additional physical therapy. (PX 3, p. 43-44)

On February 8, 2013, Petitioner saw Dr. Steven Mayer who agreed that another SI joint injection should be done. (PX 3, p. 40-41) On April 26, 2013, Dr. Chenelle noted that authorization for these injections had been denied. (PX 5, p. 41)

On May 10, 2013, Dr. Bare released Petitioner from further care of the left shoulder subject to the permanent restrictions as reflected on her earlier FCE. (PX 3, p. 34)

On July 15, 2013, Dr. Chenelle noted that Petitioner was unable to secure authorization for any further physical therapy for her lower back and that she would be seeing Dr. Alexander Ghanayem for an IME. (PX 5, p. 43-44) Petitioner testified, and the parties have stipulated, that Dr. Ghanayem was selected as a "tiebreaker" doctor to determine the appropriate course of further treatment, if any.

On August 12, 2013, Petitioner was examined by Dr. Ghanayem. He felt that Petitioner had some chronic, residual SI joint dysfunction stemming from her injury. In reviewing her FCE, he felt that she could return to work as a pharmacist but that she should have a higher barstool-type seat rather than a lower chair. He felt that a doughnut cushion would also be helpful. Although additional physical therapy and chiropractic were not indicated, Dr. Ghanayem felt that it would be reasonable to attempt one or two additional SI joint injections, beyond which she would be at MMI. (RX 3)

Petitioner returned to Dr. Bare on September 13, 2013. He administered a cortisone injection to her left shoulder and indicated that she might need a new MRI if her symptoms did not improve. (PX 3, p. 32-33) On October 11, 2013, Petitioner reported great relief from the injection which suggested to Dr. Bare that the problem was impingement. (PX 3, p. 30-31)

On October 24, 2013, Petitioner underwent bilateral SI joint injections by Dr. Mayer, as previously recommended by both Dr. Chenelle and Dr. Ghanayem. (PX 3, p. 26)

On November 12, 2013, Dr. Mayer noted that Petitioner experienced great relief but was not pain free. He recommended that Petitioner continue with her home exercise program and, if necessary, undergo additional injections or radiofrequency ablation. (PX 3, p. 24)

Petitioner returned to Dr. Mayer on January 21, 2014 due to ongoing SI joint pain. Dr. Mayer felt that radiofrequency ablation was the treatment of choice and, if not authorized, additional SI joint injections would be the next best option. (PX 3, p. 21-22) Meanwhile, Petitioner's left shoulder condition continued to be problematic and on February 27, 2014 Dr. Bare prescribed more physical therapy. (PX 3, p. 19-20)

On March 17, 2014, Dr. Chenelle echoed the recommendation of Dr. Mayer for an ablation procedure. (PX 5, p. 49) On July 11, 2014, Dr. Ghanayem authored a letter to Petitioner's attorney reflecting that an ablation procedure can bring long-term relief to patients who have only transient relief from SI joint injections. (RX 4) Apparently unable to secure authorization for the ablation, Petitioner underwent additional SI joint injections by Dr. Mayer on August 18, 2014. (PX 3, p. 15) On September 24, 2014, Dr. Mayer noted that Petitioner was 60% improved. He referred her to Dr. James Wilson for the ablation procedure. (PX 3, p. 13-14)

On October 30, 2014, Dr. Chenelle recommended the ablation procedure, or more SI joint injections as an alternative. (PX 5, p. 54) When Petitioner returned on February 5, 2015, Dr. Chenelle noted that Respondent would not authorize any injections. (PX 5, p. 55) This remained the case on May 7, 2015. (PX 5, p. 58)

Authorization for the ablation procedure was eventually obtained and it was performed on August 9, 2015. (PX 5, p. 61)

On September 14, 2015, Dr. Chenelle felt that Petitioner could return to work subject to a maximum of 16 hours per week; limited standing of no more than 45 minutes; limited sitting of no more than 20-30 minutes; and no bending, twisting, pushing or pulling more than 10 lbs. (PX 10) Petitioner returned to work on October 29, 2015. (RX 11)

Petitioner returned to Dr. Chenelle on November 12, 2015 complaining that her symptoms had initially improved following the ablation but had worsened with full time work. (PX 5, p. 61) Dr. Chenelle imposed a restriction of 20 hours per week with no frequent bending, twisting or lifting and frequent changes of position. (PX 5, p. 63)

On December 18, 2015, Petitioner returned to Dr. Bare with complaints of ongoing left shoulder pain. (PX 3, p. 1) Dr. Bare felt this was a recurrence of the tendinitis. He imposed a two pound lifting restriction and concurred with Dr. Chenelle's restriction of 20 hours per week. (PX 3, p. 5)

On January 12, 2016, Petitioner returned to Dr. Mayer. He recommended SI joint injections but noted that these were denied by Respondent. (PX 3, p. 6-7)

On February 18, 2016, Dr. James Wilson, who had been treating Petitioner with medication management, prescribed cognitive and behavioral therapy for her low back pain. (PX 5, p. 69-70)

On March 14, 2016, Petitioner returned to Dr. Ghanayem for an evaluation. He felt that Petitioner's fractured coccyx had healed but that she had some residual SI joint dysfunction. He felt that she should be limited to lifting no more than 15 lbs frequently and 20 lbs occasionally. He felt that she had attained MMI and could work eight hours per day and 40 hours per week. (RX 5)

On May 12, 2016, Dr. Chenelle reiterated the restrictions that he had earlier imposed on September 14, 2015. (PX 10) Also on May 12, 2016, Petitioner saw Dr. Preston Harley, a behavioral psychologist, on referral from Dr. Wilson. Dr. Harley recommended cognitive-behavioral therapy to reduce Petitioner's "physical discomfort and emotional suffering." (PX 9)

On June 20, 2016, Petitioner underwent an ischial bursa steroid injection at the hamstring attachment by Dr. Mayer. (PX 3, p. 10-12) She continued to see Dr. Wilson for medication management. (PX 5, p. 72-74) On June 30, 2016, Petitioner mentioned to Dr. Harley that Respondent was not honoring her work restrictions. (PX 9)

On July 27, 2016, Petitioner advised Dr. Bare that Respondent was not honoring her work restrictions. He felt that she had reached MMI and he reiterated the restrictions that he had imposed upon Petitioner on December 18, 2015, including a restriction of no working more than 20 hours per week. (PX 4, p. 21-25, PX 11) On August 15, 2016, Dr. Bare injected Petitioner's shoulder with cortisone, reiterated the light duty restrictions and noted that she may return for additional injections on an "as needed" basis. (PX 4, p. 3-7)

On August 18, 2016, Dr. Chenelle renewed his previously imposed restrictions on Petitioner. (PX 6)

Petitioner testified that she currently takes Sonota for sleep; Ibuprofen as an anti-inflammatory; Nexium for her stomach; Nucynta as an opioid pain killer; Voltaren gel as an anti-inflammatory;

Lidocaine patch and Flector patch for direct relief of shoulder pain; and Chlorozone as a muscle relaxer.

II. Conclusions of Law.

In support of the Arbitrator's decision on whether Petitioner's current condition of ill-being is causally connected to the accident, the Arbitrator concludes as follows:

Given that Petitioner slipped and fell directly onto her tail bone, and given the chronicity of her lower back symptoms since then, there is no legitimate question about causation as it relates to Petitioner's lower back, tail bone and sacroiliac area. A closer question relates to Petitioner's left shoulder.

Petitioner testified that she landed on her left shoulder and left buttock area. (R-11) The records from the emergency room at Central DuPage Hospital are silent regarding any trauma to Petitioner's left shoulder. (PX 2, p. 39-42) On her initial follow-up visit five days after the accident, however, Petitioner was complaining of having injured her left shoulder. (PX 2, p. 34) On July 30, 2009, 18 days after the accident, Petitioner complained to Dr. McMahon about left shoulder pain. (PX 1, p. 2) These shoulder complaints are consistently reflected in the records of Dr. McMahon. (PX 1)

Dr. David Zoellick, Respondent's examining physician, felt that Petitioner's left shoulder condition was not causally connected to her accident. He expressly based his causation opinion on the assumption that Petitioner did not complain about her shoulder during the initial visits--plural--to the doctor. (RX 2, p. 29)

Dr. Aaron Bare, who became the principal treating orthopedic surgeon for Petitioner's left shoulder, opined "with a high degree of medical certainty that (Petitioner) re-exacerbated a pre-existing condition in her shoulder that she has been treated for based on her work injury." (PX 3, p. 46)

The Arbitrator further notes that the treating medical records generally reference Petitioner's work accident as the source of her problems. The medical treatment has been continuous without interruption. There have been no intervening accidents.

Based on the foregoing, the Arbitrator concludes that Petitioner's lower back and SI joint problems, her left shoulder problems and requisite treatment to address those conditions--including medication management and cognitive/behavioral therapy--are causally connected to the accident at work on July 12, 2008.

In support of the Arbitrator's decision relating to temporary total disability, the Arbitrator concludes as follows:

Petitioner claims that she was temporarily totally disabled for the period from July 13, 2008 through March 22, 2009, and again from December 3, 2010 through October 28, 2015. The treating medical records reflect that Petitioner was restricted from working from the time of her accident until her visit to Dr. Froese on March 19, 2009, at which time the doctor released her to return to full duty work effective March 23, 2009. (PX 3, p. 78, 114)

Petitioner testified that she began missing work again in December, 2010. (R-17) She saw Dr. John Andreshak on December 6, 2010, at which time she was given a note to remain off work. (PX 3, p. 89, 111) Petitioner remained off work and under the care of her doctors for nearly the next five years. In September, 2015, she participated in a re-training and re-certification program with Respondent as a prelude to her eventual return to work on October 29, 2015.

Based on the foregoing, the Arbitrator concludes that the period of temporary total disability from work was 288 1/7 weeks, from July 13, 2008 through March 22, 2009 and from December 6, 2010 through October 28, 2015.

In support of the Arbitrator's decision relating to temporary partial disability benefits, the Arbitrator concludes as follows:

When Petitioner returned to work on October 29, 2015, she was no longer assigned to a single store, a perquisite that she had previously enjoyed owing to her 23 year tenure as a pharmacist for Respondent. Instead, she was assigned as a "floater" who would fill-in as needed at any one of approximately 80 stores in a region that extended throughout the suburban Chicagoland area. (R-27) Although her seniority entitled her to an hourly wage rate of $63.25 under the union contract, Respondent paid her at the rate of $58.00 per hour and took away her seniority. (R-33, 34)

Petitioner worked in this capacity from October 29, 2015 through July 5, 2016. During this block of time, she remained under the care of her doctors and was subject to work restrictions, although the precise nature of those restrictions was in dispute. Petitioner's treating doctors felt that she should be limited to 20 hours per week; Dr. Ghanayem felt that Petitioner could work eight hours per day up to 40 hours per week. It would appear that Respondent honored neither restriction.

On Petitioner's first day back at work, October 29, 2015, she was assigned to work a 12 hour shift. She was also assigned to work a 12 hour shift on November 20, 2015. (RX 11) For the 35 6/7 week period from October 29, 2015 through July 5, 2016, Petitioner worked a total of 689 hours at the rate of $58.00 per hour, for a total of $39,962.00. (RX 11)

If Petitioner had been employed in the full performance of her duties during that block of time, she would have worked a total of 1,434.29 hours at the rate of $63.25 per hour, for a total of $90,718.84. The gross wage loss to Petitioner during this block of time was $50,756.84, two-thirds of which is $33,837.89. That is the amount due and owing to Petitioner for temporary partial disability benefits. Amortized over the 35 6/7 week period following Petitioner's return to work, this equates to the sum of $943.69 per week.

In support of the Arbitrator's decision relating to maintenance benefits, the Arbitrator concludes as follows:

When Petitioner requested that her work hours be adjusted to conform to the restrictions of her treating doctors, Respondent took her off the schedule. She has not worked since July 5, 2016, despite attempting to find new employment as a pharmacist with Northern Illinois University and other facilities through monster.com. (R-42) She has requested vocational rehabilitation.

Petitioner was initially provided vocational assistance by Michelle M. Peters-Pagella of Health Connection of Illinois. These services began in July, 2014 and continued until Petitioner returned to work for Respondent in October, 2015. (RX 6) Ms. Peters-Pagella testified that Petitioner was fully cooperative with vocational rehabilitation and that her educational background and work experience in a highly skilled occupation would once again make her a good candidate for vocational rehabilitation.

Regardless of whether one accepts that Petitioner can work full time or only part time hours, it is clear that Respondent is currently insisting upon a return to full duty work (and sometimes more than eight hours per shift) without restriction of any kind. Mark Harrison, Petitioner's supervisor, testified that upper management had decided that Respondent was unable to accommodate any restrictions and that Petitioner would need to return to full duty work. Harrison conveyed this to Petitioner in a text message on September 27, 2016. (PX 12)

Respondent has conducted surveillance on Petitioner at various points in the history of this case. (RX 7-9) On May 28 and 29, 2014, she is observed driving her car and grocery shopping. On July 2, 2014, she is observed attending a funeral. (The initial vocational report, RX 6, suggests that this was Petitioner's father's funeral.) On December 23, 2015, Petitioner is observed jogging up her driveway after re-positioning her cars. On December 24, 2015, she is observed entering a limousine to be transported to the airport. On January 2, 2016, she is observed scraping ice off her car windshield, driving to Dunkin' Donuts and driving to McDonalds. Surveillance conducted on January 3, January 4, March 5 and March 6, 2016 failed to yield any video of Petitioner. On August 21, August 22, August 26 and August 28, 2016, Petitioner is observed attending--and sometimes tailgating at--various college soccer games. Petitioner testified that she attends soccer games. (R-103) In general, the several hours of video surveillance do not depict Petitioner engaging in any activities inconsistent with her medical restrictions.

Petitioner has restrictions which prevent her from returning to her full duty job as a pharmacist. Given her credentials, qualifications and work experience, there can be little doubt that she is employable, but she is entitled to vocational assistance in her quest for re-employment.

Based on the foregoing, the Arbitrator concludes that Petitioner is entitled to maintenance benefits for the period from July 6, 2016 through November 3, 2016, the date on which proofs were closed. The Arbitrator further concludes that Petitioner is entitled to vocational rehabilitation pursuant to Section 8(a) of the Act.

In support of the Arbitrator's decision relating to medical bills, the Arbitrator concludes as follows:

Petitioner has incurred a number of medical expenses for the treatment of the injuries that she sustained at work on July 12, 2008. These expenses have been itemized in PX 13 and a portion of them appear to have been paid by Respondent's group health insurance carrier.

Petitioner's treatment over the course of the past 8+ years has been necessary to cure or relieve the effects of the injuries that she sustained when she fell at work. As such, Respondent is liable for the cost of such treatment. Petitioner has stipulated that Respondent shall be entitled to credit for any amounts paid, but not reflected, toward the bills contained in PX 13.

Based on the foregoing, the Arbitrator concludes that Petitioner is entitled to be paid or held harmless for the bills reflected in PX 13 subject to the limits of the Medical Fee Schedule.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Flavio Carlos Ortega,

Petitioner,
vs.

NO: 12WC 27006

Jose Pineda d/b/a Pasteleria El Nuevo Mundo and Illinois State Treasurer and Ex-Officio Custodian of the Injured Workers' Benefit Fund ,

17IWCC0807

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 6, 2017, is hereby affirmed and adopted.

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

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

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

DATED: DEC 18 2017
o120517
ELC/jrc
043

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ORTEGA, FLAVIO CARLOS
Employee/Petitioner

Case# **12WC027006**

J PINEDA D/B/A PASTELERIA EL NUEVO MUNDO AND ILLINOIS STATE TREASURER AND EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

17IWCC0807

On 1/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.63% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

3231 ENCINAS & ORNELAS PC
MARIO A ENCINAAS JR
2656 S KILDARE AVE
CHICAGO, IL 60623

1427 BERG & BERG
STEPHEN M WAUCK
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STEPHANIE KEVIL
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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)
☐ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Flavio Carlos Ortega,
Employee/Petitioner,

v.

Jose Pineda d/b/a Pasteleria El Nuevo Mundo and Illinois State Treasurer and *ex officio* Custodian of the Injured Worker's Benefit Fund,
Employer/Respondents.

Case # 12 WC 27006

Consolidated cases: N/A

17IWCC0807

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **10/13/2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

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

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

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

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

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

In the year preceding the injury, Petitioner earned **$31,200.00**; the average weekly wage was **$600.00**.

On the date of accident, Petitioner was **27** years of age, ***single*** with **1** dependent child.

Petitioner ***has*** received all reasonable and necessary medical services. Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services. Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**. Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Respondent shall pay to Petitioner the reasonable and necessary medical services, pursuant to the medical fee schedule, of **$185,062.80**, 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 **$400.00/week** for **20-2/7 weeks**, commencing **07/18/12** through **12/07/12**, as provided in Section 8(b) of the Act and shall pay the remainder of the award, if in any, in weekly payments.

Respondent shall pay Petitioner disfigurement benefits of **$360.00/week** for **130 weeks** as provided in Section 8(c) of the Act.

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

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

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

Signature of Arbitrator

1-3-2017
Date

JAN 6 - 2017

FINDINGS OF FACT

Background

Flavio Carlos Ortega ("Petitioner") seeks relief under the Illinois Workers' Compensation Act against Jose Pineda d/b/a Pasteleria El Nuevo Mundo ("Respondent") for injuries allegedly sustained on July 18, 2012 arising out of and the in course of his employment with Respondent. Ax1, Px7. This action sought further relief from the Illinois Injured Workers' Benefit Fund because Respondent allegedly did not maintain workers' compensation insurance. A hearing was held before Arbitrator Maria S. Bocanegra on October 13, 2016 in Chicago, Illinois. Respondent received notice of the trial date and through counsel, Berg & Berg, participated in the arbitration proceeding. The Illinois Attorney General's Office appeared on behalf of the Illinois State Treasurer and Ex-Officio Custodian of the Injured Workers' Benefit Fund ("the Fund") and participated in the arbitration proceeding. Ax1, Ax2.

At issue in this hearing were the following: (1)Were Petitioner and Respondent operating under the Illinois Worker's Compensation or Occupational Diseases Act and was their relationship one of employee and employer; (2) Did Petitioner sustain accidental injuries or was he last exposed to an occupational disease that arose out of and in the course of employment on July 18, 2012; (3) Did Petitioner give notice of the accident to Respondent within the time limits stated in the Act; (4) Is Petitioner's current condition of ill-being causally connected to this injury or exposure; (5) What were Petitioner's earnings during the year preceding the injury and what was his average weekly wage, calculated pursuant to Section 10 of the Act; (6) What was Petitioner's age and marital status at the time of the accident; did Petitioner have any dependent children at the time of the accident; (7) Is Respondent liable for the unpaid medical bills; (8) Is Petitioner entitled to any temporary benefits; (9) What is the nature and extent of the injury; (10) Disfigurement. Ax1, Ax2. The following is a recitation of the facts adduced at trial as to both claims.

Arbitrator's Findings as to Adequacy of Notice

The hearing proceeded on October 13, 2016. Petitioner provided evidence of proper and adequate notice of the hearing. Px6. Counsel for Respondent, Berg & Berg, participated in the arbitration proceedings. No challenge or objection to notice was raised by any party during the proceeding. The Arbitrator concludes Petitioner provided adequate notice.

Arbitrator's Findings as to Insurance Coverage

Without objection, Petitioner's counsel offered into evidence, Px5, which were records from the National Council On Compensation Insurance, Inc. ("NCCI") indicating that NCCI did not have records showing policy information filed showing proof of worker's compensation insurance on July 18, 2012 for either J. Pineda, Inc., Pasteleria El Nuevo Mundo or Nuevo Mundo Café. Based on Px5, the Arbitrator finds that Respondent lacked workers' compensation insurance coverage on July 18, 2012.

Arbitrator's Findings as to Testimonial and Other Evidence

Petitioner testified via Spanish interpreter/translator Omar Montiel was 27 years of age, single and had 1 minor dependent child on the date of accident. His testimony was given through a Spanish interpreter. Petitioner was working on July 18, 2012 for Respondent J. Pineda, Inc. d/b/a Pasteleria El Nuevo Mundo as a

baker. Respondent owned and operated a bakery and more specifically, baked bread, pastries and sold them to the public. Petitioner had been working for Respondent for approximately ten (10) months before the date of accident. Petitioner's job duties were to come in early in the morning, prepare the dough and then bake the bread and pastries. He worked approximately 60-72 hours per week. Petitioner was paid $600.00 per week in cash for his employment.

Petitioner had worked for Respondent previously at Respondent's prior bakery. Respondent sold that bakery and Petitioner stayed on as the baker. Respondent then opened Pasteleria El Nuevo Mundo. Respondent called Petitioner and offered him a job as baker at Respondent's new bakery. Respondent offered Petitioner the job as baker working six (6) days a week, 10-12 per day and was to be paid $600 per week. Petitioner started his work day at 4:00 a.m. Petitioner was always the first to arrive at the bakery. Respondent provided Petitioner with keys to the bakery and the alarm code so that Petitioner could begin work.

Petitioner would first have to prepare the dough to bake into bread and pastries. The ingredients used by Petitioner to prepare the dough were flour, eggs, sugar, yeast, etc. All those ingredients were at the bakery and provided by Respondent. Petitioner would also use utensils, an electrical industrial mixer and a gas oven. All of the tools and machines used by Petitioner were provided by Respondent and located at the bakery. To bake the bread, Petitioner had to use a gas oven. The oven was a manual oven. In order to turn on the oven, he had to turn on the switch to start the gas and then use a long lighter to ignite the pilot light. He performed this task about four times per week to turn on the oven.

On the date of the accident, Petitioner went to turn on the oven. He turned on the switches and went to light the pilot light. The oven suddenly and violently exploded. Petitioner saw a ball of fire that engulfed his chest, arms, neck and face. Petitioner felt tremendous heat and was thrown backwards against a rack. Petitioner got scared and went outside to call 911. After he called 911, he called Respondent to inform him what had happened. Petitioner was transported via ambulance to Loyola University Medical Center in Maywood.

Petitioner was diagnosed with "burn (any degree) involving 10-19% of body surface with third degree burn of less than 10% or unspecified amount. Blisters, with epidermal loss due to burn (second degree) of multiple sites of face, head, and neck. Blisters with epidermal loss due to burn (second degree) of multiple sites of upper limb, except wrist and hand. Full-thickness skin loss due to burn (third degree NOS) of multiple sites of upper limb, except wrist and hand. Blisters with epidermal loss due to burn (second degree) of multiple sites of wrist(s) and hand(s)" (PX1, pp. 3-4). Notes indicated that "11.92% flame burn, Grade 1 Inhalation. Burns to BUE and face when trying to light/fix a pilot light while at work (bakery)." (PX1, pp. 5). Petitioner was intubated, sedated, on paralytic agents, under pain control and critically ill. (PX1, pp. 21-22).

Petitioner's bilateral arms were debrided on July 20, 2012. (PX1, pp. 71). He was still listed as critically ill, was on a ventilator, intubated and in an induced coma. (PX1, pp. 76). On July 24, 2012, Petitioner was extubated, regained consciousness and began to speak. (PX1, pp. 152). From that day forward, he began language and speech therapy, physical therapy to work on his range of motion for his bilateral upper extremities, occupational therapy and was constantly being debrided, bandages changed and under pain medications and antibiotics. An assessment of Petitioner's inhalation injury found: "yellowish secretions noted throughout pharynx. Diffuse edema; reduced vallecular space secondary to edema. Suspect right vocal fold immobility; glottis gap noted. Cued and spontaneous cough responses strong." (PX1, pp. 256).

On August 7, 2012, Petitioner had a consultation with an otolaryngologist because of vocal cord paralysis caused by the inhalation injury. (PX1, pp. 338). This problem persisted and on August 13, 2012, the specialist performed a medialization of Petitioner's right vocal cord by providing an injection. (PX1, pp. 472). Petitioner was finally discharged from Loyola Medical Center on August 17, 2012 and was told to continue with physical therapy. (PX1, pp. 475-479).

Petitioner presented to Integrity Medical Group on October 17, 2012 for continued treatment of his ongoing complaints. Px4. A history was taken, he was examined and was diagnosed with "residual weakness and restriction secondary to 3rd burns; right shoulder musculoligamentous injury, possible history of dislocation. He was to begin physiotherapy to restore range of motion at the fingers, hands, wrists and to improve his strength and function as well as range of motion and pulley exercises for his right shoulder. Petitioner received the aforementioned physical therapy for seven weeks and then was discharged.

Petitioner started working again in March of 2013 at another bakery. He worked there for approximately four years. At the date of this hearing, he has been working at a different bakery for approximately three to four months. Petitioner testified that the medical bills from Loyola University Medical Center, Loyola Health System and Integrity Medical Group remain unpaid. Petitioner does not like to be in the sun anymore as it irritates his skin and he also feel embarrassed about how others look at his scars. He wears long sleeve shirts even in hot weather. His severe and disfiguring scars have impacted Petitioner's life and psychological well-being. Petitioner did not testify to or endorse any other injuries or resulting problems.

Petitioner alleged he suffered burns in both arms, hands, the shoulder and face. At trial, Petitioner removed his jacket and sweater. The Arbitrator observed burns to the top of the hand and arm with severe scarring at all digits, from the forearm up to the elbow and under the forearm up to the bicep. There was visible scarring on the shoulder down to the armpit. On the left, there was 2 patches on the left hand from the middle finger area down to thumb 4 inches in length with nickel-sized discolorations both light and dark

Scarring was also observed from the left wrist to forearm to elbow and possible keloid scar up to elbow Petitioner also showed scars on this chest above the axillary line and observed was a right sided 5 inch scar along the collar bone to the front of neck and another 4 inch scar. The scar was discolored and patch like.

On the face the Arbitrator observed white scarring above lip along lip line. There was also visible scars along the right side of face along right eye and right cheek.

Arbitrator's Credibility Assessment

Petitioner had a clear recollection of the work he performed for Respondent-Employer. He clearly recalled the events of July 18, 2012 and subsequent medical care as best as could be expected given the injuries and treatment described in the medical records. No witness challenged his account of these events.

CONCLUSIONS OF LAW

The Arbitrator adopts and incorporates the above findings of fact in support of the following conclusions of law, applicable to both pending claims, which bear the same date of accident:

ISSUE (A) Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
ISSUE (B) Was there an employee-employer relationship?

The Arbitrator finds that Petitioner and Respondent-Employer were operating under the Act on July 18, 2012. In so finding, the Arbitrator relies on Petitioner's testimony that part of his duties working in the bakery included electrical hand mixers and an oven provided by the Respondent-Employer. Section 3 provides for automatic coverage of the Act where there is, in any part, "any business or enterprise serving food to the public for consumption on the premises wherein any employee as a substantial part of the employee's work uses hand-cutting instruments or slicing machines or other devices for the cutting of meat or other foods or wherein any employee is in the hazard of being scalded or burned by hot grease, hot water, hot foods, or other hot fluids, substances or objects." 820 ILCS 305/3(14). On July 18, 2012, Respondent-Employer operated a bakery business that served food to the public for consumption. Therefore, Respondent-Employer was subject to the automatic provisions of Section 3 of the Act.

The Arbitrator further finds that prior to and on July 18, 2012, an employee/employer relationship did exist between Petitioner and Respondent-Employer. Petitioner's testimony concerning the circumstances of his hiring was detailed, believable, and unrebutted.

Petitioner's testimony established that at the time of his accident, he had been hired by the Respondent-Employer since approximately September 2011. Petitioner credibly described his job duties, his use of various tools in his job duties, his pay, his work schedule, benefits and uniform requirements. Petitioner established that Respondent-Employer controlled his work, method and form of payment, the right to control/discharge and providing of tools and equipment. No witness contradicted Petitioner's testimony concerning his duties and the type of work he did and the type of tools he used. The Arbitrator finds that Petitioner's testimony establishes that the relationship between Petitioner and Respondent-Employer on July 18, 2012 was that of employee and employer. As such, Respondent-Employer was subject to and operating under the Act.

ISSUE (C) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
ISSUE (D) What was the date of the accident?
ISSUE (E) Was timely notice of the accident given to Respondent?

The Arbitrator incorporates and adopts the findings of fact and conclusions of law as though fully set forth herein. The Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that he sustained accidental injuries on July 18, 2012 arising out of and in the course of his employment with Respondent-Employer. Petitioner's unrebutted and credible testimony was that on that date, he arrived to work as scheduled around 4 a.m. and went into the kitchen to start the oven. As he used a lighter to light the oven, the oven exploded and the Petitioner was burned by the flames. Petitioner has established he was in the course of employment as he opened the bakery, started the dough and turned on the oven. Petitioner's accident arises

out of his employment as lighting the oven constitutes a clear employment related duty for which he was required to perform. Regarding the explosion itself, Petitioner's testimony established the oven was gas and he needed to light the pilot light. This confirms the employment-related risk to which he was exposed. Petitioner's unrebutted testimony also established that he gave immediate and proper notice to J. Pineda following the accident. Petitioner's mechanism and description of accident and injuries are corroborated via his concomitant medical records. Based on the foregoing, Petitioner has proven accident, the date of his accident and that he gave proper notice.

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

The Arbitrator incorporates and adopts the findings of fact and conclusions of law as though fully set forth herein. The Arbitrator concludes that Petitioner has proven by a preponderance of evidence that his current condition of ill-being as it relates to his burn injuries is causally related to the injuries he sustained as a result of his work accident. Petitioner credibly established he was in a state of good health before the accident as he testified he was 27 years-old at the time of the accident and had no prior injuries or accidents before the date of question. Petitioner testified that upon lighting the pilot light on the oven that it exploded and burnt his face, chest, arms, and hands. Thereafter, he felt immediate onset of pain from the burns he experienced. Petitioner then sought immediate and timely treatment as he called 9-1-1 and was taken by ambulance to Loyola University Medical Center. Petitioner's recitations of how his injuries occurred were consistent with his treatment records. Petitioner's exams through-out treatment noted symptoms consistent with burn injuries. Petitioner was diagnosed with 12% total body burns to his face, chest, arms, and hands. Additionally, Petitioner was diagnosed with a grade I inhalation injury and underwent conservative treatment. Based on the foregoing, the Arbitrator concludes Petitioner's burn injuries are causally related to his work accident.

ISSUE (G) What were Petitioner's earnings?

The Arbitrator finds that Petitioner has proven by a preponderance of the evidence that his earnings were $31,200.00 in the year preceding his injury and that his average weekly wage was $600.00 as he testified at the hearing. (Ax 1). Petitioner testified he earned $600.00 per week and work approximately 9-10 hours per day, 6 days a week. Petitioner testified that he was only paid in cash by the Respondent-Employer. Petitioner's testimony was unrebutted in all aspects. Based on the foregoing reasons, the Arbitrator finds that Petitioner has proven his average weekly wage was $600.00.

ISSUE (H) What was Petitioner's age at the time of the accident?
ISSUE (I) What was Petitioner's marital status at the time of the accident?

The Arbitrator incorporates and adopts the findings of fact and conclusions of law as though fully set forth herein. The Arbitrator concludes that Petitioner has proven by a preponderance of evidence that he was 27 years-old at the time of the accident and was single based on his testimony. Ax1.

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

The Arbitrator incorporates and adopts the findings of fact and conclusions of law as though fully set forth herein. The Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that

treatment for the burn injuries has been reasonable and necessary and further that Respondent-Employer is liable for the treatment rendered to Petitioner as a result of the work accident of July 18, 2012. Petitioner's medical records document timely medical care rendered in connection with Petitioner's burn injuries sustained as a result of the accident. Petitioner alleged unpaid pre-fee schedule medical bills totaling $185,062.80. Ax1.

Px2 Loyola University Medical Center	$167,782.70
Px3 Loyola University Physicians Foundation	$13,900.00
Px4 Integrity Medical Group	$3,380.10

As to Px2, the Arbitrator finds that treatment for the burn injuries reasonable, necessary and causally related. Therefore, the Arbitrator awards Px2 in the amount of **$167,782.70**, subject to Sections 8(a) and 8.2 of the Act.

As to Px3, the Arbitrator finds that treatment for the burn injuries reasonable, necessary and causally related. Therefore, the Arbitrator awards Px3 in the amount of **$13,900.00**, subject to 8(a) and 8.2 of the Act.

As to Px4, the Arbitrator finds that treatment for the burn injuries reasonable, necessary and causally related. Therefore, the Arbitrator awards Px4 in the amount of **$3,380.10**, subject to 8(a) and 8.2 of the Act.

In summary, Respondent shall pay reasonable and necessary medical services of **$185,062.80**, as provided in and subject to Section 8(a) and 8.2 of the Act. Respondent is to pay unpaid balances with regard to said medical expenses directly to the medical providers. Respondent shall pay any unpaid, related medical expenses according to the fee schedule. See, *Springfield Urban League v. Ill. Workers; Comp. Comm'n*, 2013 IL App (4th) 120219WC.

ISSUE (K) What temporary benefits are in dispute?

The Arbitrator incorporates and adopts findings of fact and conclusions of law as though fully set forth herein. The Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that he is entitled to temporary total disability ("TTD") benefits as a result of injury. At trial, Petitioner claimed entitlement to TTD from July 18, 2012 through December 7, 2012. Ax 1; Px1. Petitioner testified he was off of work per doctor orders. Specifically, Petitioner was in treatment at Loyola University Medical Center from July 18, 2012 through August 17, 2012. Px1. Petitioner then attended physical therapy at Integrity Medical Group from October 17, 2012 until December 7, 2012. Px4. Petitioner's testimony is credible and supported by the medical records. Therefore, Respondent shall pay Petitioner, for his claim, temporary total disability benefits of **$400.00/week** for **20-2/7th weeks**, commencing **July 18, 2012** through **December 7, 2012**, and shall pay the remainder of the award, if in any, in weekly payments.

ISSUE (L) What is the nature and extent of the injury?
ISSUE (O) Disfigurement

The Arbitrator incorporates and adopts the finding of fact and conclusions of law as though fully set forth herein. The Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that he is entitled to disfigurement benefits as a result of injuries sustained. After the July 18, 2012 accident, Petitioner was diagnosed with body burns for which he underwent extensive conservative care. The evidence established

at trial showed Petitioner had significant, visible and obvious scarring, mottling, and discoloration along both of his hands and along both of his arms. He also had obvious scarring on his chest, neck and some scarring on the face. The Arbitrator observed large and unsightly scarring that corroborate Petitioner's current complaints. Records showed that Petitioner suffered burns as a result of the explosion to 10-19% of body surface with third degree burn of less than 10% or unspecified amount. Therefore, Respondent shall pay Petitioner disfigurement benefits of **$360.00/week** for **130 weeks** as provided in Section 8(c) of the Act. See also, 2016 IWCC 0367.

Petitioner also seeks permanent partial disability benefits under Section 8(d) and 8(e) of the Act. However, the Act does not permit recovery of benefits under Section 8(c) where such compensation is payable under paragraphs (d), (e) or (f). The Arbitrator concludes that not only did Petitioner seek disfigurement per Ax1, but his injuries most appropriately are awarded under Section 8(c) and are supported by his own testimony and the medical record.

ISSUE (O) Other: Insurance Coverage and Liability of the Injured Workers' Benefit Fund

As to the claim, the Illinois State Treasurer as *ex officio* custodian of the Injured Workers' Benefit Fund ("the Fund") was named as a party Respondent in this matter. Respondent-Employer was properly served with notice of these proceedings and had prior notice of this pending matter generally. (Px 6). The Arbitrator finds that Respondent-Employer was not properly insured. (Px 5). In the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner this award is hereby also entered against the Injured Workers' Benefit Fund ("the Fund") to the extent permitted and allowed under § 4(d) of the Act. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund ("the Fund") for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Fund, including but not limited to the full award in this matter, the amounts of any medical bills paid, temporary total disability paid or permanent partial disability paid. The Respondent-Employer's obligation to reimburse the Fund, as set forth above, in no way limits or modifies its independent and separate liability for fines and penalties set forth in the Act for its failure to be properly insured.

Signature of Arbitrator

1-3-2017
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Steve Humes III,
Petitioner,
vs.

NO: 11WC 35156

Aventini,
Respondent.

17IWCC0808

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, nature and extent, 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 7, 2017, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: DEC 18 2017
120517
LEC/jrc
043

L. Elizabeth Coppoletti
L. Elizabeth Coppoletti

Charles J. DeVriendt
Charles J. DeVriendt

Joshua D. Luskin
Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HUMES III, STEVE
Employee/Petitioner

Case# **11WC035156**

AVENTINI
Employer/Respondent

17IWCC0808

On 6/7/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.07% 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:

0724 JANSSEN LAW CENTER
MATTHEW A BREWER
333 MAIN ST
PEORIA, IL 61692

1454 THOMAS & PORTELA
DANA DJOKIC ESQ
500 W MADISON ST SUITE 2900
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Steve Humes III
Employee/Petitioner

v.

Aventini
Employer/Respondent

Case # 11 WC 35156

Consolidated cases: n/a

17IWCC0808

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Peoria, on April 17, 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On August 23, 2011, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was 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 $55,342.04; the average weekly wage was $1,064.27.

On the date of accident, Petitioner was 48 years of age, single with 1 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

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

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

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

William R. Gallagher

William R. Gallagher, Arbitrator

June 1, 2017

Date

ICArbDec p. 2

JUN 7 - 2017

Findings of Fact

Petitioner filed an Amended Application for Adjustment of Claim which alleged he sustained a repetitive trauma injury arising out of and in the course of his employment for Respondent. According to the Amended Application, Petitioner sustained "Repetitive use of mouse, controls and mixing chemicals" and sustained injuries to the "Right arm and hand; left hand." The Amended Application alleged a date of accident (manifestation) of August 23, 2011 (Petitioner's Exhibit 1). Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner testified he worked for Respondent for approximately 19 years. For the first seven years, Petitioner was an ash cleaner. That job required Petitioner to clean boilers, use rods to break up accumulations of ash, etc. For the following 12 years, Petitioner worked for Respondent as a control room operator, which was the job Petitioner had at the time of the accident.

Petitioner testified that his job as a control room operator required him to run/test samples of water. That procedure involved putting water in bottles, shaking the bottles by hand and then placing the bottles in various racks. The bottles were then placed in various testing machines to check their chemical balance. Petitioner also stated he would turn "L" shaped valves by hand at least every two hours. That procedure would take place with greater frequency when Petitioner was training others. Petitioner stated he entered data by using a keyboard on a daily basis. Petitioner said he used crow's foot wrenches which he said were long handled "L" shaped devices. He would use them to break up lose fuel in fuel feeders. Petitioner's job did not require a significant amount of heavy lifting. The heaviest object Petitioner had to lift was approximately 40 pounds.

Petitioner testified he previously underwent right carpal tunnel surgery in 2007, but that, over time, he experienced a gradual return of symptoms. On August 23, 2011, (the date of manifestation alleged in the Amended Application) Petitioner was seen by Dr. Steven Clark, an orthopedic surgeon. At that time, Petitioner had complaints referable to both hands. Dr. Clark referred Petitioner to Dr. Jeffrey Garst, an orthopedic surgeon, and the physician who performed the 2007 right carpal tunnel surgery on Petitioner (Petitioner's Exhibit 4).

Dr. Garst initially evaluated Petitioner on November 21, 2011. At that time, Petitioner complained of bilateral hand pain, worse on the right than left, an inability of his fingers to grasp and a loss of sensation. Dr. Garst's record noted he had previously performed right carpal tunnel surgery (Petitioner's Exhibit 5).

Dr. Garst ordered an MRI scan of Petitioner's right elbow and EMG/nerve conduction studies of both arms. The MRI was performed on November 28, 2011, and it revealed tendinosis of the common flexor tendon at the medial epicondyle as well as possible synovial fringe. The EMG/nerve conduction studies were performed on December 15, 2011, and were positive for moderate recurrent right carpal tunnel syndrome, moderate left carpal tunnel syndrome, but no evidence of cubital tunnel syndrome on either side (Petitioner's Exhibits 5, 6 and 7).

Dr. Garst subsequently saw Petitioner on January 23, 2012, and he opined Petitioner had right recurrent carpal tunnel syndrome, left carpal tunnel syndrome, synovial fringe and lateral epicondylitis of the right elbow. He treated Petitioner's conditions conservatively and recommended Petitioner use splints that he still had from his prior surgery (Petitioner's Exhibit 5).

When Dr. Garst saw Petitioner on May 29, 2012, and December 18, 2012, he recommended Petitioner have surgeries performed. Specifically, Dr. Garst recommended Petitioner have a left carpal tunnel release and a "Redo" of the right carpal tunnel release and a right lateral epicondyle release (Petitioner's Exhibit 5).

At the direction of Respondent, Petitioner was examined by Dr. Stephen Weiss, an orthopedic surgeon, on September 12, 2012. Dr. Weiss was not provided with any of Petitioner's treatment records prior to his examination of him; however, Dr. Weiss obtained a medical history from Petitioner when he examined him. Subsequent to his examination of Petitioner, Dr. Weiss was provided with a medical record from March, 2010, which indicated Petitioner had type 2 diabetes. Dr. Weiss also reviewed an on-site job analysis of Petitioner's job that was provided to him by Respondent. Dr. Weiss also obtained information from Petitioner as to his job duties. Petitioner informed Dr. Weiss he operated controls, turned knobs and handled samples. Petitioner described these tasks as repetitive and involving fine manipulation (Respondent's Exhibit 1; Deposition Exhibit 2).

Dr. Weiss diagnosed Petitioner with post right carpal tunnel release, left carpal tunnel syndrome, diabetes, a history of diabetic neuropathy and obesity. In regard to causality, Dr. Weiss opined that Petitioner's carpal tunnel syndrome was neither caused nor aggravated by Petitioner's work activities and the claimed injury of August, 2011. He based this opinion upon the fact that, while Petitioner's job duties were repetitive, they did not involve forceful gripping or exposure to vigorous vibration (Respondent's Exhibit 1; Deposition Exhibit 2).

When Petitioner was seen by Dr. Garst on January 28, 2013, he advised Dr. Garst of his job duties and asked him about whether there was a causal relationship. Dr. Garst noted Petitioner worked as a control room operator, used a computer and mouse all day and did sampling/adjustments every two hours. Dr. Garst opined that the job seemed repetitive and opined his carpal tunnel on both sides and right elbow pain would be work-related (Petitioner's Exhibit 5).

Petitioner was subsequently seen by Dr. Garst on July 2, 2013. At that time, Petitioner had more symptoms in regard to the left hand than the right hand/elbow. Dr. Garst recommended proceeding with carpal tunnel surgery on the left hand only. Dr. Garst performed surgery on July 19, 2013, and the procedure consisted of a left carpal tunnel release (Petitioner's Exhibit 5).

Dr. Garst saw Petitioner on July 31, 2013. At that time, Dr. Garst discharged Petitioner from care and stated that if the symptoms on the right side got worse, Petitioner should follow up with him (Petitioner's Exhibit 11; pp 22-23).

Petitioner stopped working for Respondent in May, 2014. At trial, Petitioner testified that after his leaving the employment of Respondent, his symptoms were not as severe or as constant as they were previously. Petitioner stated his left hand symptoms improved following surgery, but that he still had a diminished grip strength and a little bit of numbness. In regard to his right hand, Petitioner stated it still bothers him. Petitioner also stated he has had some flare ups of his right elbow symptoms. Petitioner has not sought any medical treatment since he was last seen by Dr. Garst on July 31, 2013.

Dr. Garst was deposed on February 15, 2017, and his deposition testimony was received into evidence at trial. In regard to his diagnosis and treatment of Petitioner, Dr. Garst's testimony was consistent with his medical records. In regard to causality, Dr. Garst testified that Petitioner's use of the computer and mouse and doing sampling was repetitive and caused the conditions he diagnosed in the left and right hands and right elbow (Petitioner's Exhibit 11; pp 18-20).

On cross-examination, Dr. Garst agreed he had not received an on-site job analysis of Petitioner's job and that information would have been helpful in determining whether Petitioner's conditions were work-related. He also agreed that Petitioner being diabetic would have contributed to, or predisposed, Petitioner to having carpal tunnel syndrome (Petitioner's Exhibit 11; pp 27-29).

Dr. Weiss was deposed on February 22, 2017, and his deposition testimony was received into evidence at trial. Dr. Weiss' testimony was consistent with his medical report and he reaffirmed the opinions contained therein. In regard to the on-site job analysis provided to him, Dr. Weiss stated that this did not differ from the information Petitioner provided to him. He testified that Petitioner's job activities did not involve vigorous forceful gripping. While he agreed Petitioner's activities were repetitive, he noted that Petitioner engaged in a wide variety of activities over the course of a day. He also noted that Petitioner was obese and had diabetes, both of which were systemic conditions that contributed to carpal tunnel syndrome (Respondent's Exhibit 1; pp 12-15).

On cross-examination, Dr. Weiss agreed he had not been provided with Petitioner's medical records with the exception of the March, 2010, record where it noted Petitioner had diabetes. However, Dr. Weiss stated that not having the records was not critical to his opinions unless they were inconsistent with the medical history provided to him by Petitioner. Further, Dr. Weiss agreed he did not opine as to the etiology of Petitioner's right elbow condition (Respondent's Exhibit 1; pp 19-25, 37).

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner did not sustain a repetitive trauma injury arising out of and in the course of his employment for Respondent that manifested itself on August 23, 2011, and Petitioner's current condition of ill-being is not related to his work activities.

In support of this conclusion the Arbitrator notes the following:

When Petitioner testified regarding his job activities, he described a variety of activities which involved the use of both arms/hands, but he would periodically move from one activity to another.

None of the job activities described by Petitioner involved use of vibratory tools or a significant amount of gripping.

Petitioner's treating physician, Dr. Garst, opined that Petitioner's upper extremity conditions were causally related to Petitioner's work activities; however, Dr. Garst had very little specific information about Petitioner's job duties, only that Petitioner used a computer and mouse all day and did sampling. Dr. Garst agreed that a review of an on-site job analysis would have been helpful in determining causality. He also agreed Petitioner's having diabetes would contribute to, or predispose, Petitioner to having carpal tunnel syndrome.

Respondent's Section 12 examiner, Dr. Weiss, had the benefit of reviewing an on-site job analysis and described Petitioner's job as involving a wide variety of tasks, none of which involved forceful gripping.

When Dr. Weiss opined that Petitioner's condition was not work-related, he also noted Petitioner was obese and had diabetes, both of which were systemic conditions that contributed to carpal tunnel syndrome.

Based upon the preceding, the Arbitrator finds the opinion of Dr. Weiss in regard to causality to be more persuasive than that of Dr. Garst.

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

William R. Gallagher, Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jessica Raymer,
Petitioner,
vs.

NO: 13WC 3941

17IWCC0809

Salem Village,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 23, 2017 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $21,300.00. 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: DEC 18 2017
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MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MER, JESSICA
Employee/Petitioner

Case# 13WC003941

SALEM VILLAGE
Employer/Respondent

17IWCC0809

On 2/23/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.67% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0924 BLOCK KLUKAS MANZELLA & SHELL
BRYAN SHELL
19 W JEFFERSON ST
JOLIET, IL 60432

0208 GALLIANI DOELL & COZZI LTD
ROBERT J COZZI
20 N CLARK ST 18TH FL
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)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jessica Raymer
Employee/Petitioner

v.

Salem Village
Employer/Respondent

Case # **13** WC **03941**

17IWCC0809

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **(Peter O'Malley) Christine M. Ory**, Arbitrator of the Commission, in the city of **New Lenox**, on **August 14, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. X Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. X What was the date of the accident?
E. X Was timely notice of the accident given to Respondent?
F. X Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. X Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. X 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 **December 12, 2012,** Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* 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 **$19,143.80**; the average weekly wage was **$368.15.**

On the date of accident, Petitioner was **32** years of age, ***married*** with **0** dependent children.

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

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

To date, Respondent has paid $ **0** in TTD and/or for maintenance benefits, and is entitled to a credit for any and all amounts paid.

Respondent shall be given a credit of $ **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

Respondent shall pay the medical bills totaling **$16,913.00**, subject to the fee schedule, pursuant to §8 and §8.2 of the Act and subject to any credit for any portion of the bill paid.

Temporary Total Disability

Respondent shall pay temporary total disability from December 20, 2012 through February 6, 2013, or 7 weeks @ $253.00 per week.

Permanent Disability

Respondent shall pay $253.00 per week for a period of 10 weeks, as provided in §8 (d) 2 of the Act, as petitioner's injuries she sustained caused 2% person as a whole.

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

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

Christine MOy

02/22/2017

Signature of Arbitrator — Date

FEB 23 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jessica Raymer	)	
Petitioner,	)	
vs.	)	**No. 13 WC 03941**
Salem Village	)	
Respondent.	)	**17IWCC0809**
	)	

ADDENDUM TO ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing in New Lenox on August 14, 2015 before Arbitrator Peter O'Malley. Arbitrator O'Malley did not issue a decision before his term expired. Arbitrator Christine Ory writes this decision after reviewing the transcripts of the proceeding and the evidence.

The parties agree that on December 12, 2002, petitioner and the respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that in the year preceding the injuries, petitioner earned $19,143.80 and her average weekly wage was $368.15.

At issue in this hearing was as follows:

1. Whether the petitioner sustained accidental injuries that arose out of and in the course of her employment;
2. Whether petitioner provided respondent notice of the accident within the time limits stated in the Act;
3. Whether petitioner's current condition of ill-being is causally connected to the claimed injury;
4. Whether respondent is liable for medical bills totaling $16,913.00;
5. Whether petitioner is entitled to temporary total disability from December 12, 2012 through February 14, 2013; and
6. The nature and extent of petitioner's injury.

STATEMENT OF FACTS

Petitioner testified she began her employment with respondent in September, 2012 as a certified nursing assistant (CNA). As such, petitioner assisted respondent's residents getting them up and out of bed in the morning, getting them dressed, into the bathroom and showering, as well as getting them to and from lunch and dinner. The residents were in wheelchairs. Petitioner's job required her to move the residents in their beds in order to dress and undress them. She also bent down to put on the resident's socks. She was required to change and clean the residents if they soiled themselves. She physically helped the resident into the wheelchair using a gait belt. She did a lot of bending, lifting, moving and guiding of patients.

Prior to her employment with respondent she did mainly secretarial work. She denied having back problems prior to December 12, 2012. She had been in an auto accident five years

prior to 2012 when another person ran a stop sign and sideswiped petitioner's car. Petitioner was seen in the emergency room. She had a sore head and neck and a rug burn on her forehead. She denied lower back pain.

On December 12, 2012 she noticed pain in her lower back. She specifically noticed the pain when she was trying to lift and carry a tray of lunches for everyone at the table. Petitioner testified that someone from the kitchen carried the tray for her as she had sharp stabbing pain in her lower back. She reported to Mary Alice on December 12, 2012 that she was having back problems. She did not complete an incident report.

She went to see a chiropractor, whom she found through her father-in-law. She was first seen by the chiropractor on December 17, 2012. She checked the box on the chiropractor intake form indicating she did not have an accident or work injury. She reasoned that because she could not point to any specific incident that caused her back pain she marked the box in that manner. She described her work activities to the chiropractor. She received minor adjustments and heat. It did not provide benefit.

Petitioner next sought treatment from Dr. Papaeliou at Meridian Medical, which was on December 19, 2012. Petitioner provided details of the work she did for respondent to Dr. Papaeliou. Upon arrival at Dr. Papaeliou's office, due to her condition, the doctor's office put her in a wheelchair. At Dr. Papaeliou's direction, she obtained an MRI of her lumbar and thoracic spine. Petitioner contacted Mary Alice to report the doctor's recommendation. No report was completed.

Petitioner saw Dr. Papaeliou again on December 20, 2012. Dr. Papaeliou referred petitioner to Dr. Joel See. Petitioner saw Dr. See the following day, who performed an SI joint injection. This provided some benefit. Dr. See kept her off work.

She returned to Dr. See on January 10, 2013. An SI epidural steroid injection and physical therapy was ordered. She was kept off work. Dr. See suggested petitioner find a different line of work and then offered petitioner a job at his facility. Dr. See did an SI epidural steroid injection at the L4-L5 and L5-S1 level on January 11, 2013. The injections and physical therapy helped.

Dr. See referred petitioner to Dr. Rebecca Kuo with Meridian Medical. Dr. Kuo recommended continuing with the epidural steroid injections. The last time petitioner saw Dr. See was on February 6, 2013 when he did another epidural steroid injection. Dr. See also referred petitioner to Dr. Nadkarni. Dr. Nadkarni was curious as to petitioner's family history of ALS. She testified she did not have ALS.

Petitioner has not received any treatment since physical therapy ended. She moved to Arizona in October, 2013. The Arizona warm weather seems to have helped her back condition. She is now employed as a care coordinator at a primary care physician's office. This is mainly clerical work.

Petitioner testified it is difficult to sit all day. She has not returned to a doctor as she claimed there was nothing further that could be done; she just had to deal with her condition. She has numbness and tingling in her left leg. At times she has myoclonus. She does not work out as she once did; only stretching and yoga type work out. She takes Advil for the pain.

On cross examination, she agreed she contacted chiropractor on March 14, 2013, but denied telling the chiropractor's office not to submit records as it would jeopardize her workers' compensation claim as the accident was claimed to have occurred on December 19, 2012.

Petitioner agreed some residents did not need as much assistance as others. Some days she would lift 20 to 30 times per hour; other days she would assist fewer residents and thus do less lifting.

Each of respondent's floor contained 28; some rooms had two people in the room. There were a total of three CNAs per shift on each floor.

Meridian Medical Associates Records (PX.2)

These records show petitioner received treatment from March 17, 2011 through December 1, 2012 for a variety of conditions including tenosynovitis of the left thumb, anxiety and hot flashes. There was no mention of any back problems or conditions during this period of time.

Petitioner was seen by Dr. Papaeliou on December 19, 2012 for lower back and left leg pain. Petitioner denied awareness of any injury but stated she was a CNA and, as such, lifted patients. She was referred for an MRI. She stated the onset of the symptoms began on December 12, 2012. Dr. Papaeliou did not give any indication of petitioner's ability to work.

The December 19, 2012 lumbar MRI showed disc bulging at the L4-5 and L5-S1 level. The December 20, 2012 thoracic spine MRI was overall unremarkable.

Petitioner was next seen by Dr. Papaeliou on December 20, 2012 for left lumbar radiculopathy. She was advised to rest at home and referred to Dr. See.

She was seen by Dr. See on December 21, 2012 as a referral from Dr. Papaeliou. She related the pain's onset ten days earlier while working as a CNA. A left sacroiliac joint and piriformis injections and sciatic nerve block were performed.

She received physical therapy from January 3, 2013 through January 9, 2013.

Petitioner followed up with Dr. See on January 10, 2013. Dr. See kept petitioner off work and recommended she find different type of work.

Petitioner underwent a L4-L5 and L5-S1epidural injection by Dr. See on January 11, 2013.

On January 22, 2013, petitioner was seen by Dr. Rebecca Kuo, in consultation with Dr. Joel See, due to low back pain. Petitioner's complaint was pain in lower back radiating down thighs which was present for about a month. Although petitioner did not provide details of a specific incident, she indicated she was employed as a CNA.

Petitioner was seen by Dr. Katherine Spangenberg on January 25, 2013 for routine check of her medications and also to discuss the injury to her lower back from 12/19/13 (sic).

Petitioner was seen by Dr. See on February 6, 2013 due to back pain that was radiating down the left side. Dr. See performed a left sacroiliac joint and piriformis injections and sciatic nerve block due to sacroilitis and piriformis syndrome.

Petitioner was seen by Dr. Nadkarni for demyelinating disorders on February 14, 2013 and was admitted to the hospital.

The neurological consult at Provena St. Joseph Medical Center by Dr. Steven Cataldo indicated petitioner was having paresthesia and numbness of the left leg. Dr. Cataldo recommended an MRI of the brain and cervical spine due to possible cervical myelopathy or demyelinating.

Petitioner was seen by Dr. Nadkarni for anxiety, arthralgias in multiple sites, demyelinating disorder and lumbar radiculopathy on February 21, 2013.

Complete Chiropractic and Wellness Center Records (PX.3)

Petitioner was seen only once by Doctor Skaggs at Complete Chiropractic and Wellness Center, which was on December 17, 2012. Petitioner had complaints of shooting pain down her left side first that appeared on December 12, 2012. Petitioner signed a statement that the appointment for care was not related to any accident or work injury.

Meridian Medical Bills (PX.4)

Petitioner claims a total of $16,561.00 for bills from Meridian Medical (for services rendered from December 19, 2012 through February 7, 2013.)

Complete Chiropractic and Wellness Center Bill (PX.5)

Petitioner claims a $352.00 bill from Complete Chiropractic and Wellness Center.

Complete Chiropractic Records (RX.1)

These are duplicate records to those of Petitioner's Exhibit 1, with the exception that these records include a form from NHRMA Mutual with a notation at the bottom "Pt. requested info on 3/14/2013, before sending I called and spoke with Jennifer. She asked me not to send any documentation since her injury date was 12/19/12 and said she saw Dr. Skaggs on 12/17/12, as not to jeopardize her work/comp case."

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

C. With respect to the issue of whether an accident occurred that arose out of and in the course of Petitioner's employment by respondent, the Arbitrator finds the following facts:

Petitioner testified, without rebuttal that she developed low back pain on December 12, 2012 while performing her job as a CNA with respondent. She was not sure exactly what precipitated the back pain, but confirmed her job required her to help respondent's residents that were mostly wheel-chair bound to get dressed; required her to lift and move the residents in order to dress them. She also had to lift the residents out of bed and into the wheel chair with use of a gait belt. Petitioner also provided assistance to residents going to and from the bathroom. She remembered specifically on December 12, 2012 she was required to lift a tray full of lunches but was unable to do so due to back pain.

Although she signed a statement with Dr. Skaggs, D.C. on December 17, 2012, that her condition was not due to a work injury, she explained she did so as she could not pinpoint any specific incident that precipitated the back pain. She gave the onset as December 12, 2012.

Also, when petitioner first saw Dr. Papaeliou on December 19, 2012, she did not give any specific injury, only related that she was employed as a CNA and as such did heavy lifting.

Based upon the preponderance of the evidence, the Arbitrator finds petitioner sustained an injury to her lower back as a result of repetitive lifting from a work accident that arose out of, and in the course of, her employment with respondent on December 12, 2012.

D. With respect to the issue regarding the date of accident, the Arbitrator finds the following facts:

Petitioner's testimony, the records of Dr. Skaggs from December 17, 2012, and Dr. Papaeliou from December 19, 2012 placed the onset of petitioner's back pain on December 12, 2012. The Arbitrator therefore finds petitioner's date of accident, or manifestation date, as December 12, 2012.

E. With respect to the issue as to whether petitioner provided timely notice of the accident to respondent, the Arbitrator finds the following facts:

Petitioner testified, without rebuttal, that she notified her charge nurse who advised her to report to Mary Alice on both December 12, 2012 when she first notice the pain and then on December 19, 2012 after she had seen Dr. Papaeliou. Respondent did not call anyone to rebut petitioner's testimony. Therefore, the Arbitrator finds petitioner provided notice of the accident to respondent within the time limits of the Act.

F. With respect to the issue of whether the petitioner's condition of ill-being is related to the injury, the Arbitrator finds the following:

Petitioner testified she had no back problems prior to December 12, 2012. Records from Meridian Medical confirmed that as of December 1, 2012 petitioner had no back complaints. The records of Dr. See and Dr. Papaeliou support a finding that petitioner's occupation as a CNA, which required lifting, precipitated petitioner's back pain.

Respondent offered no evidence to refute petitioner's claim.

Based upon the foregoing, the Arbitrator finds petitioner sustained a back strain with bulging discs that required injections and physical therapy as a result of the repetitive work accident that manifested itself on December 12, 2012.

J. In support of the Arbitrator's decision with regard to the medical bills incurred, the Arbitrator finds the following:

The evidence supports petitioner's claim for medical bills from Meridian Medical totaling $16,561.00 and from Complete Chiropractic and Wellness Center for $352.00 and awards payment of same pursuant to §8 and §8.2 of the Act.

K. In support of the Arbitrator's decision with regard to TTD, the Arbitrator finds the following:

The medical records support petitioner's claim for temporary total disability from December 20, 2012 through February 6, 2013, which is seven weeks at $253.00 per week.

L. In support of the Arbitrator's decision with regard to the nature and extent of petitioner's injury, the Arbitrator finds the following:

Petitioner sustained a back strain/two-level disc bulging, necessitating injections, physical therapy and seven weeks of lost time.

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

With regard to subsection (i) of §8.1b (b) the Arbitrator notes that there was no permanent partial disability impairment rating provided. The Arbitrator, therefore, cannot give any weight to this factor.

With regard to (ii) of §8.1b (b) the occupation of the injured employee, the Arbitrator notes petitioner was employed as a CNA. As such, she was required to do constant lifting and bending to assist respondent's residents in activities of daily living. Therefore, the Arbitrator gives some weight to this factor.

With regard to (iii) of §8.1b (b) the age of the employee at the time of the injury was 32 years of age. Therefore, the Arbitrator gives more weight to this factor.

With regard to (iv) of §8.1b (b) the employee's future earning capacity, the Arbitrator notes petitioner is now employed in a sedentary clerical position. Dr. See had recommended petitioner seek other employment. There was no evidence petitioner's earning capacity has been reduced given the low wages she was receiving as a CNA. The Arbitrator, therefore, gives little weight to this factor.

With regard to (v) of §8.1b (b) evidence of disability corroborated by the treating medical records, the Arbitrator notes the medical records indicate petitioner had only two bulging discs, which Dr. See did find to be significant. She received injections and physical therapy. There is no indication she needs any ongoing treatment. Therefore, the Arbitrator gives little weigh 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 2% loss of use of body as a whole pursuant to § 8 (d) 2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
KANKAKEE

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Chalina Craybeek,

Petitioner,

vs. NO: 13WC 12107

Prairie Materials,

17IWCC0810

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 19, 2017, is hereby affirmed and adopted.

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

17IWCC0810

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:
o121217
MJB/jrc
052

DEC 18 2017

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

CRAYBEEK, CHALINA
Employee/Petitioner

Case# **13WC012107**

PRAIRIE MATERIALS
Employer/Respondent

17IWCC0810

On 1/9/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.63% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0659 BRILL & FISHEL PC
FRANCINE R FISHEL
180 N LASALLE ST SUITE 3700
CHICAGO, IL 60601

1109 GAROFALO SCHREIBER HART ETAL
ANDREW L RANE
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF KANKAKEE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Chalina Craaybeek
Employee/Petitioner

v.

Prairie Materials
Employer/Respondent

Case # 13 WC 12107

Consolidated cases: _____

17IWCC0810

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Kankakee**, on **November 15, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ 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 Chain of Referral

FINDINGS

On the date of accident, **March 6, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $55,854.76; the average weekly wage was $1074.13.

On the date of accident, Petitioner was **34** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of **$39,866.84** 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 the reasonable, necessary and casually related medical expenses incurred in the care and treatment of her injuries pursuant to Sections 8 and 8.2 of the Act. PX 7.

Respondent shall pay Petitioner temporary total disability benefits of $716.09 week for 192 weeks, commencing 3/13/2013 through 11/15/2016, as provided in Section 8(b) of the Act.

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

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

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

Carolyn M. Oheesy

Signature of Arbitrator

1/6/17
Date

ICArbDec19(b)

JAN 9 - 2017

FINDINGS OF FACT

The Arbitrator notes that accident and notice are not in dispute at trial. It is not disputed that on March 6, 2013, Petitioner sustained an accident at work when she slipped and fell on ice. Petitioner was employed as a quality control technician for Respondent in the Manteno yard and fell in Respondent's yard. Petitioner testified that she immediately noticed pain in her right shoulder but that she completed her shift that day. She testified that her yard supervisor Richard was not in the yard on the day of the accident, that she did not call his cell phone to report, and that she did not report the accident on the same day.

Petitioner worked for three days after the accident, a Thursday, Friday and Monday. Petitioner testified that she worked in a different yard on Monday. Petitioner returned to the Manteno yard thereafter and completed an accident report on March 12, 2013. Petitioner testified that she met with HR and yard supervisor Richard and on March 12, 2013, Petitioner was suspended for failing to report the accident on the day it occurred. In an undated statement at RX 1, Petitioner reported her fall and that she landed on her right shoulder and arm. Two co-workers were present and one helped her get up. She stated, "I was not in any pain at the time so I went on about my day as usual. I started having pain in the shoulder then the next day and just thought it was sore from the fall and thought it would work itself out after a couple days. As of today it is not getting better and I feel I should see a doctor about it." RX 1. Petitioner further testified that she was told to attend another meeting on March 14, 2013 and on that day she was terminated for failure to report the accident on the same date it occurred. Petitioner testified that she continued to have health insurance for 3 months after she was terminated.

On 3/14/13, the same day as her termination, she saw a primary care doctor, Dr. Woitas. Petitioner testified that it took her a week to find Dr. Woitas as she did not have a primary care doctor prior to the accident. She testified that she verbally reported pain in her neck and right shoulder indicating that the pain came up from her shoulder to her neck. The records of the visit from 3/14/13 indicate that Petitioner fell on ice at work on 3/6/13 and hurt her right shoulder. The records document a report of ongoing pain and grinding sensation with certain movements. Exam revealed decreased right shoulder abduction against resistance. The diagnosis was "OTH/UNS injury shoulder/upper arm" and Petitioner was prescribed a shoulder MRI with a likely ortho referral pending the MRI results. PX 1. At trial, Petitioner agreed the records make no mention of neck pain complaints.

Petitioner returned to Dr. Woitas on March 18, 2013. The records indicate complaints of "c/o pain radiating to her neck from shoulder since Saturday" and "presents with a complaint of pain in neck and shoulder x 2 days. Denies injury or trauma. Is 4 weeks pregnant. ..." Exam revealed "decreased extension/flexion/rotation cervical." The diagnosis was sprain/strain of the neck. Petitioner was prescribed Flexeril and told to follow up if her symptoms worsened. PX 1. Petitioner agreed that her neck pain started two days prior to the visit and 10 days after the accident.

Petitioner's right shoulder MRI of 3/28/13 ordered by Dr. Woitas was normal. PX 1. On April 3, 2013, she again saw Dr. Woitas for a "follow up on her shoulder pain." It was noted that the MRI "came back normal but she still has pain." The visit records indicate that Petitioner was now reporting coldness and numbness in her right hand along with right shoulder pain. Petitioner testified that she also reported neck pain, night shoulder pain and pain radiating down her arm at this visit which are not reflected in the records. Petitioner asked for a referral specifically to Dr. Nikkel, whom she knew to be an orthopedic physician. Petitioner testified she was given the referral for right shoulder treatment as is indicated in RX 5. Petitioner further testified that Dr. Woitas did not order any testing for her neck.

On April 18, 2013, Petitioner presented herself at Dr. Mark Nikkel's office for an initial evaluation. Petitioner completed a questionnaire for Dr. Nikkel stating "Fell on ice was walking to my truck and slipped on ice. Caught myself with my right arm." (Pet Ex. 2, pg. 32)
Dr. Nikkel's note indicated that, "She has pain with the anterior aspect of her shoulder that radiates into her trapezius and paraspinals on the right cervical spine as well as scapular stabilizers." (Pet Ex. 2, pg. 30) The doctor noted in the IMPRESSION:

> *"1. Probably impingement right upper extremity with associated paraspinal spasm and scapular stabilizer inflammatory changes.*
> *2. Neuropathy right upper extremity, more likely than not, the fall resulting in contusion to the ulnar nerve. This should be self-limiting and should resolve over time. Further diagnostic testing including EMG may be necessary."*

Dr. Nikkel recommended Petitioner attend therapy while she remained off work and told her to be re-evaluated in 6 weeks. (Pet. Ex. 2, pg. 30)

On May 30, 2013, Petitioner returned to Dr. Nikkel's office with continued complaints of pain to her right upper extremity. She presented for "recheck exam right shoulder." Exam was positive for shoulder internal derangement. Dr. Nikkel determined there was some "ongoing neuropathy with internal derangement shoulder". Dr. Nikkel determined that Petitioner was "unable to perform the critical demands of her job" and recommended that she remain off work for the next 6 weeks. Additionally, Dr. Nikkel referred Petitioner to undergo an EMG if it was not contraindicated by her pregnancy. (Pet. Ex. 2, pg. 28)

On July 23, 2013, Petitioner underwent an EMG study to her right upper extremity (Pet Ex. 2, pg. 57-8). Dr. George Charuk, administrating physician, indicated that Petitioner had "evidence of acute axonal neuropathy" and that there "are positive waves and high frequency discharge in the cervical paraspinal in the lower cervical region over the C7 region". He noted that the findings were consistent with likely C7 radiculitis. Dr. Charuk provided his recommendations that Petitioner should continue with physical therapy, obtain an epidural steroid injection after her pregnancy and follow up with Dr. Nikkel. (Pet. Ex. 2, pg. 26)

On August 1, 2013, Petitioner saw Dr. Nikkel. Dr. Nikkel discussed Petitioner's treatment options and advised her that due to her pregnancy they cannot proceed with the epidural injections until after delivery. In the interim, Dr. Nikkel recommended physical therapy and Petitioner was kept off work. (Pet. Ex. 2, pg. 22,25)

On October 3, 2013, Petitioner returned to Dr. Nikkel's office with complaints of ongoing right should pain, as well as neuropathy. After further evaluation, Dr. Nikkel recommended that Petitioner discontinue physical therapy and obtain a possible new MRI after delivery. (Pet. Ex. 2, pg. 22)

On January 30, 2014, Petitioner saw Dr. Nikkel post-delivery. Petitioner continued to complain of C7 radiculitis along with right shoulder pain and lower back pain. She also complained of right lower extremity radiculopathy. Exam revealed continued positive speed, dynamic SLAP and O'Brien's testing. The Spurling maneuver reproduced neck pain as well as C7 radicular complaints. The diagnosis was ongoing C7 radiculitis, internal derangement right shoulder. Dr. Nikkel recommended an epidural steroid injection for the cervical spine noting, "we will see if that clears up her shoulder pain. If not I may recommend and injection." Noting that the last shoulder MRI was of poor quality, he recommended an updated MRI of the shoulder. He also recommended a lumbar spine MRI due to low back and lower extremity complaints. Dr. Nikkel also recommended that Petitioner remain off work. (Pet. Ex. 2, pg. 20)

On March 6, 2014, Petitioner was seen by Dr. George Charuk. Dr. Charuk noted that when he last saw her, the EMG showed evidence of a C7 radiculitis with positive waves noted in several muscles of her right upper extremity. Dr. Charuk recommended a repeat MRI of the cervical spine to rule out any possible nerve root impingement and to start physical therapy. Lastly, Dr. Charuk opined "I strongly believe that her symptoms do correlate with her present state of ill being, which is directly correlated to the injury that she sustained from her fall on ice on March 2013." (Pet. Ex. 2, pg. 18) He noted the objective evidence on exam as well as on the EMG.

On April 8, 2014, Petitioner returned to Dr. Charuk after obtaining the cervical MRI. The MRI findings were as follows:

> *"2. C4-C5 disk osteophyte complex, mild central narrowing.*
> *3. C5-C6 mild disk osteophyte complex with mild central canal narrowing and mild neural foraminal narrowing.*
> *4. C6-C7 moderate broad based disk bulge with no central or neural foraminal narrowing noted."*

Petitioner complained to Dr. Charuk that her neck pain is about 7/10 and right upper extremity pain is 8/10. She had instances of dropping objects and pain traveling into hands. Dr. Charuk recommended that Petitioner undergo a right C7-T1 interlaminar epidural injection for both pain management and diagnostic purposes. Dr. Charuk explained to Petitioner that if she "gets good relief of her right arm pain then we have a better conclusion that her right arm and shoulder pain is related to her neck and therefore is related to the fall and work related injury." (Pet. Ex. 2, pg. 16)

On June 25, 2014, Petitioner followed up with Dr. Charuk after receiving the C7-T1 interlaminar epidural injection on 6/11/14 which provided no relief. Petitioner continued to complain of the same pain in the neck going down her right arm. Dr. Charuk recommended a 2nd epidural injection at the right C7-T1 and a referred Petitioner to Dr. George Miz for an evaluation. (Pet. Ex. 2, pg. 13)

On July 15, 2014, Petitioner was examined by Dr. George Miz for her cervical radiating pain. Dr. Miz noted that Petitioner was a reasonable candidate for an anterior decompression and fusion at C6-C7 to resolve her cervical radiculopathy. (Pet. Ex. 2, pg. 12) He also advised her to follow up with Dr. Nikkel for her right shoulder. He noted further that in his opinion, the cervical radiculopathy results from aggravation of her pre-existing spondylosis.

One August 6, 2014, Petitioner followed up with Dr. Nikkel regarding her continues complaints of shoulder and neck pain. Dr. Nikkel's impression is that Petitioner has:

> *"1. Persistent cervical pain with radiculopathy C7 distribution, all findings correlated with subjective and objective findings.*
> *2. Internal derangement right shoulder."*

Dr. Nikkel also noted, "as specified by Dr. Charuk and Dr. Miz this radicular complaint of neck pain that they have evaluated her for are directly related to her fall." Dr. Nikkel again recommended that Petitioner obtain an MRI of her shoulder and continue to treat with Dr. Miz and Dr. Charuk for her cervical issues. (Pet. Ex. 2, pg. 11)

On November 14, 2014, Petitioner obtained a right upper extremity MRI with contrast at Ingalls Memorial Hospital. (Pet. Ex. 2, pg. 33) The MRI showed "very mild distal supraspinatus tendinosis and no evidence of a labral tear." No rotator cuff was seen.

On November 20, 2014, Petitioner followed up with Dr. Nikkel. Dr. Nikkel diagnosed Petitioner with" impingement syn right shoulder, C7 rad right" and administered a cortisone injection to Petitioner's right shoulder. Dr. Nikkel also recommended for Petitioner to followed with Dr. Miz. (Pet. Ex. 2, pg. 6-10)

December 4, 2014, Petitioner returned to Dr. Miz's office. Petitioner complained about her continuous pain. Dr. Miz recommended that Petitioner see Dr. Charuk for another epidural injection to continue to treat her cervical symptoms non-surgically. Dr. Miz indicated that if the injection is not successful, Petitioner "can be followed up for possible surgical intervention." He noted that he previously deemed Petitioner a candidate for an anterior decompression and fusion at C6-7 if she had ongoing symptoms that were unrelenting." (Pet. Ex. 2, pg. -5)

Petitioner testified that her attorney sent her to see Dr. Ghanayem in July 2015 for an exam. RX 9. On July 2, 2015, Petitioner presented at Dr. Alexander Ghanayem office for an examination. Upon review of Petitioner's medical records and examination, Dr. Ghanayem opined:

> *"Ms. Craaybeek aggravated her cervical spondylosis and disc disease from her slip and fall accident in March of 2013. I believe she has ongoing bilateral radicular type symptoms related to that. Her EMG was positive for C7 radiculitis. At this point, unless an additional injection and therapy can help her symptoms, she would require an anterior cervical discectomy and fusion ... I do believe there is a causal connection between her fall and her current condition"* (Pet Ex. 3, pg. 21-2) (Pet. Ex. 9)

Petitioner testified that she then chose to continue treatment with Dr. Ghanayem as her second choice of treating physician. However, Petitioner did not return to Dr. Ghanayem until January 11, 2016, and testified that the delay resulted from her lack of health insurance and the inability to pay out of pocket during that period of time. Petitioner testified that in January 2016, she obtained health insurance again so she returned to Dr. Ghanayem. Petitioner returned to Dr. Ghanayem's office complaining that her symptoms were unchanged since her last visit. Dr. Ghanayem recommended that Petitioner undergo an anterior cervical discectomy and fusion from C4-C5 through C6-C7. Surgery was set for February 2, 2016. (Pet. Ex. 3, pg. 30)

On February 2, 2016, Petitioner underwent an "anterior cervical discectomy and fusion at C4-5, C5-6 and C6-7, using interbody prosthetic devices at each of the three levels and anterior plate stabilization from C4-C7." (Pet. Ex. 3, pg. 58-61). On March 10, 2016, Petitioner followed up with Dr. Ghanayem post-surgical. Petitioner indicated that her neck and arms were feeling better. X-rays demonstrate that the fusion was healing nicely. Dr. Ghanayem recommended that Petitioner start physical therapy for her neck and remain off work. (Pet. Ex. 3, pg. 225-6)

On April 21, 2016, Petitioner followed up with Dorota Pietrowski RN, MSN, ONC. Petitioner stated that she was attending physical therapy, and felt that the frequency was causing her to have pain in right trapezius area. RN Pietrowski decreased Petitioner's physical therapy from 3x to 2x a week and to remain off work. (Pet. Ex. 3, pg. 232). Petitioner reported making progress in PT with her upper extremities.

On May 26, 2016, Petitioner returned to Dr. Ghanayem's office. Petitioner complained of weakness in her right arm and grip. She also noted some slight numbness and tingling. Dr. Ghanayem recommended another 4 weeks of physical therapy and 5 week follow up while the Petitioner remained off duty. Dr. Ghanayem further

noted that at the follow up another set of cervical x-rays may be ordered and work conditioning would be considered. (Pet. Ex. 3, pg. 239-40)

On June 30, 2016, Petitioner was seen by Dr. Ghanayem wherein she continued to have come subscapular pain on the right side with shoulder and elbow pain. She also indicated she had right hand weakness. Dr. Ghanayem recommended that the Petitioner continue with her physical therapy for another 4 weeks with an emphasis on home exercise and return to his office. (Pet. Ex. 3, pg. 247-8). Petitioner remained off work. X-rays on that date revealed a stable fusion.

On August 11, 2016, Petitioner returned to Dr. Ghanayem's office. Petitioner noted some shoulder pain during therapy exercises. Dr. Ghanayem opined that she may have a shoulder impingement. He referred her to Dr. Dane Salazar for further evaluation of the right shoulder. (Pet. Ex. 3, pg. 255). Dr. Ghanayem ordered another 4 weeks of PT for the neck. Petitioner remained off work.

On 8/17/16, Petitioner saw Dr. Salazar and complained of continued shoulder pain although she experienced improvement in her radicular symptoms following the cervical fusion surgery. PX 4. Dr. Salazar ordered a right shoulder MRI completed on 8/22/16 which revealed no rotator cuff tear, mild tendinosis of the supraspinatus and very mild tendinosis of the infraspinatus tendons with mild to moderate acromioclavicular joint osteoarthritis. PX 4. Dr. Salazar administered an injection to the right shoulder on September 12, 2016.

On September 15, 2016, Petitioner was evaluated by Dorota Pietrowski RN, MSN, ONC. Petitioner's neck issues had stabilized since the surgery and there were no complaints of numbness or tingling in her upper extremities. Petitioner was treating with Dr. Salazar for her right shoulder. She reported that since the injection for her shoulder her right arm symptoms have subsided and "she is quite happy" but continues with the weakness and with some of the pain that she has in her neck. Physical therapy was ordered for her neck and shoulder and it was noted that she was to see both Drs. Ghanayem and Salazar in follow up. (Pet. Ex. 4, pg. 2)

On October 27, 2016, Petitioner returned to Dr. Ghanayem's office for a re-examination of her cervical spine. Dr. Ghanayem opined that Petitioner had completed all physical therapy for her neck and transferred her care to Dr. Salazar for the right "biceps tendon issues." Dr. Ghanayem indicated that the Petitioner should remain off duty until she is released from Dr. Salazar's care. (Pet. Ex. 4, pg. 7). Specifically, he indicated that "once she gets the all clear from Dr. Salazar, she will undergo and FCE. In the interim, she will remain off work." PX 4.

At the time of trial, Petitioner testified that she continued with physical therapy for both her neck and shoulder. She testified to having continued pain and that she continued anti-inflammatory medication. She testified that she is to follow up with Dr. Ghanayem after she completes her treatment with Dr. Salazar.

Petitioner testified that she has not been released to return to work at any point since her accident by her treating physicians. Her medical bills are currently paid under an individual policy from Blue Cross paid for by Petitioner. Petitioner testified that she received TTD from Respondent for approximately one year before the payments were stopped. Prior to the accident, Petitioner had no problems with or treatment to her neck or right shoulder.

Petitioner underwent two Section 12 examinations at Respondent's request with Dr. Goldberg. On June 3, 2013, Dr. Goldberg recorded a history of the accident where she "slipped on ice and snow...and tried to catch herself with her right arm..." The doctor's reports document that he reviewed the following medical records:

03/04/2013 office note by Dr. Megan Woitas, D.O.
03/27/2013 MRI "felt to be a normal right shoulder MRI"
04/03/2013 referral from the First Care Family Clinic to Dr. Nikkel and a note regarding an ultrasound of the right arm "which was felt to be unremarkable."
04/18/2013 office note by Dr. Mark Nikkel, D.O.

Dr. Goldberg stated that she had a diagnosis of right shoulder subjective pain and neck pain radiating to her shoulder blade and upper arm. In his answers to specific questions he noted that she had "neck pain radiating into her shoulder blade which should be evaluated with an MRI..." and stated that she did not initially complain of neck or radiating pain or hand numbness after this injury "so it is likely not related to this injury." (Resp. Ex. 3, pg. 4) Dr. Goldberg recommended a shoulder injection and to evaluate a cervical MRI. Although recommending a cervical MRI, he noted "I do not believe that cervical pathology or arm numbness is related to this injury based upon her complaints in the initial documentation." RX 3. He did not release her to return to work and she was not at maximum medical improvement for her shoulder injury.

On February 14, 2014, Petitioner returned to Dr. Goldberg. The report noted her present complaints of right shoulder and neck pain. (Resp. Ex. 4, pg. 1) Dr. Goldberg reviewed additional medical records from the doctors at Bone & Joint Physicians. (Resp. Ex. 4, pg. 2-4) In response to specific questions, Dr. Goldberg noted, "neck pain radiating into her shoulder blade, which should be evaluated with an MRI. Her EMG was reportedly abnormal. However, she did not initially complain of neck or radiating pain or hand numbness after this injury, so it is likely not related to this initial incident." (Resp. Ex. 4, pg. 5) Dr. Goldberg did not believe that she was at maximum medical improvement at that time and recommended shoulder injection. The doctor reiterated his opinion that the cervical pathology or arm numbness was not related to the injury despite Petitioner's complaints and an abnormal EMG "based upon her complaints in the initial documentation" and "when she began having symptoms" in her neck. (Resp. Ex. 4, pg. 5,6)

Dr. Ghanayem testified via evidence deposition. PX 6. Dr. Ghanayem concluded that there was a causal connection between her fall of March, 2013 and her shoulder and cervical injury. Dr. Ghanayem explained that her cervical spondylosis as aggravated by the accident and her herniated disc could have been new as a result of the accident or aggravated by the accident. (Pet. Ex. 6, pg. 12) Most importantly, he stated that her clinical symptomology was related to the accident. Dr. Ghanayem performed a three-level fusion on February 2, 2016. (Pet. Ex. 3, pg. 58-61) He testified that during the surgery he observed that the posterior ligament at C6-7 was causing compression because the disc was herniated and then calcified and the ligament thickened causing neurologic compression. (Pet. Ex. 6, pg.17) At C5-6 the disc had not calcified and he concluded that it was a new disc herniation relative to the accident. (Pet. Ex. 6, pg.18)

He was asked to opine on the fact that Petitioner did not initially complain of neck pain and then 10 days after the accident she began making cervical complaints. Dr. Ghanayem testified that the "two parts of the body are so intimately related because the nerves are so close to one another, that all the muscles that move the shoulder, the prime movers and secondary stabilizers, they all take origin from the cervical spine in terms of physical location." (Pet. Ex. 6, pg. 22) Dr. Ghanayem further explained why a patient could come in and say they have a shoulder injury but would ultimately be diagnosed with a neck injury instead. (Pet. Ex. 6, pg. 22) He stated that not only do patients not have the ability to make the diagnosis, but "90 plus percent of physicians have no idea either, because they're not properly trained to delineate between the two." (Pet. Ex. 6, pg. 23) Dr. Ghanayem explained, "So the nature of the confusion is normal, it's pervasive, and it's what we deal with all the time as highly trained specialists within the field." (Pet. Ex. 6, pg. 23)

On cross examination, Dr. Ghanayem confirmed that Petitioner's symptoms were consistent with the MRI findings and that the fall caused pre-existing disc conditions to become symptomatic. (Pet. Ex. 6, pg. 32-33) Dr. Ghanayem was then asked about the time frame when one can expect the symptoms to be present after an injury. Dr. Ghanayem stated, "The symptoms can evolve over a few weeks, but if it's left untreated for a long period of time, they can get worse." (Pet. Ex. 6, pg. 34).

Dr. Ghanayem further clarified the issue of the timing of her report of neck pain wherein he testified as follows:

"Q: So according to what Mr. Rane showed you and what I just showed you (record of 3/18/13 Dr. Woitas), Ms. Craaybeek came back to her doctor four days later and complained of neck pain?
A: Yes
Q: Okay. And that's consistent with your diagnosis that the fall caused neck pain?
A: It's consistent with—
Q: The timing?
A: —the confusion from the mimicking that can occur with neck/shoulder and how the symptoms can evolve.
Q: And that was within four days of the first visit?....
A: It's four days. It's consistent. There's no issue there. If that's the defense, it's no defense."
(Pet. Ex. 6, pg. 46-47)

CONCLUSIONS OF LAW

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

In support of the Arbitrator's decision relating to (F), is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator concludes as follows:

Based on a preponderance of the credible evidence and the record in its entirety, the Arbitrator finds that Petitioner's current conditions of ill-being in her neck and right shoulder are casually connected to the undisputed slip and fall at work on March 6, 2013. The Arbitrator finds Petitioner credible wherein she testified that when she slipped and fell on ice at work she injured her shoulder and her neck. Initial accident documentation indicates right shoulder pain as do the initial treating records of Dr. Woitas on March 14, 2013, 8 days after the fall. The notes from the second visit to Dr. Woitas on March 18, 2013, specifically and clearly indicate that she had pain in her neck radiating from the shoulder at that visit which started two days before the visit or March 16, 2013, 10 days after the fall. Petitioner agreed with the records at trial.

Petitioner's treatment thereafter focused on both her right shoulder and cervical complaints. The Arbitrator notes that Petitioner's treatment for both injuries was consistent and that any gaps in treatment were related solely to Petitioner's pregnancy discovered shortly after the accident date. After delivery, Petitioner immediately resumed active treatment for both her shoulder and neck injuries. The Arbitrator notes that Respondent's dispute is mainly focused on causal connection for Petitioner's cervical condition and treatment based on the lack of immediate complaint to her neck documented in the initial medical records as noted by Dr. Goldberg. Although the 10 day delay in cervical complaint is not lost on the Arbitrator, the Arbitrator places greater weight on the opinion of Dr. Ghanayem in finding causal connection for the cervical condition as well as the shoulder complaints. Specifically, the Arbitrator notes Dr. Ghanayem's testimony that shoulder and neck injuries can mimic each other leading to some confusion in initial treatment and diagnosis. As such, the Arbitrator finds that any delay or confusion in Petitioner's cervical treatment in light of her shoulder complaints is reasonable and does not provide a sufficient basis on which to deny a finding of causal connection for the cervical injury. Lastly, in finding causal connection for both the right shoulder and cervical injury, the

Arbitrator further notes the opinions of Drs. Charuk and Miz as detailed in their respective treatment records, assigning greater weight to those opinions than to the opinion of Dr. Goldberg. Accordingly, the Arbitrator finds that there is a causal connection between her accident of March 6, 2013 and Petitioner's current condition of ill-being in her right shoulder and neck.

In support of the Arbitrator's decision relating to (J) & (O), were the medical services that were provided to Petitioner reasonable and necessary and did the Petitioner stay with proper chain of referral, the Arbitrator concludes as follows:

Based on the Arbitrator's findings on the issue of causal connection, the Arbitrator further finds that the medical bills submitted were reasonable and necessary and related to Petitioner's injury of March 6, 2013. Petitioner submitted medical bills pursuant to the fee schedule. (Pet. Ex. 7).

The records reflect that primary care physician, Dr. Woitas, referred Petitioner for an orthopedic evaluation and referred Petitioner to Dr. Nikkel. (Resp. Ex. 5) Petitioner testified credibly that she knew Dr. Nikkel from her father. Respondent has taken issue with the chain of referral and argues that Dr. Nikkel is her second choice of doctor. Respondent then argues that Dr. Ghanayem would be her third choice of doctor and Respondent would not be responsible for Dr. Ghanayem's bills or any other bills stemming from referrals from Dr. Ghanayem. The Arbitrator finds that Dr. Nikkel was a referral from Dr. Woitas, regardless of Petitioner's specific physician request, remaining within the chain of Petitioner's initial provider choice. Dr. Ghanayem is Petitioner's second choice of provider. Accordingly, Respondent shall pay to Petitioner the reasonable and necessary and causally related medical expenses incurred in the care and treatment of her right shoulder and cervical conditions pursuant to Sections 8 and 8.2 of the Act. PX 7. Respondent shall receive credit for amounts paid, if any.

In support of the Arbitrator's decision relating to (L), what amount of compensation is due for temporary total disability the Arbitrator concludes as follows:

The Arbitrator finds that Petitioner has not been released to return to work by any doctor throughout the course of her treatment nor had her condition stabilized during that period. Based further on the Arbitrator's findings on the issue of causal connection for both the neck and shoulder injuries, the Arbitrator further finds that Petitioner was temporarily and totally disabled from work from March 13, 2013 through November 15, 2016, for a total of 192 weeks. Respondent shall pay Petitioner this period of temporary total disability and shall receive credit for amounts paid. ARB EX 1.

In support of the Arbitrator's decision relating to (M) whether penalties and fees are appropriate the Arbitrator concludes as follows:

Based on the record in its entirety, the Arbitrator finds that Respondent's conduct was neither so unreasonable nor vexatious so as to justify the imposition of penalties or fees under the Act. Petitioner's request is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Amelia Ramirez de Trejo,

Petitioner,

vs.

NO: 13 WC 35295

17IWCC0811

Labor Network,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 27, 2016, is hereby affirmed and adopted.

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

17IWCC0811

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $33,200.00. 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: DEC 18 2017
TJT:yl
o 10/24/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

RAMIREZ de TREJO, AMELIA
Employee/Petitioner

Case# **13WC035295**

LABOR NETWORK
Employer/Respondent

17IWCC0811

On 5/27/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.48% 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:

1427 BERG & BERG
STEPHEN M WAUCK
2100 W 35TH ST
CHICAGO, IL 60609

5001 GAIDO & FINTZEN
LUKE S BEHNKE
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

17IWCC0811

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Amelia Ramirez de Trejo
Employee/Petitioner

v.

Labor Network
Employer/Respondent

Case # **13** WC **35295**

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 **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **February 11, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **July 19, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$4,450.88**; the average weekly wage was **$278.18**.

On the date of accident, Petitioner was **67** 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 **$506.37** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$506.37**.

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $253.00/week for 133 weeks, commencing July 26, 2013, through February 11, 2016, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $506.37 for temporary total disability benefits that have been paid.

Medical benefits

The Petitioner has not exceeded the number of doctors permitted by the Act.

Respondent shall pay the reasonable and necessary medical services as included in Petitioner's exhibit 8, as provided in Section 8(a) of the Act and Section 8.2 of the Act.

Prospective Medical Care

Respondent shall authorize and pay for the left knee replacement and the associated aftercare, as recommended by Dr. Chhadia, as well as continuing right shoulder care, as recommended by Dr. Chhadia.

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.

Deborah L. Simpson

Signature of Arbitrator

May 27, 2016
Date

MAY 27 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Amelia Ramirez de Trejo,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 13 WC 35295**
	)	
Labor Network,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on July 19, 2013, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that in the year preceding the injuries, the Petitioner earned $4,450.88, and that her average weekly wage was $278.18.

At issue in this hearing is as follows: (1) Did an accident occur that arose out of and in the course of the Petitioner's employment with Respondent; (2) Was timely notice of the accident given to Respondent; (3) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (4) What was the Petitioner's marital status at the time of the injury; (5) Is the Respondent liable for the outstanding medical bills; (6) Is Petitioner entitled to TTD; (7) Is the Petitioner entitled to prospective medical care; and (8) has the Petitioner exceeded her choice of medical providers.

The Petitioner does not speak English, her native language is Spanish. She testified with the assistance of Noel Cortez, a certified interpreter, qualified to translate Spanish to English and English to Spanish. Mr. Cortez testified that he has been qualified and permitted to serve as an interpreter at the Commission since 2004, and that he works for an interpreting agency as well as being available for hire on his own. On February 11, 2016, he was working through the agency. He testified that approximately 70 percent of the time he is hired by the Petitioner, and 30 percent of the time it is the Respondent that hires him to interpret. After being duly qualified and accepted by both parties as an interpreter Mr. Cortez served as an interpreter for the Petitioner.

STATEMENT OF FACTS

Petitioner testified that she has worked as a laborer her entire life. In Mexico she worked in a marmalade production factory. In the United States she worked in whatever companies that she was sent to by the Respondent, going from one place to another. Petitioner began working for the Respondent in 2012, going from one place to another, as directed by the Respondent.

Petitioner testified that she used to work in Arlington Heights at the race track. When working there she cleaned the race depot. She would vacuum and clean the bathrooms, she would have to kneel on the floor to do some of the cleaning. She stated she cannot do that anymore.

Petitioner testified that she is married to Jose Trejo, they got married in 1960. When she was single her name was Amelia Ramirez, she testified that she took her husbands' name when she became a US resident. She is Amelia Ramirez de Trejo.

According to the Petitioner she never had a work accident before July 19, 2013. She had never injured her right shoulder, right knee, left knee, or lower back prior to that date. She testified that she was physically active, doing all of her own cleaning—which involved kneeling on the ground—as well as her own gardening. She also took long, brisk walks, ranging in time from 45 minutes to over an hour, without feeling any pain in either of her knees.

On July 19, 2013, Petitioner was sent by the Respondent to work at a warehouse where they were packing promotional materials for the Marlboro cigarette company. At about 11:45 am, Petitioner was working in a small space that had three wooden containers. She was grabbing materials that were inside one of the containers when her feet "got stuck" under the container that was slightly raised off of the ground. When she pulled her first foot out from under the container, her left knee "popped." She remained there because she could not move her other foot. When she tried pulling her other foot out, there was a point where she went forward, hitting her chest, then she went back, hitting her head on the container behind her. She hurt her neck and the upper part of her back at this time. After she hit the container behind her, Petitioner tried to get her other foot out. When she pulled her other foot out she fell to the ground and hit both knees on the ground. Petitioner testified that she grabbed the pallet/container and used it to stand up. At this time she called the person who runs the line, the boss of personnel and reported the accident.

According to the Petitioner, when she reported the accident to the supervisor, the supervisor asked if she wanted an ambulance, the Petitioner testified that she said "yes" but no ambulance ever came. A secretary and another co-worker came from the office and grabbed her arms and helped her walk to the cafeteria where she sat down. Petitioner later called Respondent and spoke with Leticia, and told her that she had had an accident. The person who assigns workers to the jobs came to Respondents facility for Petitioner. They did not take her to the hospital.

Later that day, Petitioner's son took her son to the emergency department at St. Alexius Medical Center. The records from St. Alexius state that Petitioner "presents to the ED with family because of her injuries. Pt. fell down at work from standing position and injured her RLE. She reported bruising and swelling and pain to bilat. knees, back, neck" (PX1, p. 3). The physical examination by the doctor revealed "Pt. has diffuse mild bilat neck discomfort, no spine tenderness. Diffuse L hip discomfort, bilat knee discomfort, no effusion or laxity. Moderate bruise and hematoma over R knee area of RLE. No open wound." (PX 1, p. 3) The records indicate that she had "Normal ROM in all four extremities; non-tender to palpation; distal pulses are normal ; no edema." (PX 1, p.3)

The doctors on staff in the Emergency Dept. ordered X-rays of the cervical spine, chest, lumbar spine, both knees, both legs, and the pelvis (PX1, pp. 3, 4). These X-rays showed that Petitioner did not fracture any bones in her fall (PX1, pp. 4-10). The left knee X-ray showed "no appreciable degenerative joint changes" (PX1, p. 7), and the right knee X-ray showed "mild osteoarthritic changes involving the medial femoral-tibial and patellofemoral compartments" (PX1, pp. 8-9). After the X-rays were taken, Petitioner was prescribed Norco and Naproysn and given a walker before being discharged (PX1, pp. 10).

After being seen in the emergency room the Petitioner sought treatment with Dr. Marsiglia. She saw him for the first time on July 25, 2013. (PX2, p. 106). At her initial appointment, Petitioner told Dr. Marsiglia that on July 19, 2013, she was lifting promotional materials off of a pallet, her feet were on the inside of the front of the pallet, as she was twisting to transfer the objects her feet remained on the inside of the front of the pallet, she lost her balance and fell forwards. She was able to pull her left leg out to brace herself and she felt a snap in her left knee, she adjusted herself and fell backwards onto an adjacent pallet. Her right leg and lumbar spine twisted and she felt pain in her neck, back and right knee down to her ankle as well. She is complaining of cervical pain with radiation to the right upper extremity, lumbar paraspinal pain with radiation to the right leg, as well as bilateral knee pain. (PX 2, p. 108)

Dr. Marsiglia then did a physical examination of the Petitioner. The examination of the cervical spine showed "tenderness on palpation (over right cervical paraspinals, right trapezius, right proximal arm over humerus and distally to her elbow" with a positive Spurling's sign "for reproduction of pain to her right shoulder" (PX2, p. 108). The examination of the lumbo-sacral spine showed "tenderness on palpation (right lumbar paraspinals), straight leg raise positive right (for right low back pain and right leg pain to the lateral calf)" (id.). Lastly, the physical examination of Petitioner's lower extremity was positive for "tenderness on palpation (over right leg from her hip to her ankle with tenderness over dorsal right foot. Tenderness over medial and lateral knee compartments bilaterally)" (id.). All of Petitioner's injuries were, in the opinion of Dr. Marsiglia, "consistent with the reported mechanism of injury" and "causally connected to the incident outlined above" (PX2, p. 109). The Petitioner was kept off of work by Dr. Marsiglia. (id.)

Dr. Marsiglia also ordered MRI's of all the relevant body parts. The MRI's were completed on August 5, 2013 (PX2, pp. 115-133). The MRI of the cervical spine showed joint degenerative changes and facet hypertrophy at several levels, with left neural foraminal narrowing at C4-C5 and C5-C6 (PX2, pp. 122, 123). The MRI of the lumbar spine revealed "advanced multilevel disc and facet degenerative changes," "moderate spinal stenosis at L3-L4," and "severe spinal stenosis at L4-L5" (PX2, p. 129). The MRI of the right knee showed several problems. First, there was an "extensive tear involving the medial meniscus" as well as "associated mild medial joint compartment osteoarthritic changes" (PX2, p. 119). This tear "likely extend[ed] into the anterior horn as well" (PX2, p. 118). There was also "advanced lateral patellar chondromalacia with subchondral marrow signal change" and a "suspected distal quadriceps tendinopathy with a possible partial tear" (PX2, p. 119). The MRI of the left knee showed "probable degenerative signal change in the anterior horn of the lateral meniscus" with "no definite evidence of a meniscal or ligamentous tear" (PX2, p. 121). There was also possible "mild prepatellar bursitis" (id.).

Dr. Marsiglia kept Petitioner off work and prescribed 4-6 weeks of physical therapy (id.). Petitioner started her physical therapy at Universal Health Care, P.C. on July 31, 2013, and continued there through October 7, 2013 (PX3, pp. 155-186).

Petitioner's follow-up appointment with Dr. Marsiglia came on August 19, 2013. Dr. Marsiglia reviewed the MRI's and diagnosed Petitioner with thoracic or lumbosacral neuritis or radiculitis, lumbosacral spondylosis without myelopathy, brachial neuritis or radiculitis, cervical spondylosis without myelopathy, lower leg pain, and derangement of the posterior horn of the medial meniscus of the right knee (PX2, p. 136). Dr. Marsiglia again kept Petitioner off work until further notice and recommended continued physical therapy (PX2, p. 137). He also recommended right L3-L4, L4-L5, and L5-S1 transforaminal epidural steroid injections, to be carried out at the "Laramie Clinic" (id.). These were done on August 22, 2013 (PX2, pp. 142-145). A referral was made by Dr. Marsiglia for evaluation by Dr. Ronald Silver given the significant right knee pain Petitioner continued to experience and having been found to have a meniscus tear at the posterior horn of the medial meniscus. (PX 2, p. 137)

Petitioner was re-evaluated by Dr. Marsiglia on September 5, 2013. Petitioner was experiencing "minimal relief" from the injections (PX2, p. 147), which led Dr. Marsiglia to conclude that she might be "suffering from facet mediated pain" and to recommend "a right L3-L4, L4-L5, and L5-S1 intra-articular facet joint injection." (PX2, p. 148). These injections were performed on September 19, 2013. (PX2, p. 150; PX4, pp. 191, 192).

Petitioner saw Dr. Marsiglia for the last time on October 3, 2013. Petitioner stated that the injections again gave her "minimal relief," but that a back brace was providing her with some relief. (PX2, p. 153). He continued further physical therapy and medications. (PX2, p. 154).

Petitioner saw Dr. Silver on September 24, 2013. The doctor noted that Petitioner reported getting her left foot stuck under a pallet and feeling a "cracking sensation" in her left knee when she twisted it (PX5, p. 193). The doctor also reported that Petitioner hurt her spine, and mentioned that "she also injured her right shoulder at the time of the accident" (id.). Dr. Silver did a physical examination of Petitioner and noted problems in both knees, which included crepitation, medial joint line tenderness, mild effusions and limited range of motion beyond 90° of flexion (id.). He reviewed the MRI, which demonstrated "a large tear of her medial meniscus of her left knee as well as damage to the articular cartilage in both the left and right knees" (id.). His impression was "that of a torn medial meniscus of the left knee with damaged articular cartilage on the patellofemoral articulation and in the right knee damage to the articular cartilage in the patellofemoral articulation due to her fall on the anterior aspect of the right knee" (id.). Dr. Silver recommended arthroscopic surgery on both knees, but first on the left knee "as that is more symptomatic causing her to ambulate with the use of the cane" (PX5, p. 194). Dr. Silver gave Petitioner a knee brace, as well as Norco and Meloxicam (id.). He placed her off work (id.). Finally, Dr. Silver examined Petitioner's right shoulder and recorded "positive impingement and Hawkins tests with anterior tenderness; he opined that, this represents some degree of inflammation of her rotator cuff" (id.).

Petitioner testified that she only saw Dr. Silver one time, because his office was "too far away" and she did not have transportation. Petitioner decided to consult with another orthopedic surgeon, Dr. Chhadia of Suburban Orthopedics, she testified that he was her husband's doctor.

Dr. Chhadia is a board certified orthopedic surgeon and has been in private practice since the fall of 2009 (PX6, p. 204). At his evidence deposition on December 14, 2015, Dr. Chhadia stated that he first saw Petitioner on October 28, 2013 (PX6, p. 207). Petitioner told Dr. Chhadia that she was at work on July 19, 2013, when she fell while retrieving paper from inside a box (id.). Petitioner was stuck between the "pulleys" [sic] and when she tried to extract herself, "her knees popped with all the movement" (id.). After the ambulance failed to come to the work site, she went to St. Alexius Medical Center (id.). At her initial consultation, Petitioner's right shoulder was tender to palpation and had a limited range of motion (PX6, p. 208). Dr. Chhadia ordered an MRI of her right shoulder, which was taken on December 24, 2013, and showed a "large, full thickness tear of the supraspinatus tendon" (PX6, p. 209). Dr. Chhadia then performed an arthroscopic rotator cuff repair on August 7, 2014 (id.). After surgery, Petitioner went through physical therapy at St. Alexius Medical Center (PX1, pp. 45-105). Since the surgery, Petitioner has only done "fair, not good and not excellent," because she was only able to have "intermittent physical therapy" due to insurance issues (id.). After the surgery, she continued to have some pain and weakness (PX6, p. 211). In the future, in Dr. Chhadia's opinion, Petitioner might benefit from additional therapy, and an injection (id.).

Dr. Chhadia testified that Petitioner's rotator cuff tear was a traumatic injury, and not the result of degeneration (PX6, p. 210). Petitioner had "a traumatic mechanism of injury that was consistent and forceful enough to cause tearing of her rotator cuff" (id.). She also "had a full thickness tear" with "no prior shoulder symptoms of pain, weakness, or prior injuries or treatment and no prodromal symptoms of rotator cuff problems" (id.). Finally, Dr. Chhadia found that his surgical findings were "consistent with a clean, full thickness tear." Dr. Chhadia concluded that Petitioner's work accident of July 19, 2013, was the cause of her right shoulder problem (PX6, p. 211). Dr. Chhadia acknowledged that it was "possible that [Petitioner] could have had some degenerative changes in her shoulder…but it's my opinion that the trauma caused her to have the symptoms to require treatment for the shoulder" (PX6, p. 231). Dr. Chhadia acknowledged that typically you would expect to see some sort of complaint of pain when you have a large full thickness right rotator cuff tear, and that Petitioner did not report anything related to her right shoulder in the emergency room at St. Alexius medical Center. (PX6, p. 231) Dr. Chhadia did not deny that the injury to the shoulder could have been degenerative in nature, he reiterated that it was his opinion that the traumatic injury Petitioner suffered had a causal contribution and connection to the injury. The trauma caused her to have the symptoms and the symptoms required treatment for the shoulder. (id.)

Dr. Chhadia then addressed the injuries to Petitioner's knees. On physical examination, Petitioner had "tenderness of both knees" and the X-rays "revealed moderate joint space narrowing and moderate degenerative knee arthritis" (PX6, p. 212). The results of diagnostic injections also were consistent with the finding of "pain being generated from her knees" (id.). Dr. Chhadia's diagnosis of Petitioner's injury is "bilateral knee arthritis" (PX6, p. 214). For this condition, he ordered "physical therapy, knee braces, medications, work restrictions, and injections" (id.). However, he would also recommend further treatment, specifically a "left knee

replacement" (id.). A left knee replacement would require admission to a hospital for about three days, as well as possibly discharge to a rehab center "for a week or two"; after that Petitioner would require home nursing and extensive physical therapy before reaching MMI "at six months to one year" after the surgery (PX6, pp. 215, 216). During this time Petitioner would also "need medications for pain control and inflammation," as well as blood thinners (PX6, p. 216). Petitioner "will likely pursue the right knee replacement once the left knee has healed adequately" (PX6, p. 217). A right knee replacement would involve similar treatment and a similar timeline as for the left knee (id.).

According to Dr. Chhadia, Petitioner's work accident is the cause of her knee problems. His opinion is that Petitioner "has symptomatic bilateral knee arthritis that is persisting for a prolonged period despite prolonged nonoperative treatments and that the symptomatic knee arthritis was caused from the July 19, 2013, accident." Petitioner most likely had some preexisting structural arthritic change in her knee prior to this injury, "however, this was not symptomatic to the point where she needed treatment or sought out a doctor or complained of treatment to my knowledge" (PX6, p. 215). Dr. Chhadia also testified that the "popping" sound that Petitioner described in her accident report was consistent with an injury to her knee, because that sound "typically means there's some sort of traumatic force that's been applied, and typically it's associated with a suspicion for something tearing or getting stressed or strained or sprained" (PX6, p. 234).

Dr. Chhadia also referred Petitioner to Dr. Dmitry Novoseletsky, also of Suburban Orthopaedics, for treatment of her lumbar and cervical spine complaints. On November 18, 2013, Petitioner saw Dr. Novoseletsky for the first time (PX6, p. 296). Dr. Novoseletsky recommended cervical epidural steroid injections and recommended that she remain off work (PX6, pp. 298, 300). Dr. Novoseletsky's impression was of "mild degenerative disease throughout the cervical spine" with "several levels of neuroforaminal narrowing" (PX6, p. 272).

Respondent sent Petitioner to a Section 12 examination with Dr. Jay Levin of Adult & Pediatric Orthopedics, S.C., which was conducted on December 19, 2013. Dr. Levin later conducted a review of additional medical records on October 20, 2014. Both his reports were introduced into evidence, as RX3 and RX4 respectively.

Petitioner told Dr. Levin that she was injured at work on July 19, 2013 (RX3, p. 1), when her feet got stuck in a pallet and she bumped against another pallet before falling to the ground (RX3, p. 2). She reported her fall to a coworker and asked for an ambulance, which never came (id.). Petitioner also reported her accident to a female employee at Respondent's office (id.). After being told she could not see a company doctor until a few days later, Petitioner went to the emergency department at St. Alexius Medical Center (id.).

According to Dr. Levin, Petitioner did not sustain any injury to her knees as result of the accident and any findings on the MRI were due to degenerative changes (RX3, p. 8). He also concluded that Petitioner sustained no injury to either her neck or her right shoulder (id.). Her only injury was a lumbar contusion (id.). Dr. Levin was of the opinion that there was a general "lack of correlation based upon the mechanism of this examinee's injury and the medical records regarding any injury to her neck, right shoulder, or left knee" (id.). He opined further that

Petitioner's physicians should not have even administered any medical care to these body parts (RX3, pp. 8, 9). He cleared Petitioner for "work in a full duty capacity without restrictions referable to any injury sustained in the occurrence of July 19, 2013" (RX3, p. 9).

In his record review of October 20, 2014, Dr. Levin agreed with Dr. Chhadia that the MRI of Petitioner's right shoulder showed a full thickness rotator cuff tear, but he diagnosed it as a "chronic tear with a proximal retraction of the supraspinatus and infraspinatus muscle" that was degenerative in nature (RX4, p. 2). Dr. Levin again denied that Petitioner sustained any injury to her right shoulder in the "event of July 19, 2013" (id.).

CONCLUSIONS OF LAW

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

An injury is accidental within the meaning of the Worker's Compensation Act when it is traceable to a definite time, place and cause and occurs in the course of the employment unexpectedly and without affirmative act or design of the employee. *Matthiessen & Hegeler Zinc Co. v Industrial Board,* 284 Ill. 378, 120 N.E. 2d 249, 251 (1918)

Longstanding Illinois law mandates a claimant must show that the injury is due to a cause connected to the employment to establish it arose out of employment. *Elliot v. Industrial Commission*, 153 Ill. App. 3d 238, 242 (1987).

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

The burden of proving disablement and the right to temporary total disability benefits lies with the Petitioner who must show this entitlement by a preponderance of the evidence. *J.M. Jones Co. v. Industrial Commission,*71 Ill.2d 368, 375 N.E.2d 1306 (1978)

Employment need only remain a cause, not the sole cause or even the principal cause, of a claimant's condition. *Rotberg v. Industrial Comm'n,* 361 Ill.App.3d 673, 682, 297 Ill.Dec. 568, 838 N.E.2d 55 (2005).

Proof of an employee's state of good health prior to the time of injury, and the change immediately following the injury, is competent as tending to establish that the impaired condition was due to the injury. *Westinghouse Electric Co. v. Industrial Commission*, 64 Ill. 2d 244,356 N.E. 2d 28 (1976).

While it is true than an employee's uncorroborated testimony will not bar a recovery under the Act, it does not mean that the employee's testimony will always support an award of

benefits when considering all the testimony and circumstances shown by the totality of the evidence. *Caterpillar Tractor Co. v. Industrial Commission,* 83 Ill. 2d. 213, 46 Ill. Dec. 687, 414 N.E. 2d 740 (1980).

In support of the Arbitrator's decision with regard to whether Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

An injury is accidental within the meaning of the Worker's Compensation Act when it is traceable to a definite time, place and cause and occurs in the course of the employment unexpectedly and without affirmative act or design of the employee. *Matthiessen & Hegeler Zinc Co. v Industrial Board,* 284 Ill. 378, 120 N.E. 2d 249, 251 (1918) Proof of an employee's state of good health prior to the time of injury, and the change immediately following the injury, is competent as tending to establish that the impaired condition was due to the injury. *Westinghouse Electric Co. v. Industrial Commission*, 64 Ill. 2d 244,356 N.E. 2d 28 (1976).

Petitioner testified that she has worked her entire life as a laborer. Up until July 19, 2013, she had not sustained any injuries to her neck, shoulders, lower back, or knees. She had not sought any medical treatment for any injuries to these body parts and had not lost any time from work due to pain or injury to the recited body parts. Petitioner was working full duty with no restrictions at the time of her accident on July 19, 2013. No testimony or evidence was introduced to contradict the Petitioner's testimony regarding her physical condition prior to the work injury she described as occurring on July 19, 2013.

Petitioner described a specific accident that occurred on July 19, 2013 while she was working for Respondent. Petitioner stated that her foot got stuck and that her knee "popped" while she was trying to get her foot out. Petitioner stated that she did not fall to the ground right away, but instead swayed and bumped up against another container in front of her before completely losing her balance and falling to the ground landing on her knees. Petitioner requested medical treatment and when she did not receive said treatment through Respondent she sought medical treatment on her own through the emergency department of St. Alexius Medical Center. It appears from the medical reports submitted by the parties that the Petitioner described her injuries and the mechanism of injury consistently throughout her treatment, the Section 12 medical examination and the hearing.

Based upon all the evidence introduced at trial the Petitioner has proven by a preponderance of the evidence that she sustained accidental injuries that arose out of and in the course of her employment with Respondent on July 19, 2013.

In support of the Arbitrator's decision with regard to whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

To be compensable under the Act, the work accident "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, Inc. v. Indus. Comm'n.*, 207 Ill.2d 193, 205 (2003). It is long-settled law in Illinois that the "aggravation or acceleration of a pre-existing disease is an injury which is compensable under the statute." *Quaker Oats Co. v. Indus. Comm'n.*, 414 Ill. 326, 330 (1953). Employers take their employees as they find them. *O'Fallen School Dist. No. 90 v. Indus. Comm'n.*, 313 Ill.App.3d 413, 417 (5th Dist. 2000).

The treating physicians agree that the mechanism of injury described by the Petitioner is consistent with the injuries she sustained and that the injuries are causally connected to the accident described by the Petitioner. They acknowledge that some of the Petitioner's current condition of ill being were more than likely present before the accidental injuries were sustained on July 19, 2013, however Petitioner had no prior treatment or complaints regarding her neck, shoulders, knees or lower back before that date. Petitioner had not lost any time off of work because of pain or injury to those specific body parts before the accident of July 19, 2013 either.

The Petitioner has proven by a preponderance of the evidence that her current condition of ill-being is causally related to the injury she sustained on July 19, 2013, in the work accident.

In support of the Arbitrator's decision with regard to whether Petitioner gave timely notice of the accident to Respondent, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

Petitioner testified that she first reported the accident to the supervisor of the line, "the boss of the personnel," at the warehouse where she was working on July 19, 2013, and asked for an ambulance to be called. Petitioner testified that personel from the office came and helped her to another part of the facility where she waited for someone to come for her from the Respondents office where job assignments are made. Petitioner spoke with Leticia in Respondent's office, who confirmed to her that Respondent had been notified of her accident. They came to the facility where she was working and gave her a ride back to the Respondent's office. Respondent presented no witnesses to refute this testimony.

The Arbitrator therefore finds that the Petitioner has proven by a preponderance of the evidence that she gave timely notice of the accident to Respondent.

In support of the Arbitrator's decision with regard to whether Petitioner is entitled to TTD, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

Section 8(b) of the Act provides that the employer shall pay weekly compensation to an injured worker during the period of temporary total disability; if "the temporary total incapacity for work continues for a period of 14 days or more from the day of the accident compensation shall commence on the day after the accident." *820 ILCS 305/8(b).* "The employer's obligation to pay TTD workers' compensation benefits continues until the employee's medical condition has stabilized and he has reached maximum medical improvement." *Interstate Scaffolding, Inc. v. Workers' Compensation Comm'n.,* 236 Ill.2d 132, 135 (2010).

Petitioner's treating physicians have all restricted her from performing any work during the periods in which she was under their care. The Petitioner provided off work slips from the treating physicians on the following dates:

July 26, 2013 (PX2, p. 108); August 19, 2013 (PX2, p. 136); September 24, 2013 (PX5, p.194); October 28, 2013 (PX6, p. 304); November 8, 2013 (PX6, p. 300); November 27, 2013 (PX6, p. 295); February 5, 2014 (PX6, p. 315); July 16, 2014 (PX6, p. 310); August 11, 2014 (PX6, p. 306); September 15, 2014 (PX6, p. 305); October 15, 2014 (PX6, p. 283); November 19, 2014 (PX6, p. 282); January 28, 2015 (PX6, p. 277); March 3, 2015 (PX6, p. 273); March 9, 2015 (PX6, p. 268); June 24, 2015 (PX6, p. 256) and; October 14, 2015 (PX6, p. 252)

Dr. Levin, the Section 12 examiner found that Petitioner suffered only a sprain to her lower back and as such she was at MMI with respect to that specific injury and could return to work. He did however agree that she had a torn rotator cuff and needed surgical repair for the injury, however as it was his opinion that this was not related to the accident, nor were the conditions of her knees related to the accident he did not give an opinion regarding her ability to work with respect to those medical conditions.

The Arbitrator concludes, therefore, that Petitioner has been restricted from work by her treating physicians from July 26, 2013, through the date of hearing (February 11, 2016), and is therefore entitled to a total of 133 weeks of TTD benefits.

In support of the Arbitrator's decision with regard to the Petitioner's marital status, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

Petitioner testified that she was married to Jose Trejo, in Mexico, in 1960. She testified that when she was single and while she was married in Mexico, she was referred to as simply "Amelia Ramirez," but when they moved to the United States she became Amelia Ramirez de Trejo. Petitioner stated that she was not wearing a wedding ring because at the time in Mexico "there was no rings." Nothing in the records offered as evidence contradicts Petitioner's testimony.

The Arbitrator finds that Petitioner was married on the date of the accident with no dependent children under the age of 18, based upon the unrebutted testimony of Petitioner.

In support of the Arbitrator's decision with regard to whether the medical services provided to the Petitioner were related to the work accident, reasonable and necessary and whether the Respondent has paid for all reasonable and necessary treatment provided to the Petitioner, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

First, Respondent has alleged that Petitioner exceeded the number of doctors allowed under Section 8(a). Section 8(a) of the Act directs employers to pay for employees' reasonable and necessary medical treatment, including (1) first aid emergency treatment; (2) medical, surgical and hospital services provide by a physician of the employee's choice, and by any physicians within the chain of referrals from this physician; and (3) medical, surgical and hospital services provided by a physician of the employee's second choice, and by any physicians within the chain of referrals from this physician. Whether an employee's physician falls within one of the two chains of referrals allowed for under Section 8(a) is a question of fact for the Commission. *Absolute Cleaning/SVMBL v. Workers' Compensation Comm'n.*, 409 Ill.App.3d 463, 468 (4th Dist. 2011).

In the present case, it is clear that Petitioner's emergency treatment at St. Alexius Medical Center on the day of the accident is not affected by the "two chains" rule and should have been paid for by Respondent. One week after the accident, Petitioner presented to her first choice of physician, Dr. Marsiglia of Innovative Pain Specialists. Dr. Marsiglia then referred her out for physical therapy and later to an orthopedic surgeon, Dr. Ronald Silver. While Petitioner's testimony about how she came to be seen by Dr. Silver was not entirely clear, the records from Dr. Marsiglia are clear. Dr. Marsiglia unequivocally wrote on August 19, 2013, that he was referring Petitioner to see "Dr. Ronald Silver for evaluation" for her ongoing knee pain (PX2, p. 137). Dr. Marsiglia's subsequent reports also refer to Dr. Silver's treatment recommendations, indicating that he and Dr. Silver were in communication regarding their mutual patient and that a referral relationship existed between them. The Arbitrator therefore finds that Dr. Marsiglia referred Petitioner to Dr. Silver. Petitioner, as she admitted on direct examination and on cross-examination, later chose to see Dr. Chhadia of Suburban Orthopedics, based on the recommendation of her husband, who also treated with him. Dr. Chhadia was Petitioner's second choice of physician. The Arbitrator concludes that Petitioner has not exceeded the number of doctors allowed under Section 8(a) of the Act.

As to the substance of the bills, the Arbitrator finds that Petitioner's medical treatment thus far has been reasonable and necessary, and should be paid for by Respondent.

Petitioner's right shoulder treatment has been medically reasonable and necessary. There is no dispute that Petitioner had a full thickness rotator cuff tear and that surgery for this condition was appropriate. Respondent's UR specifically certified the rotator cuff repair and subacromial decompression as medical necessary (RX5, p. 11).

Second, the Arbitrator finds that Petitioner's bilateral knee treatment has been medically reasonable and necessary. Conservative treatment has failed to alleviate the Petitioner's symptoms and pain. Respondent's UR agreed with Petitioner's treating physicians that surgery is required for both knees (RX5, p. 11).

Petitioner's treatment for her lumbar and cervical spine has been medically reasonable and necessary. Dr. Marsiglia prescribed physical therapy for several months before proceeding to interventional pain management for Petitioner's lumbar spine. Petitioner underwent months of physical therapy before resorting to interventional pain management for her cervical spine with Dr. Novosoletsky.

The Arbitrator therefore concludes that the medical services provided to Petitioner were reasonable and necessary; The Respondent is liable for the cost of the medical services that have been provided to date; and that the Respondent has not paid any of the appropriate charges. The outstanding medical bills were introduced into evidence as PX8. Respondent shall pay Petitioner the bills as set forth in PX8 pursuant to the fee schedule in Section 8(a) and Section 8.2 of the Act.

In support of the Arbitrator's decision with regard to whether Petitioner's is entitled to prospective medical treatment the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Petitioner has not reached MMI for the injuries that she sustained to her bilateral knees and her right shoulder, as result of the accident on July 19, 2013. Petitioner has gone through extensive conservative treatment for her left knee injury, including physical therapy and injections. Petitioner testified that currently she has difficulty performing certain basic activities of daily living. She testified at trial that she is no longer able to kneel down, and often needs to walk with a cane. She only walks 20 or 30 minutes at the most, and that is only so that she can reach the bus station on her way to the doctor's office. She no longer works in her garden either

Petitioner's left knee condition has been confirmed by all the diagnostic testing. The Respondent's doctors do not all dispute Dr. Chhadia's diagnosis, they deny liability for the injuries and the required medical treatment. Respondent's UR acknowledges that there are "degenerative knee changes with associated pain" in Petitioner's left knee MRI. The Arbitrator concludes that the surgery recommended by Dr. Chhadia is reasonable and necessary to cure Petitioner of the effects of her injury and that the Respondent is responsible for the costs of the treatment. Petitioner has testified that although she would prefer not to have surgery, she realizes that it is her only option and will have the surgery if it is approved.

According to Dr. Chhadia, Petitioner's recovery after the arthroscopic surgery has been hindered by an "insurance denial" of the physical therapy that Petitioner needs to completely recover from the injury to her shoulder. It is possible, according to Dr. Chhadia that Petitioner my also require an injection to her shoulder as well. The injury to the Petitioner's right shoulder

has been determined to be causally connected to the accident of July 19, 2013. Respondent shall authorize and pay for the additional treatment recommended by Dr. Chhadia for the Petitiner's shoulder and her left knee.

ORDER OF THE ARBITRATOR

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $253.00/week for 133 weeks, commencing July 26, 2013, through February 11, 2016, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $506.37 for temporary total disability benefits that have been paid.

Medical benefits

The Petitioner has not exceeded the number of doctors permitted by the Act.

Respondent shall pay the reasonable and necessary medical services as included in Petitioner's exhibit 8, pursuant to the fee schedule or by prior agreement, whichever is less, as provided in Section 8(a) of the Act and Section 8.2 of the Act.

Prospective Medical Care

Respondent shall authorize and pay for the left knee replacement and the associated aftercare, as recommended by Dr. Chhadia, as well as continuing right shoulder care, as recommended by Dr. Chhadia.

Deborah L. Simpson

Signature of Arbitrator

May 27, 2016

Date

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Christopher Cates,

Petitioner,

vs. NO: 10 WC 40512

SOI/Pickneyville Correctional Center,

17IWCC0812

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission notes that since the date of accident in this case (9/21/10) preceded the effective date of the amendment (9/1/11), an analysis pursuant to §8.1b of the Act is not mandated.

Petitioner was a 37-years old correctional officer at the time of the accident. A review of prior medical records show that an EMG/NCV study performed on 9/21/10 revealed mild bilateral carpal tunnel syndrome, worse on the right than the left. It was noted that the findings were suggestive of a conduction slowing, but that there was no evidence of denervation changes in abductor pollicis brevis. (PX4).

An EMG/NCV study performed on 4/6/12 revealed mild right median neuropathy at the wrist (carpal tunnel syndrome) affecting only the sensory components, and no evidence of median neuropathy at the wrist in the left upper limb, ulnar neuropathy at the elbow, radial neuropathy, or cervical radiculopathy in the nerves/muscles that were tested in either upper limb. (PX6).

In an office note dated 4/12/12, Dr. Steven Young referenced the above EMG/NCV study as well as a positive Tinel's, median nerve compression test at the wrist bilaterally and positive Phalen's upon exam. (PX6). Dr. Young noted that he explained to the patient that the nerve conduction results "... could be a false negative. He does have provocative signs and symptoms of both cubital and carpal tunnel syndrome bilaterally, and his main complaint is not only numbness in the index finger but numbness in the small finger that wakes him up at night. He has tried splints and anti-inflammatories... He states he has to decide a good time to have surgical intervention; however, he would like to wait at this time." (PX6).

The matter eventually proceeded to trial pursuant to §19(b) of the Act on 11/13/14. In a decision dated 1/16/15, Arbitrator Lee found that Petitioner sustained accidental injuries arising out of and in the course of his employment in the form of bilateral carpal tunnel syndrome, with a manifestation date of 9/21/10, and that his current condition of ill-being was causally related to said accident. The Arbitrator further awarded reasonable and necessary medical expenses as well as prospective medical treatment recommended by Drs. Brown and Young, including but not limited to surgery.

The Commission on Review subsequently affirmed and adopted the Arbitrator's decision, with minor changes, on 10/5/16.

Petitioner testified that since the last hearing on 11/13/14, and after the issuance of the Commission's decision, he returned to his treating surgeon, Dr. Young. (T.14-15). He agreed that he continued to perform the same job following the accident, and that his symptoms continued to progress thereafter. (T.16).

An EMG study performed on 2/8/17 revealed bilateral median neuropathy at the wrist, mild in degree of neuropathic abnormality. (PX6; PX7).

On 2/28/17, Petitioner underwent right carpal tunnel release at the hands of Dr. Young. (PX6). The pre- and post-operative diagnosis was right carpal tunnel syndrome. (PX6; PX8).

On 3/22/17, Petitioner underwent left carpal tunnel release at the hands of Dr. Young. (PX6). The pre- and post-operative diagnosis was left carpal tunnel syndrome. (PX6; PX8).

Petitioner indicated that surgery helped him. (T.16). He noted that he used two sick days following the first surgery and "may have used one personal sick day" following the second surgery, and that he returned to full duty after both surgeries. (T.17). He indicated that he also underwent a course of physical therapy, which he noted helped "[s]omewhat...", and has participated in home exercises and strengthening. (T.17).

In an office note dated 4/4/17, Dr. Young's office recorded that Petitioner was five weeks post right carpal tunnel release and 13 days post left carpal tunnel release, and that "[h]e is doing well in terms of both. He has good resolution of his numbness and tenderness. He denies any particular concerns today." (PX6). Following examination, it was noted that "[w]e will release him to full duties on the right hand. He will be under five-pound lifting restriction for the next four weeks on the left and we will see him back in four weeks for final recheck." (PX6).

17IWCC0812

In an office note dated 5/2/17, Dr. Young's office recorded that Petitioner was "... now almost 12 weeks status post right carpal tunnel release. He is doing very well. Has some very mild incisional tenderness. It is not particularly consistent with any activity, some activities bother him very little to none and some activities cause a little more discomfort. He essentially reports that he is back doing all normal activities of daily living. He feels ready to be released to full duties." (PX6). As a result, Petitioner was released back to full duties without restrictions and instructed to return on an as-needed-basis at that time. (PX6).

Petitioner testified that he is currently working full-duty without restrictions at the DuQuoin boot camp and that he had not seen any doctors in follow-up since his release. (T.19,22-23). He noted that the doors he has to pull at work are made of steel and that the weight of these doors can sometimes cause an issue. (T.26). He also noted that despite the improvement resulting from surgery and physical therapy, he still has symptoms relating to his condition. (T.18). Specifically, Petitioner agreed that his current complaints include tenderness, pain, some weakness and some discomfort. (T.26). He indicated that he discussed these issues with Dr. Young's assistant prior to his release. (T.26-27).

When asked which activities seem to aggravate his symptoms, Petitioner responded: "I don't have much of a problem at work, maybe pulling on the doors. You know, the doors are a little heavier at an institution, of course. But other than that, I don't really have much of a problem at work." (T.19). When asked what bothers him outside of work, Petitioner stated: "[y]ard work. If I – you know, a lot of the pulling, sometimes the driving, anything that really twists my wrists. There's some things that I may do that I would think would aggravate my hands, that doesn't, and then something simple that hits the right spot in there may really get me, so it's – you know, turning a screwdriver, I try to turn a screwdriver. I just take breaks. It's a little weaker right now." (T.19-20). He noted that when his symptoms increase he "... just stop[s] what [he's] doing" and that he ".... normally ice[s] [his] wrist in the evening, and [his] hands." (T.20). He indicated that he ices his wrist "[q]uite a bit, probably at least every other day right now." (T.20).

In addition, Petitioner noted that he was unable to work out and lift weights during his recovery, but that he has since returned to that hobby, going at least three times a week if he can. (T.25). He noted that when he lifts weights now he notices that "[i]t's tender, some pain, some discomfort. It's a little weaker." (T.18). He also noted that his grip on the bars is "... uncomfortable right now." (T.18). He indicated that he has started wearing gloves when he works out, presumably because of these complaints. (T.19). Petitioner testified that he is also a hunter and that he continues to engage in this hobby in the fall and winter, including deer hunting with both a shotgun and a bow. (T.24). He indicated that he was able to hunt during the past season and that he'll try to do so in the upcoming fall or winter season. (T.25).

Based on the above, and the record taken as a whole, the Commission modifies the award of the Arbitrator to find that Petitioner suffered the permanent partial loss of use of 7.5% of the left hand and 7.5% of the right hand pursuant to §8(e)9 of the Act.

All else is otherwise affirmed and adopted.

17IWCC0812

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $645.85 per week for a period of 30.75 weeks, as provided in §8(e)9 of the Act, for the reason that the injuries sustained caused the loss of use of 7.5% of the left hand and 7.5% of the right hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

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

DATED:
o:11/21/17
TJT/pmo
51

DEC 18 2017

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CATES, CHRISTOPHER
Employee/Petitioner

Case# **10WC040512**

SOI/PINCKNEYVILLE CORRECTIONAL CTR
Employer/Respondent

17IWCC0812

On 6/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.07% 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:

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

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

0558 ASSISTANT ATTORNEY GENERAL
SHANNON D RIECKENBERG
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JUN 6 - 2017

Ronald A. Piasecki, Acting Secretary
Illinois Workers' Compensation Commission

17IWCC0812

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

Christopher Cates
Employee/Petitioner

v.

State of Illinois/Pinckneyville Correctional Center
Employer/Respondent

Case # **10** WC **40512**

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 **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **May 9, 2017.** By stipulation, the parties agree;

On the date of accident, **September 21, 2010**, 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's earnings were **$55,973.50** and the average weekly wage was **$1,076.41.**

At the time of injury, Petitioner was **37** 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 **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0.**

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

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 **$645.85/week** for a further period of **20.5** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **5% loss of use of the left hand and 5% loss of use of the right hand.**

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

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

Melinda M. Rose Gillman

Signature of Arbitrator

6/2/17

Date

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Christopher Cates
Employee/Petitioner

Case # **10** WC **40512**

v.

Consolidated cases: **N/A**

State of Illinois/Pinckneyville
Correctional Center
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

At the outset, the Arbitrator notes that the case was previously tried on a 19(b) Petition, that findings were rendered in favor of Petitioner and that such findings were affirmed by the Commission. (PX9).

At the time of arbitration, Petitioner testified that following the first surgery, he used two sick days and that following the second surgery, he used one personal sick day for his time off. He testified that despite the improvement resulting from surgery, he notices pain when he lifts weights and now has to wear gloves while gripping the bars. He testified that he has transferred to the DuQuoin boot camp and has difficulty pulling on doors. He testified that his ability to do yard work, maintain his home and turn a screwdriver has been adversely affected because of weakness. He testified that he tries to avoid taking any sort of medication and uses ice on his hands for his symptoms.

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The Medical Records List was entered into evidence at the time of arbitration as Petitioner's Exhibit 2.

The medical records of Dr. Sudeep Nair were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on September 14, 2010 for a chief complaint of bilateral wrist pain and numbness in the hands. It was noted that Petitioner had worsening wrist pain, numbness, that he worked in "segregation" at the prison and that he had to twist several locks every day. The assessment was noted to include, among other issues, bilateral carpal tunnel syndrome. Petitioner was instructed to undergo a nerve conduction study. At the time of the October 15, 2010 visit, it was noted that Petitioner was involved in a struggle with an inmate at work on October 13, 2010 and that he had pain in the left side of his neck and in the left upper arm. The assessment was noted to be that of left trapezoid muscle strain; bicipital tendonitis. Petitioner was given medications. The records reflect that Petitioner underwent a Physical Therapy Evaluation on October 18, 2010 for left cervical, left shoulder and biceps pain. It was noted that Petitioner complained of difficulty looking upward or to the left, that he had pain with left shoulder active range of motion and resisted left shoulder active range of motion, and that he complained of increased left biceps pain with gripping. (PX3).

The medical records of Orthopaedic Center of Southern Illinois/Dr. Nemani were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner underwent

an EMG/Nerve Conduction Study on September 21, 2010, which was interpreted as revealing mild bilateral carpal tunnel syndrome worse on the right than the left. (PX4).

The medical records of Dr. David Brown were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on November 1, 2010, at which time it was noted that he continued to work for Pinckneyville as a correctional officer, that his job entailed turning keys, cuffing and uncuffing inmates and opening and closing heavy doors repeatedly throughout the day. It was noted that Petitioner explained that he had a six-month history of pain, numbness and tingling in both of his hands and that he underwent nerve conduction studies in September which revealed findings consistent with bilateral carpal tunnel syndrome. The impression was noted to be that of bilateral carpal tunnel syndrome. Petitioner was instructed to wear wrist splints over both wrists at night and to take medications. At the time of the November 29, 2010 visit, it was noted that Petitioner called in and stated that he had noticed no improvement in his symptoms and that he was still having pain, numbness and tingling in both hands. It was noted that Petitioner had failed conservative treatment and that he was a candidate for a carpal tunnel release. (PX5).

The medical records of Southern Orthopedic Associates/Dr. Steven Young were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner was seen on March 19, 2012 for a consultation, at which time it was noted that he had numbness and tingling of his bilateral upper extremities. It was noted that Petitioner stated that he had been having numbness and tingling for quite some time and that he had a nerve conduction study in 2010 which showed mild carpal tunnel syndrome of his bilateral wrists. It was noted that Petitioner stated that he had tried braces in the past without much improvement and that the symptoms had progressed. It was noted that Petitioner stated that his right hand was much more problematic than his left, that he felt like it had progressed and that even his ring and small fingers were quite numb as well. The assessment was noted to be that of bilateral carpal tunnel syndrome, numbness and tingling in all fingers. Petitioner was recommended to undergo repeat nerve conduction studies. (PX6).

The records of Dr. Young reflect that Petitioner was seen on April 12, 2012, at which time it was noted that his nerve conduction study showed evidence of mild carpal tunnel syndrome on the right and that there was no evidence of cubital tunnel syndrome in either of the elbows or carpal tunnel syndrome in the left wrist. It was noted that a lengthy discussion was had concerning the nerve conduction results and that it could have been a false negative. It was noted that Petitioner had provocative signs and symptoms of both cubital and carpal tunnel syndrome bilaterally. It was noted that Petitioner requested to be placed "PRN." (PX6).

The records of Dr. Young reflect that Petitioner was seen on October 27, 2016, at which time it was noted that he complained of bilateral hand numbness and tingling involving the whole hand, including the small finger. It was noted that Petitioner had had symptoms for at least six years and that he had had carpal tunnel splints but no other treatment. It was noted that aggravating activities included holding a book and talking on a cell phone, that he noted grip weakness and that he had difficulty with driving. It was noted that Petitioner was interested in surgery. Petitioner was recommended to proceed with a Medrol Dosepak, anti-inflammatories and night splints, and that a new nerve conduction study would be ordered. At the time of the February 23, 2017 visit, it was noted that Petitioner had tried carpal tunnel splints. It was noted that the right hand was slightly worse than the left and that sometimes the entire hand would go numb. It was noted that a nerve conduction study was performed at Rehab Institute of Chicago on February 8, 2017, which revealed bilateral median neuropathy at the wrist, mild in nature, and mild chronic C7 radiculopathy. The assessment was noted to be that of bilateral carpal tunnel syndrome, subjectively the right is worse than the left. It was noted that Petitioner wished to proceed with surgery. (PX6).

The records of Dr. Young reflect that Petitioner was seen on March 15, 2017, at which time it was noted that he was two weeks status post right carpal tunnel release. It was noted that Petitioner presented doing well with good resolution of his symptoms on the right side and that he was anxious to pursue the left carpal tunnel release. At the time of the April 4, 2017 visit, it was noted that Petitioner was five weeks status post right carpal tunnel release and 13 days status post left carpal tunnel release. It was noted that Petitioner was doing well in terms of both and had good resolution of his numbness and tenderness. Included within the records was the Operative Report dated February 28, 2017 pertaining to the right carpal tunnel release and the Operative Report dated March 22, 2017 pertaining to the left carpal tunnel release. (PX6).

The records of Dr. Young reflect that Petitioner was seen on May 2, 2017, at which time it was noted that he was six weeks status post left carpal tunnel release and almost 12 weeks status post right carpal tunnel release. It was noted that Petitioner was doing very well, that he had some very mild incisional tenderness and that it was not particularly consistent with any activity. It was noted that some activities bothered Petitioner very little to none and that some activities caused a little more discomfort. It was noted that Petitioner essentially reported that he was back doing all normal activities of daily living and that he felt ready to be released to full duties. Petitioner was released to full duties without restrictions and he was instructed to return as needed. (PX6).

The medical records of Rehab Institute of Chicago were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner underwent an EMG/Nerve Conduction Study on April 6, 2012 to evaluate for neuropathy, which was interpreted as revealing evidence of a mild right median neuropathy at the wrist (carpal tunnel syndrome) affecting only the sensory components and no evidence of median neuropathy at the wrist in the left upper limb, ulnar neuropathy at the elbow, radial neuropathy or cervical radiculopathy in the nerves/muscles that were tested of either upper limb. (PX7).

The medical records of Southern Illinois Orthopedic Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records contained the Operative Reports dated February 28, 2017 and March 22, 2017. (PX8).

The Decision and Opinion on Review dated October 5, 2016 was entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The Decision and Opinion on Review affirmed and adopted the 19(b) Arbitration Decision and remanded the 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. The 19(b) Arbitration Decision found that Petitioner sustained an accident that arose out of and in the course of his employment for Respondent on September 21, 2010, that Petitioner's current condition of ill-being was causally related to the accident and that Respondent was to authorize and pay for any medical treatment recommended by Dr. Brown and Dr. Young, including but not limited to, surgery. (PX9).

The medical records of Nova Care Rehabilitation were entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The records reflect that Petitioner underwent physical therapy for the timeframe of March 3, 2017 through March 13, 2017. At the time of the Initial Evaluation on March 3, 2017, it was noted that Petitioner reported incisional pain with end range movements and that he denied numbness and tingling. The Discharge Summary dated April 28, 2017 noted that Petitioner was discontinuing therapy due to physician direction. (PX10).

The CMS Summary of Disability was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The CMS Workers' Compensation Employee's Notice of Injury was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The CMS Supervisor's Report of

Injury or Illness was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The CMS Demands of the Job was entered into evidence at the time of arbitration as Respondent's Exhibit 4.

The Settlement Contract Lump Sum Petition and Order for case number 09 WC 19589 was entered into evidence at the time of arbitration as Respondent's Exhibit 5. The Settlement Contract Lump Sum Petition and Order referenced a date of accident of February 8, 2009 pertaining to the restraining of inmates and noted that the body part affected was that of the left elbow, and further documented that the claim was settled for 20% loss of use of the left arm. (RX5).

CONCLUSIONS OF LAW

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, the Arbitrator notes that as a result of his accidental injuries, Petitioner developed bilateral carpal tunnel syndrome which ultimately required surgical intervention. At the time of his final office visit with Dr. Young on May 2, 2017, it was noted that Petitioner was doing very well, that he had some very mild incisional tenderness and that it was not particularly consistent with any activity. It was noted that some activities bothered Petitioner very little to none and that some activities caused a little more discomfort. It was further noted that Petitioner essentially reported that he was back doing all normal activities of daily living and that he felt ready to be released to full duties. Petitioner was released to full duties without restrictions and he was instructed to return as needed. (PX6).

Having reviewed and considered the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of 5% loss of use of the left hand (*i.e.*, 10.25 weeks) and 5% loss of use of the right hand (*i.e.*, 10.25 weeks) as provided in Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tawana Kemp,

Petitioner,

vs.

NO: 14 WC 38231

Echo Joint Agreement,

Respondent.

17IWCC0813

DECISION AND OPINION ON REVIEW

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

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner is a Teacher's Assistant. On the date in question she was working with special needs students.

2. On November 3, 2014 Petitioner helped a student off the school bus and pushed her towards the school door in a wheelchair. While pushing, she noticed excruciating pain in her right shoulder. Once at the door, she gathered herself for a few minutes before lifting the student again and transferring her to a school wheelchair. She then pushed the student to her classroom. Once in the room, she lifted the student into a lift-stander.

3. The student was unable to do anything on her own, and had to be diapered as well.

She was between eleven and thirteen years of age, and weighed between eighty and ninety-five pounds. She was the same height as Petitioner, standing five feet two inches.

4. Petitioner stated that when she placed the student in the stander, her shoulder pain increased. She informed the teacher, and then visited the school nurse. She was given paperwork to complete, finished her day helping the student, and once she got her on the bus home Petitioner was told to go to Ingalls Urgent Care.

5. Prior to the accident date, Petitioner had been experiencing a little right arm pain for two to three weeks. However, subsequent to the accident, she was unable to lift her right arm and developed constant shooting pains. She had no shoulder symptomatology at all when she was hired by Respondent.

6. At Urgent Care, Petitioner underwent x-rays and a hip injection. Her arm was placed in a sling. The next morning she went to work, but the Principal told her she had to go home with the sling on.

7. Petitioner returned to Ingalls and was recommended for physical therapy. In December 2014, she underwent a right shoulder MRI which revealed a full thickness tear of the supraspinatus tendon. Petitioner was recommended for rotator cuff repair surgery.

8. Petitioner underwent shoulder surgery on May 13, 2015. The post-operative diagnoses were right shoulder rotator cuff repair, rotator cuff impingement, AC joint arthrosis, possible biceps tendon tear, diffuse synovitis and labral tear.

9. After surgery Respondent was unable to accommodate Petitioner's restrictions of light duty. Petitioner was not accepted back to work by Respondent until August 17, 2015. She was not released to full duty until October 30, 2015, although it was noted she still had pain and discomfort, has been avoiding pushing and pulling, and cannot perform activities above shoulder level.

10. At the time of trial, Petitioner stated that the shooting pains have subsided. However, she still suffers from morning stiffness and arm weakness.

The Commission affirms the Arbitrator's findings of accident, causal connection, medical expenses and temporary total disability benefits. However, the Commission modifies the Arbitrator's finding related to permanent partial disability.

Like the Arbitrator, the Commission notes that no AMA impairment report was submitted into evidence.

Petitioner was employed as an Instructional Paraprofessional, which requires the physical ability to participate in the lifting and restraining of students.

17IWCC0813

Petitioner was 46 years of age at the time of accident.

Petitioner has returned to her pre-injury employment, and there is no evidence of any diminished earning capacity.

Petitioner has been released to full duty, but still complains of pain and discomfort, and has been avoiding pushing and pulling, and cannot perform activities above shoulder level.

The Commission views these factors slightly different than does the Arbitrator, and accordingly modifies the award for permanent partial disability benefits down from a 15.18% loss of a person as a whole to a 10.12% loss of a person under §8(d)(2) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $330.00 per week for a period of 40-4/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $330.00 per week for a period of 50.6 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused a 10.12% loss of use of Petitioner's person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $112,585.36 for medical expenses under §8(a) of the Act.

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

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

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

DATED: DEC 18 2017
O: 10/19/17
DLG/wde
45

David L. Gore

Stephen Mathis

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KEMP, TAWANA
Employee/Petitioner

Case# **14WC038231**

ECHO JOINT AGREEMENT
Employer/Respondent

17IWCC0813

On 4/17/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.95% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1120 BRADY CONNOLLY & MASUDA PC
WILLIAM P DEWYER
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

0000 SKLARE LAW GROUP LTD
MICHAEL R TRYBALSKI
20 N CLARK ST SUITE 1450
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

Tawana Kemp
Employee/Petitioner

v.

Echo Joint Agreement
Employer/Respondent

Case # 14 WC 38231

Consolidated cases: _____

17IWCC0813

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian T. Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **August 24, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **11/3/14**, 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 **$18,242.64**; the average weekly wage was **$350.82**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **3** dependent children.

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

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

Respondent is entitled to a credit of **$3,891.28** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total indemnity credit of **$3,891.28**.

Respondent is entitled to a credit of **$5,674.87** for medical bills paid.

ORDER

Medical benefits

Respondent shall pay Petitioner **$112,585.36**, which is an amount equal to a total of the medical bills for the necessary and related medical services, pursuant Section 8(a) and subject to Section 8.2 of the Act.

Respondent shall be given a credit of **$5,674.87** for medical bills paid.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of **$330.00**/week for **40-4/7** weeks, commencing **11/6/14** through **8/16/15**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$3,891.28** for TTD benefits paid.

Permanent Partial Disability

Respondent shall pay Petitioner **$330.00**/week for **75.90** weeks since Petitioner, as a result of the 11/3/14 accident, has sustained a loss of use of her person as a whole to the extent of **15.18%.**

Respondent shall pay Petitioner benefits that have accrued since October 30, 2015, which is the day Dr. Goldvekht declared Petitioner to be at MMI, and shall pay additional benefits, 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

April 17, 2017
Date

APR 17 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tawana Kemp	)	
Petitioner	)	
	)	
vs.	)	**14 WC 38231**
	)	
Echo Joint Agreement	)	
Respondent	)	

FINDINGS OF FACT

Petitioner's Testimony

Petitioner testified that on November 3, 2014, she was employed by Respondent as a teacher's aide, and that she had worked as such since August of 2014. As a teacher's aide, Petitioner would work under the direction of a teacher and provided assistance to those students with special needs or disabilities. Petitioner stated that the students with whom she worked were often unable to care for themselves, and would require assistance with everything from personal hygiene to transportation around the facility where classes took place.

Prior to beginning her employment with Respondent, Petitioner worked as an aide for the hearing impaired and was not required to move students.

Petitioner testified that from the time she began working for Respondent in August 2014 through the date of injury alleged (November 3, 2014), she was not provided with any training as to the proper technique for lifting patients or heavy objects. Petitioner denied having any experience with such from her prior employment as an aide to the hearing impaired.

Petitioner described a "lift stander" as a device that would move a student from a sitting position to a standing position.

Petitioner testified that on the morning of November 3, 2014, she assisted a student named Aliah, who was 11-13 years old and approximately 5' 2" tall. Aliah arrived to the facility via bus that morning, and needed to be physically transferred from her personal wheelchair to the school wheelchair. After that, Petitioner would need to be transferred when she reached the classroom and again when she was toileted and diapered.

During the initial transfer, when she took Aliah out of her personal wheelchair and put her in the facility wheelchair, Petitioner felt a sharp pain in her right shoulder. Because the pain was so bad, Petitioner stopped doing what she was doing for a little. Then, during the second

transfer, when Petitioner lifted Aliah out of the school wheelchair and placed on the "lift stander", she again experienced pain in her right shoulder.

At that time, Petitioner was told to see the school nurse. The school nurse was not in her office, so Petitioner returned to the classroom. A little while later, Petitioner went back to the nurse's office and completed some paperwork. The nurse told Petitioner to come back at the end of the day. The nurse told Petitioner to go to Ingalls Urgent Care to get checked out.

Petitioner testified that prior to lifting Aliah on November 3, 2014, she had a little soreness and pain in her right shoulder for 2-3 weeks off and on. She felt constant pain and symptoms; if she made the wrong movement, her shoulder would hurt. Petitioner noticed that she had had such symptoms since the end of September.

Petitioner testified that prior to August 2014, she did not have pain or symptoms in her right shoulder. The symptoms went from being soreness to sharp pains that then became constant. Before November 3, 2014, Petitioner continued, she did not receive any treatment for her right shoulder.

Petitioner went into further detail with regard to the initial transfer. On the morning of November 3, 2014, she had to unlock the wheelchair. She stood directly in front of Aliah and lifted her out of her own wheelchair by pulling Aliah toward her. Then, she had to turn Aliah to put her in the school wheelchair. Next, Petitioner would stand behind Aliah who was in the school wheelchair and pull her up because Aliah was unable to sit up straight in the wheelchair.

Petitioner does overhead work in the classroom. She is the one who has to put everything away on the shelves.

On November 3, 2014, Petitioner left work and went to Ingalls Urgent Care. She had x-rays and the Ingalls nurse gave her an injection in her hip. She was given a sling for her arm and told to keep her arm in a sling.

Petitioner went back to work the next day. The school nurse saw Petitioner wearing the sling and told her that she cannot be there with a sling, and sent her home.

Petitioner was recommended to undergo a course of physical therapy. She began the physical therapy at Ingalls Occupational Health. Then, she went to Advanced Physical Medicine.

On December 11, 2014, she had an MRI of her right shoulder. Her doctor gave her a treatment plan. He recommended that she continue with the physical therapy and then have her rotator cuff repaired. Petitioner underwent the surgery and post-op physical therapy. During that time, her doctor gave her light-duty restrictions. She was released from care with light-duty restrictions.

Petitioner testified that her benefits stopped on February 10, 2015 and it was not until August 17, 2015 that she was able to return to work without restrictions. Since August 17, 2015, Petitioner has performed the same job without restrictions.

In January 2015, she underwent a Section 12 examination. The doctor spent only 3 minutes with her. He asked her 2 or 3 questions and said goodbye.

Medical bills were incurred as a result of this treatment for her right shoulder. It is Petitioner's understanding that none of those bills have been paid.

Currently, the sharp, lightning-like pain in her right shoulder has gone away. However, her shoulder is not 100%. In the morning, her right shoulder is extremely stiff. She is not able to lift her right arm up in the shower as she was able to do before. She finds that she does not have the strength in her arm that she used to have.

On cross-examination, Petitioner reiterated that she still has pain in her right shoulder, but no sharp, lightning-like pain. In August 2015, Doctors Primus and Goldvekht released Petitioner to return to work. No treatment has been recommended. She was told to come back if she has any problems, but she has not gone back.

On November 3, 2014, which was the date of accident, the accident happened between 8:15 and 8:30. Aliah was her first or second lift of the day. The injury did not happen in the afternoon that day. Petitioner's work day ends at 3:00 p.m. Petitioner worked the whole afternoon.

Petitioner's title is teacher's assistant, or parapro.

Petitioner does not have a photo of the stander device. She does not know the height of such device. Petitioner was taking Aliah from her personal wheelchair to the school wheelchair. At the time the injury occurred, Petitioner was moving Aliah from her personal wheelchair to the school wheelchair. Aliah is very tall for her age.

Jennifer Collison is her principal. Petitioner never spoke to Ms. Collison about the injury and did not speak to her when she returned to work with her notes.

Petitioner spoke with Ms. Bogan in H.R. about the accident, and also talked to Ms. Rita. The school nurse gave her a note to go to Ingalls. Other than these 3 ladies, no one else from the school came to talk to her.

Petitioner went to Ingalls on the day of the accident. It was Monday, November 3, 2014.

Petitioner stated that, no, it was the next day. She went to Ingalls the next day.

Petitioner filled out a form for the school nurse. Respondent's attorney showed Petitioner Px.14, which was offered into evidence as Rx.5. Petitioner testified that Rx.5 was not the form that she filled out with the school nurse.

Petitioner's testimony was that she filled out some paperwork at school and gave it to Missy, whose last name Petitioner could not recall.

Petitioner received treatment at Ingalls and was then sent to Advanced Medicine by her attorney. Advanced Medicine is in Matteson. She saw Dr. Goldvekht. Petitioner does not know if any of the medical bills from Dr. Goldvekht have been paid.

Dr. Primus is not with Advanced Medicine but is with Chicago Orthopedic Associates.

The surgery was on May 13, 2015 and was not done at an outpatient facility. She spent the night, or 2 nights, at Holy Cross Hospital. Petitioner does not recall if she received a bill from the hospital.

After she was released by the hospital, she followed up with Dr. Primus. She had maybe 5 visits. She was also seeing Dr. Goldvekht at Advanced Physical Medicine but was also sent out for physical therapy. Both doctors prescribed medicine.

On January 23, 2015, which was the first time Dr. Primus saw her, he recommended that she undergo surgery. She did not recall if she received a bill from the first visit for drug/toxicology testing. They prescribed pain pills and 2 types of cream to apply to her shoulder. Dr. Goldvekht prescribed the pain pills and the cream. She was told to use the cream or the pills, but not both.

The Ingalls staff did not tell her the reason that they injected her in the hip and not the shoulder.

Petitioner did not recall the names of the medications that she took. She did not recall seeing Dr. Ronald Silver.

She went to her IME by Dr. Walsh on about January 18, 2015. She was there a total of 3 minutes and he asked 2-3 questions. He put his hand on her shoulder. He had her lift her arm and push out. He did nothing else. He asked about pain in her arm and she told him about the lightning she felt in her shoulder.

She testified earlier that she had problems with her right shoulder before November 3, 2014. It was constant pain in her right shoulder whether she was at home or at work. She has 3 children who are 14, 8 and 5 years of age. Petitioner has been able to take care of her children. At the end of September, she began to have constant pain and soreness in her right shoulder.

After November 4, 2014, the shoulder pain felt like lightning.

Petitioner works with special needs children. She was never taught how to move the children in and out of wheelchairs.

In February of 2015, Petitioner had a fall at home. She was walking in her yard, stepped on ice and slid. She had been off work at that time. For the slip on ice, she treated at Ingalls. She did not stay off work for her arm. When she slid, she injured her knee and low back. She did not strike her right shoulder when she slid on ice that day.

On redirect examination, Petitioner testified that she went to Ingalls because she has Blue Cross/Blue Shield insurance through work and that is where she goes. Petitioner testified that she did not have an option of treating anywhere else. At Ingalls, she did not have an MRI of her shoulder taken. Prior to the MRI, Ingalls gave her a diagnosis of a sprained shoulder.

The pain and soreness in her right shoulder began at the end of September.

She saw Dr. Primus for the surgery and Dr. Goldvekht for the physical therapy and rehabilitation.

Prior to her treatment at Advanced Physical Medicine, Ingalls referred her for physical therapy.

Accident Reports

Petitioner testified that she notified the school nurse on the date of accident and that she filled out paperwork in the nurse's office the same day. No such paperwork was offered into evidence.

Petitioner testified that Rx.5 was not the form she completed in the nurse's office. Rx.5, which Petitioner signed and dated November 10, 2014, indicates that at 1:15 p.m. on November 4, 2014, she experienced a sharp pain in her right shoulder. Petitioner did not check either the "yes" or "no" box with regard to whether the accident was directly related to her work. Petitioner indicated on such form that her job is physically stressful and that the pain in her shoulder "never stops."

Medical Records, Reports and Opinions

A company authorization form included with the records of Ingalls Memorial Hospital indicates that authorization for treatment was given by Dr. Margaret W. Longo, Executive Director of Echo Joint Agreement. (Px. 1, pg. 4) That form is signed and dated November 4, 2014 and lists the date of injury as November 3, 2014. (Px. 1, p. 4)

The Ingalls Memorial Hospital records indicate that Petitioner arrived at 16:15 on November 4, 2014 and her Primary Complaint Details are as follows:

"Pt presents to urgent aid with cc of intermittent R sided shoulder clavicle neck pain s/p picking up a child at work yesterday." (Px. 1, p. 9)

The Ingalls staff examined her, took x-rays of the right, and gave her an intermuscular injection of Ketorolac. X-rays did not show any sign of fracture or dislocation (Px. 1, p. 24). Petitioner was provided with an arm sling, prescribed medication, and cleared to return to work with the restriction of lifting and carrying of up to 5 pounds with the right arm and "no lifting or restraining clients." (Px. 1, p. 25) The diagnosis was right shoulder/pectoralis/trapezius pain as well as cervical pain. (Px. 1, p. 25)

Petitioner followed up at Ingalls on November 6, 2014, at which time it was recommended that Petitioner continue with restricted work duties. (Px. 1, pp. 26-29) Petitioner was prescribed medication and advised to begin a course of physical therapy at a rate of 2-3 times a week for a period of 1-2 weeks. (Px. 1, pp. 26-29)

On November 10, 2014, Petitioner presented to Aleksandr Goldvekht, M.D., of Advanced Physical Medicine, for an examination. (Px. 3, p. 4) Dr. Goldvekht recorded, in pertinent part, the following subjective complaints:

"Ms. Kemp, a right hand dominant female, reported that on 11/3/14, she was working for 'Echo Joint Agreement' with developmentally disabled kids, moving someone from a 'standard' to a 'chair,' and as she pulled her upwards towards her, she felt severe, sharp and tearing pain in the front of the right shoulder as well as neck pain. She stated that the day following, she went to Ingalls Urgent Care, where she was examined, x-rays were taken and a sling and x-rays were prescribed. (sic) She stated that since the incident, she has been experiencing severe headaches, neck pain and right shoulder pain. Since the incident, she reports that he has been unable to turn her head to the right without discomfort and unable to perform any activities over shoulder level. She denies any previous similar complaints. She denies any allergies and any PMH. VAS today is 9/10." (Px. 3, p. 4)

Dr. Goldvekht assessed Petitioner with right rotator cuff syndrome and cervical discogenic pain, and noted that her condition remains guarded. (Px. 3, p. 4) Dr. Goldvekht prescribed medication and a topical compound, as well as a urine test to make sure there are no interactions with the prescribed medications. He noted that an MRI of Petitioner's right shoulder should be considered if her condition fails to improve. (Id.) Petitioner was advised to begin a course of physical therapy (Id.), and held off of work from November 10, 2014 through December 8, 2014. (Px. 3, p. 5)

Petitioner presented for an initial physical therapy evaluation at Advanced Physical Medicine on November 12, 2014. Petitioner's course of therapy at APM continued through May 8, 2015. (Px. 3, pp. 19-36) Physical therapy stopped at that time in order to proceed with surgical intervention as detailed below.

While physical therapy was ongoing, Petitioner continued to follow up with Dr. Goldvekht, on December 22, 2014, February 16, 2015, March 16, 2015, April 13, 2015, May 6, 2015, July 6, 2015, and August 14, 2015. (Px. 1, pp. 4-18)

At Dr. Goldvekht's referral, an MRI of Petitioner's right shoulder was obtained at Archer Open MRI on December 11, 2014. (Px. 5) The "impressions" of the images by Travis B. Lutz, M.D., are as follows:

"The focal tear of the supraspinatus tendon insertion, most of which is full thickness in nature. (sic) There appear to be small spurs at the lateral margin acromion process which likely result in impingement." (Px. 5)

On December 22, 2014, Dr. Goldvekht examined Petitioner and reviewed the MRI report. Dr. Goldvekht referred Petitioner to see an orthopedic surgeon for a second opinion. (Px. 3, p. 6)

Pursuant to Dr. Goldvekht's referral, Petitioner presented to Gregory Primus, M.D., at Chicago Center for Sports Medicine and Orthopedic Surgery on January 23, 2015. (Px. 9, pp. 4-11) Petitioner completed a "Workers' Compensation Case Information Form" wherein she gave a narrative of how her injury occurred. She wrote:

"I was moving a student from one wheelchair to another and as I pulled her to her feet I had a pain in my shoulder to my neck on the right side." (Px. 9, p. 6)

In his chart notes, Dr. Primus recorded, *inter alia*, the following:

"CC: Ms. Kemp is a 46 year old female who presents for consultation of right shoulder pain. The date of injury was 11/3/2014. This was due to an injury while at work

HPI: She presents for right shoulder pain and weakness. The apparent precipitating event was lifting, and the mechanism of injury was lifting a patient out of a wheelchair at work. The pain initially started 2 months ago. The location of the pain is lateral, superior, and deep. She describes it as moderate in severity, weakness, intermittent, pain at night, sharp, aching, and stabbing. It radiates to the chest and clavicle. Especially the lateral upper arm. Discomfort increases with overhead activities, external rotation, abduction, and lifting. The pain is relieved with rest and NSAIDs. Related symptoms include weakness with overhead lifting and pain at night. Patient denies numbness/tingling/instability/'catching.' Pertinent medical history is unremarkable. Pt has been to PT regarding shoulder pain, but has not had any significant relief of symptoms." (Px. 9, p. 9)

Dr. Primus assessed Petitioner with the following: shoulder pain, rotator cuff tear, bicipital tenosynovitis, rotator cuff tendinitis. (Id.) He recommended right shoulder arthroscopic surgery since Petitioner has failed conservative treatment. (Id.)

On January 12, 2015, Petitioner presented to Kevin F. Walsh, M.D., for an examination, pursuant to Section 12 of the Act. (Rx. 1, Dep. Ex. 2) The doctor wrote that Tawana Kemp-Jordan reported a work-related event that occurred on November 3, 2014 in which she noted pain in her right clavicle and right shoulder when she was trying to transfer an 80-pound child from the stander to the wheelchair. She reported that she had a little pain earlier in the day but denies any past history of problems with her clavicle or shoulder. (Rx. 1, Dep. Ex. 2) Dr. Walsh confirmed that Petitioner did have a right shoulder rotator cuff tear, but opined that it was not related to the incident of November 3, 2014. (Rx. 1) Dr. Walsh noted that this opinion was reached, in part, by the fact that Petitioner demonstrated a 5/5 strength test as well as the doctor's belief that an incident of the type, i.e., the mechanism of injury, as described by Petitioner was unlikely to result in a torn rotator cuff. (Rx. 1) Dr. Walsh diagnosed Petitioner with "most likely" a strain of her right shoulder and trapezial area as well as a cervical strain as a result of the injury described. Dr. Walsh stated that Petitioner may consider additional treatment to address the rotator cuff condition, but that such treatment was not related to her employment for Respondent. Dr. Walsh stated that Petitioner was capable of returning to full-duty work immediately. (Rx.1)

On May 13, 2015, Dr. Primus, with First Surgical Assistant Emmett Smith, performed surgery on Petitioner's right shoulder. The procedures performed included the following: right shoulder arthroscopic rotator cuff repair, subacromial decompression with acromioplasty, AC joint arthroplasty with distal clavicle excision, and diffuse glenohumeral joint synovectomy and labral debridement. The post-operative diagnoses were right shoulder rotator cuff repair, rotator cuff impingement with acromial spur, AC joint arthrosis with internal derangement, possible biceps tendon tear, and diffuse synovitis and labral tear. (Px. 7, pp. 5-7)

On July 8, 2015, Petitioner resumed physical therapy with Advanced Physical Medicine. (Px. 3, pp. 36-38)

A Work Status & Recommendations form from Chicago Center for Sports Medicine and Orthopedic Surgery dated July 24, 2015 indicates no use of the right upper extremity and next follow up appointment in 4 weeks. (Px. 9, p. 54)

On August 14, 2015, Dr. Goldvekht released Petitioner to return to work with no restrictions, effective August 17, 2015. He instructed Petitioner to continue her course of physical therapy until further notice. (Px. 3, p. 18)

Petitioner continued to treat post-operatively, and concluded the course of physical therapy on October 28, 2015. (Px. 3, pp. 36-45)

Petitioner's last date of treatment was on October 30, 2015 with Dr. Goldvekht. (Px. 3, p. 46) At that time, Dr. Goldvekht noted that physical therapy had helped Petitioner's condition, but that she was still experiencing "some pain and discomfort." (Px. 3, p. 46) Petitioner was released from care at MMI and told to follow up in the event of any aggravation or exacerbation of her current complaints. (Id.)

CONCLUSIONS OF LAW

The above FINDINGS OF FACT are incorporated into the following conclusions of law.

In support of his decision as to issue (C) "Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?", the Arbitrator concludes:

Petitioner's unrebutted testimony is that on November 3, 2014, she reported to the school nurse that she hurt her right shoulder. She also provided unrebutted testimony that she spoke that day to Ms. Bogan in H.R. for Respondent, and also Ms. Rita, about the accident.

A company authorization form included with the records of Ingalls Memorial Hospital indicates that authorization for treatment was given by Dr. Margaret W. Longo, Executive Director of Echo Joint Agreement. (Px. 1, pg. 4) That form is signed and dated November 4, 2014 and lists the date of injury as November 3, 2014. (Px. 1, p. 4)

Petitioner testified that on November 3, 2014, she experienced sharp pain in her right shoulder when she first transferred Aliah from 8:15 – 8:30 a.m. Then, during the second transfer, when Petitioner lifted Aliah out of the school wheelchair and placed on the "lift stander", she again experienced pain in her right shoulder. Petitioner testified that she later went to see the nurse and filled out paperwork that day.

The supervisor's report, which was completed on November 10, 2014, states that the accident happened at 1:15 in the afternoon.

Although there is some question about the time of day that the accident happened, the Arbitrator finds that Petitioner was in the course and scope of employment on November 3, 2014 when she experienced right shoulder and neck pain.

As a teacher's aide/parapro, Petitioner's employment duties include assisting with the transportation of special needs students, such as Aliah. The job description of a "Instructional Paraprofessional" as prepared by Respondent and offered into evidence by Petitioner indicates, in relevant part, that two of the qualifications for employment are: (1) Physical ability to participate in lifting of students, and (2) Physical ability to participate in physical restraint of students. (Px. 15, p. 1)

Petitioner's testified that the student she was attempting to lift at the time of her injuries was approximately 11-13 years old, 5' 2" tall. Dr. Walsh's report indicates that the student was approximately 80 pounds. Petitioner testified further that she was responsible for physically moving the previously-described student multiple times each day she worked.

Petitioner testified that prior to lifting Aliah on November 3, 2014, she had a little soreness and pain in her right shoulder for 2-3 weeks, off and on. She felt constant pain and symptoms; if she made the wrong movement, her shoulder would hurt. Petitioner noticed that she had had such symptoms since the end of September.

However, Petitioner also testified that prior to August 2014, when she was first employed by Respondent, she did not have pain or symptoms in her right shoulder. The symptoms went

from being soreness to sharp pains that then became constant. Before November 3, 2014, Petitioner continued, she did not receive any treatment for her right shoulder.

Even Dr. Walsh, Respondent's Section 12 examiner, did not deny that Petitioner sustained an injury to her right shoulder on November 3, 2014. He opined that she most likely sustained a strain of her right shoulder and trapezial area as well as a cervical strain as a result of the injury described.

Based on the foregoing, the Arbitrator finds that on November 3, 2014, Petitioner sustained an accident that arose out of her employment.

In support of his decision as to issue (F) "Is Petitioner's current condition of ill-being causally related to the injury?", the Arbitrator concludes:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Arbitrator finds that Petitioner's current condition of ill-being of her right shoulder is causally related to the injury of November 3, 2014. In holding so, the Arbitrator relies on the treating medical records and Petitioner's testimony.

The Arbitrator notes that although Dr. Walsh, Respondent's Section 12 examiner, provided the only opinion on the issue of causation, his opinions are not persuasive.

Dr. Walsh testified that on days when he is not performing surgery, he sees 65 patients a day. The Arbitrator takes judicial notice, given this statement by Dr. Walsh, that for a 10-hour work day, not including lunch, Dr. Walsh would have the opportunity to see each patient for 9.23 minutes.

Petitioner testified that for the Section 12 examination, Dr. Walsh spent 3 minutes with her. He asked 2 or 3 questions and said goodbye.

In light of Dr. Walsh's testimony as to the number of patients he sees in a day, the Arbitrator finds that Petitioner may not have underestimated the length of Dr. Walsh's examination.

Dr. Walsh states in his report that at the time of his examination Petitioner demonstrated "5/5 motor strength" and that "the mechanism of injury described *** by the patient is unlikely to result in a rotator cuff tear." (Rx 1) Dr. Walsh opined that the only finding that would be consistent with a rotator cuff tear would be the decreased range of motion. Therefore, Dr. Walsh continues "there is no causal relationship between the MRI finding of a torn rotator cuff and the incident described." (Rx. 1)

During his deposition, Dr. Walsh testified further that "rotator cuff tears don't usually happen because of the type of incident described by the petitioner but rather as a result of

repetitive trauma." (Rx. 1) When asked whether rotator cuff tears always happen as a result of repetitive trauma versus an acute injury, Dr. Walsh replied "no" (Rx. 1).

When asked whether 80 pounds (the approximate weight of the child being lifted by Petitioner in the incident alleged) was sufficient to tear a rotator cuff, Dr. Walsh responded that "the question is very broad" and that "certainly the patient's not lifting the child just with the rotator cuff. She's using her body. They're instructed, you know. People who work in these facilities are instructed how to lift. You lift with your legs; you lift with your back; you bend your knees." (Rx. 1, p. 30, lines 5-16)

However, Dr. Walsh testified later that the Petitioner "didn't specifically say [that she was] squatting down, no." (Rx. 1, p. 31, lines 4-6)

Moreover, there is no evidence that Respondent trained Petitioner on how to lift patients.

Dr. Walsh also denied discussing what level of overhead lifting was involved in her job (Rx. 1, p. 31, lines 21-24), and that he had no understanding as to what level of overhead lifting was required of Petitioner's job. (Rx. 1, pg. 32, lines 3-8)

Dr. Walsh is simply not persuasive in finding that Petitioner "most likely" sustained a strain of her right shoulder and trapezial area as well as a cervical strain as a result of the injury described. The MRI clearly shows a focal tear of the supraspinatus tendon at insertion, most of which is full thickness in nature. After failing conservation management, Petitioner underwent rotator cuff surgery on May 13, 2015. Petitioner testified that, presently, her shoulder is not 100%, but she is back to full-duty work and no longer experiences the sharp, lightning-like pain that she felt after the accident of November 3, 2014.

Prior to the accident, she had been experiencing some pain/soreness in her right shoulder. Petitioner stated that she first noticed the pain/symptoms around the end of September 2014, and that for 2-3 weeks prior to November 3, 2014 that pain/soreness was present on a daily basis.

Prior to November 3, 2014, Petitioner testified, she had not sought any medical treatment for right shoulder. That testimony was unrebutted at trial. In contrast, the medical records establish that Petitioner sought medical treatment beginning one day after the injuries described herein.

Furthermore, there is no evidence that the pain/soreness which had been present in her right shoulder prior to November 3, 2014 resulted in lost time from work. After November 3, 2014, Petitioner's treating physicians kept her off work completely, or restricted her from performing some aspect of her normal employment through August 16, 2015. (Px. 1, Px. 3, Px. 7, Px. 9)

Significantly, there was a change in the type of pain that Petitioner experienced prior to, and on/after, November 3, 2014. She testified that at the end of September, she began to have

constant pain and soreness in her right shoulder. However, after the accident, the pain in her shoulder felt like lightning.

Upon her arrival at Ingalls Memorial Hospital on November 4, 2014, Petitioner related a history of right shoulder and neck pain since "picking up a child at work yesterday." (Px. 1, p. 9) Dr. Susan T. Gomez, PA-C of Ingalls Memorial Hospital, noted, on November 6, 2014, the following: "The cause of this problem is related to work activities." (Px. 1, p. 28)

On November 10, 2014, when Petitioner presented to Dr. Aleksandr Goldvekht, she reported right shoulder and neck pain beginning on November 3, 2014, while "moving someone from a standard chair to a chair" and that "as she pulled her upwards towards her, she felt a severe, sharp and tearing pain in the front of her right shoulder as well as neck pain." (Px. 3, p. 4)

When Petitioner was seen by Dr. Gregory L. Primus on January 23, 2015, she noted a history, stating in relevant part, "I was moving a student from one wheelchair to another and as I pulled her to her feet I had a pain in my shoulder to my neck on the right side." (Px. 9, p. 6) Dr. Primus notes in his records that "the apparent precipitating event was lifting, and the mechanism of injury was lifting a patient out of her wheelchair at work." (Px. 9, p. 9) In every "Work Status & Recommendations" report prepared by Dr. Primus following each examination of Petitioner, he affirmed that Petitioner's injuries were related to work. (Px. 9, pp. 13, 26, 31, 36, 39, 42, 45, 54)

On multiple occasions, Dr. Goldvekht stated his agreement with Dr. Primus' assessment and recommendation for treatment. (Px. 3, pp. 8, 11, 13)

Petitioner testified that she does overhead work in the classroom. She is the one who has to put everything away on the shelves.

The Arbitrator viewed the surveillance video. Petitioner is shown performing activities of daily life, but is not shown performing heavy lifting or overhead work. The Arbitrator places no weight on the opinions of Dr. Walsh that he rendered after viewing the surveillance video.

Based on Petitioner's testimony and the treating medical records, the Arbitrator finds that Petitioner's current condition of ill-being of her right shoulder is causally related to the accident of November 3, 2003.

In support of his decision as to issue (J) "Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?", the Arbitrator concludes:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

Petitioner claims medical bills that total $112,585.36:

(1) Ingalls Occupational Health	$ 601.85
(2) Advanced Physical Medicine	$15,458.76
(3) Archer Open MRI	$ 1,800.00
(4) APM Surgical Group, Ltd.	$40,342.84
(5) Dr. Gregory L. Primus	$46,891.98
(6) EQMD, Inc.	$ 4,643.03
(7) Metro Health Solutions	$ 2,846.88

The Arbitrator finds this amount, particularly the amount charged by Dr. Primus, to be excessive. However, the Medical Fee Schedule has not yet been applied to the total charges above.

Petitioner did not identify each of the bills, but testified that it was her understanding that none of the bills for this accident has been paid.

Petitioner testified as to the treatment that Dr. Goldvekht at Advanced Physical Medicine rendered to her. She further testified that an MRI of her right shoulder was taken.

Petitioner testified that Dr. Primus performed the surgery and that it took place on May 13, 2015. She testified that such surgery was not done at an outpatient facility. She further testified that she spent the night, or 2 nights, at Holy Cross Hospital. Petitioner did not recall if she received a bill from the hospital.

The Arbitrator notes that Petitioner did not submit a bill from Holy Cross Hospital, but did submit one from APM Surgical Group, Ltd. Such bill appears to be from an outpatient surgical facility and the date of service for the surgery is May 13, 2015.

The bills from EQMD, Inc., and Metro Health Solutions are for the medications prescribed to Petitioner, including the 2 types of analgesic creams that she described. Petitioner could not recall the names of the medications that she took.

The Arbitrator interprets Dr. Walsh's opinions on the reasonableness and necessity of the medical treatment as premised on his opinion that no causal connection existed between the torn rotator cuff finding on the MRI and the work injury alleged. As the Arbitrator has causally related Petitioner's right shoulder condition with the accident, he gives no weight to Dr. Walsh's opinion on this matter.

Therefore, the Arbitrator finds that Petitioner is entitled to $112,585.36 in medical bills for the necessary and related treatment rendered to her as a result of the accident of November 3, 2014, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Respondent is entitled to a credit of $5,674.87 for medical bills previously paid.

In support of his decision as to issue (K) "What temporary benefits are in dispute? TTD", the Arbitrator concludes:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Arbitrator finds that Petitioner is entitled weeks of TTD benefits, from November 6, 2014 through August 16, 2015, or 40-4/7 weeks, at a rate of $330.00/week. Based on Dr. Walsh's opinions following his January 18, 2015, Section 12 examination of Petitioner, Respondent terminated Petitioner's TTD benefits on February 10, 2015.

Yet, the Arbitrator finds Dr. Walsh's opinions to be unpersuasive.

On August 14, 2015, Dr. Goldvekht released Petitioner to return to work with no restrictions, effective August 17, 2015.

Respondent claims that they paid TTD benefits from November 6, 2014 through February 10, 2015. (Ax. 1) Such claim is supported by the figures in Rx.3.

The parties agree that Respondent paid $3,891.28 in TTD benefits. Such claim is supported by the figure in Rx.3.

However, Respondent paid Petitioner at the rate of $220.00, instead of the correct rate of $330.00.

In support of his decision as to issue (L) "What is the nature and extent of the injury?", the Arbitrator concludes:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of laws as is fully restated herein.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability AMA 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 "Instructional Paraprofessional" at the time of the accident. Petitioner's employment duties include assisting with the transport-tation of special needs students. The job description of a "Instructional Paraprofessional"

indicates, in relevant part, that two of the qualifications for employment are: (1) Physical ability to participate in lifting of students, and (2) Physical ability to participate in physical restraint of students. (Px. 15) The Arbitrator gives major weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 46 years old at the time of the accident. The Arbitrator gives moderate 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 her pre-injury employment position with Respondent. No evidence was presented of any diminishment of earnings. The Arbitrator gives moderate weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that on August 16, 2015, Dr. Goldvekht released Petitioner to return to work with no restrictions. However, upon discharge at MMI by Dr. Goldvehkt on October 30, 2015, he wrote that Petitioner is still experiencing "some pain and discomfort" that she "still has been avoiding pushing and pulling and cannot perform activities over shoulder level." Upon examination, Dr. Goldvekht found the following:

"**Objective:** Cervical ROM is WFL. ROM of the right shoulder is flexion of the right shoulder at 100% and abduction of the right shoulder at 80 to 90%. Moderate hypertonicity noted at the right lower cervical paraspinals and right supraspinatus and deltoid. Multiple tender trigger points noted at the right upper trapezius, right levator scapulae and right supraspinatus.

Assessment: Right Rotator Cuff Syndrome. Cervical Discogenic Pain. Her condition remains guarded."

Notwithstanding Petitioner's complaints and examination findings, Dr. Goldvekht did not impose any work restrictions on Petitioner.

The Arbitrator gives major weight to this factor.

Determination of permanent partial disability ("PPD") is not simply a calculation, but is an evaluation of the 5 factors. The Arbitrator has carefully considered all 5 factors. By applying §8.1b and by considering the relevance and weight of all 5 factors, the Arbitrator finds that as a result of the November 3, 2014 accident, Petitioner has sustained a loss of use of her person as a whole to the extent of 15.18%, pursuant to §8(d)2 of the Act.

Signature of Arbitrator

4/17/2017
Date

ICArbDec p. 2

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Scott Carlson,

Petitioner,

vs. NO: 16 WC 10184

New England Motor Freight Inc.,

Respondent.

17IWCC0814

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 penalties and fees, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner has been a Truck Driver for Respondent since July 2015. He drives a semi-truck tractor trailer, delivering household goods, hazardous materials, 55-gallon drums and skidded materials among other things. He is a local driver, driving forty-five miles daily. Most of his work is done on the docks, loading and unloading. He lifts up to one hundred fifty pounds at any given time.

2. On February 17, 2016 Petitioner was injured when he slipped and fell on some ice while walking to the back of his trailer to close the doors after completing a delivery. He landed on his left hip.

3. Petitioner reported the incident to his supervisor the same day, but continued working the next few days. One week after the accident, however, Petitioner called off work due to

17IWCC0814

pain. He came into work to complete an accident report, and was then sent to the company clinic.

4. In March 2016, after previously recommending conservative care and light duty restrictions, the company clinic referred Petitioner to Dr. Grear, an orthopedic specialist.

5. Dr. Grear noted hip and groin pain upon examination, and took Petitioner off work. He also recommended a left hip MRI. On April 8, 2016 Dr. Grear continued Petitioner off work.

6. Petitioner provided Respondent with the off work note from Dr. Grear.

7. Petitioner made written demand for benefits throughout the month of April 2016, but failed to provide the medical documentation necessary to support Dr. Grear's off-work designation.

The Commission views the evidence slightly different than does the Arbitrator, and thus reverses the award for §19(l) penalties. The Commission notes that there was only one month separating Petitioner's initial demand for workers' compensation benefits and the date that Respondent made substantial payment. The Commission finds that this does not constitute unreasonable conduct on the part of Respondent, especially when coupled with the fact that Petitioner failed to provide the necessary medical documentation to support Petitioner's off-work designation.

The Commission hereby reverses the Arbitrator's award of §19(l) penalties.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent is not liable to Petitioner for §19(l) penalties.

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.

DEC 18 2017

DATED:
O: 10/19/17
DLG/wde
45

David L. Gore

Stephen Mathis

Elizabeth E. Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

CARLSON, SCOTT P
Employee/Petitioner

Case# **16WC010184**

NEW ENGLAND MOTOR FREIGHT INC
TRUMBULL INSURANCE COMPANY
Employer/Respondent

17IWCC0814

On 3/21/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.89% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1876 CZAPLA LAW
EDWARD ADAM CZAPLA
1821 WALDEN OFFICE SQ #400
SCHAUMBURG, IL 60173

0560 WIEDNER & McAULIFFE LTD
KENDRA GARSTKA
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION
19(b)

SCOTT P. CARLSON
Employee/Petitioner

v.

NEW ENGLAND MOTOR FREIGHT, INC.; TRUMBALL INSURANCE COMPANY.
Employer/Respondent

Case # **16** WC **10184**

Consolidated cases: _____

17IWCC0814

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. S**, Arbitrator of the Commission, in the city of **Chicago**, on **May 13, 2016 and June 8, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **February 17, 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 Respondents.

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 Respondents.

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

In the year preceding the injury, Petitioner earned **$27,549.56**; the average weekly wage was **$888.70**.

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

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

Respondent shall be given a credit of **$2,965.25** for TTD, **$-0-** for TPD, **$-0-** for maintenance, and **$-0-** for other benefits, for a total credit of **$2,965.25**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$592.47**/week for **10-6/7** weeks, commencing March 25, 2016 through June 8, 2016, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of **$782.42** for light duty work from February 27, 2016 through March 24, 2016, per Section 8(a) of the Act.

Respondent shall pay for medical expenses Petitioner incurred through June 8, 2016, per Section 8.2 of the Act, the Medical Fee Schedule.

Respondent shall authorize and pay for the Aqua therapy ordered by Dr. Grear.

Because Respondent failed to respond in writing to the Petitioner's demands for benefits within the 14 days prescribed by the Act explaining the basis for denying benefits, Respondent shall pay penalties pursuant to Section 19(l) in the amount of **$3,180.00** for Respondents' delay in payment of temporary partial disability benefits and **$2,880.00** for Respondent's delay in payment of temporary total disability benefits.

Petitioner is not entitled to penalties or attorneys' fees per Sections 19(k) or 16 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.

Deborah L. Simpson

Signature of Arbitrator

September 30, 2016
Date

MAR 21 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Scott P. Carlson,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 16 WC 10184**
	)	
New England Motor Freight, Inc., Trumbull Insurance Co.,	)	
	)	
Respondent.	)	
	)	**17IWCC0814**

CORRECTED FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on February 17, 2016, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They further agree that on that date the Petitioner sustained accidental injuries that arose out of and in the course of the employment and that the Petitioner gave the Respondent notice of the accident within the time limits stated in the Act. They agree that in the year preceding the injuries, the Petitioner earned $30,543.22.

At issue in this hearing is as follows: (1) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (2) What is the Petitioner's average weekly wage calculated pursuant to Section 10 of the Act; (3) 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; (4) Is Petitioner entitled to TTD from March 25, 2016 through May 13, 2016; (5) Is Respondent entitled to credit for payments previously made; (6) Is the Petitioner entitled to penalties and attorney's fees; and (7) Is the Petitioner entitled to prospective medical treatment.

STATEMENT OF FACTS

The Petitioner has been employed as a truck driver since 1988; he worked for JB Hunt for six years prior to becoming employed by the Respondent in July of 2015. The Petitioner testified that he was hired as a local driver for the Respondent, driving a semi, picking up and delivering freight at various locations. Petitioner has a CDL, and is required to pass a physical examination every two years in order to keep his license. He stated that he passed his last physical examination before the accident.

Petitioner testified that his job involved driving a truck, opening trailer and dock doors, lifting dock plates, operating a fork lift, a manual pallet jack and unloading freight by hand.

Petitioner stated that he handled a variety of materials including household goods, hazardous materials, 55 gallon drums, skidded material, crated material and airport freight. Although there was no limit on the weight, Petitioner guessed that the heaviest material he handled weighed about one hundred fifty pounds. Petitioner testified that it was a physically demanding job that required lifting, carrying, stacking, pushing or pulling freight 50 percent of the time and driving the other 50 percent of the time. He stated that he drove about forty-five miles per day. Petitioner was working full-duty/full-time at the time of his injury.

According to the Petitioner, overtime was mandatory in his position. He explained that if your time was up for the day, and you were in the middle of a delivery you could not stop and return to the company, you have to finish making the deliveries. Petitioner testified that overtime is anything over eight hours a day. The Petitioner stated that they punch in and out on a time clock.

Petitioner testified that prior to the fall on February 17, 2016 he had not had any medical treatment for or injuries to his left leg, groin, hip or low back. He did not have any work restrictions prior to the accident either. Petitioner also denied sustaining any injuries to his left hip, leg, groin or low back after the fall on February 17, 2016.

Petitioner was injured on February 17, 2016 while making a delivery in Schiller Park or Franklin Park. Petitioner had completed the delivery and had pulled out of the dock and across the street into a parking lot where he planned to take his lunch break. He had been unable to close the back doors of the trailer when he was in the dock so he got out of his truck before eating his lunch. He was walking alongside the trailer to close the doors when he slipped and fell on ice. Petitioner's left foot slipped on the ice and petitioner caught himself against the trailer. Petitioner testified that when he "started walking again, my feet came right out from underneath me, and I fell back and landed on my hip." He stated that this occurred around five or six p.m.

The Petitioner got up from the ground and closed the doors to the trailer and took his half-hour lunch break in the tractor. Petitioner reported the injury to Nick Straneland, the dispatcher/supervisor at the Elk Grove terminal.

Petitioner continued working until February 24, 2016 when he advised the, head terminal manager, Dave that he was unable to work due to the pain from the injury he sustained on February 17, 2016, and he needed to see a doctor. Respondent had Petitioner fill out an accident report and sent him to Concentra for medical treatment. On that day Petitioner was seen at the Occupational Health Center complaining of shooting pain in his left hip and groin. The history recorded states "This is the result of slip and fall and walking outside at a delivery and slipped on ice and left scissors kick to the left side and slipped again and fell towards his left side and landed on his left buttock/hip area". (PX 1) Petitioner's symptoms were located in the left lateral hip, left groin, left buttock and left posterior hip. (PX 1) The pain radiated to the left buttock with left hip stiffness. (PX 1) Petitioner described the level of pain at 8/10.

Petitioner was diagnosed with a contusion/sprain of the left hip and prescribed Cyclobenzaprine, Metaxalone and Methylprednisolone and physical therapy. (PX 1) X-rays of

the left hip were ordered along with physical therapy. Petitioner was issued work restrictions of a 20 pound limit for lifting constantly and push/pull constantly; he could bend occasionally, no driving company vehicle, change positions periodically and no squatting, kneeling or climbing ladders.

According to the Petitioner, the Respondent did accommodate his light duty restrictions. They had him shredding papers, sorting and filing. They also put him to work on the dock measuring skids for billing customers. He did cleaning and any odd jobs that they could find for him. They changed his pay rate to $16.05 per hour.

On February 25, 2016 Petitioner completed a physical therapy evaluation at the Occupational Health Center. (PX 1) Petitioner completed six physical therapy sessions in March along with at home exercises. (PX 1) The physical therapy was discontinued on March 24, 2016. (PX 1)

Petitioner was re-examined by Dr. Weaver on March 11, 2016 and reported his symptoms were improving with medications. (PX 1) Dr. Weaver continued Petitioner's work restrictions and medications and ordered an MRI of the left hip. (PX 1)

Petitioner was seen by Dr. Weaver on March 24, 2016 complaining of left lateral hip pain, radiating anteriorly. Petitioner described the symptoms as "constant" and "sharp". (PX 1) Petitioner reported a pain level of 6/10 that radiates to the left groin. (PX 1) Petitioner's work restrictions were continued and he was prescribed additional medications for pain. Petitioner was referred to Dr. Suchy for an orthopedic consultation. (PX 1)

On March 25, 2016 petitioner saw Dr. Michael Grear complaining of left hip and groin pain. (PX 2). The history reported states: "This overweight 49-year old truck driver on 2/17/16 while walking to his truck slipped and fell sustaining a contusion to the left buttocks and pain to his left groin." (PX 2) Examination revealed slight antalgic gait with localized discomfort in the left groin anteriorly, internal and external rotation elicited discomfort in the left groin at 45°. (PX 2) Petitioner was diagnosed with capsulitis left hip with possible labral tear left acetabulum. (PX 2) Dr. Grear restricted Petitioner from all work activity, recommended an MRI of the left hip and prescribed Relafen for the left hip pain. (PX 2)

Petitioner saw Dr. Theodore Suchy at United States Medical Group of Illinois on March 29, 2016. Petitioner was complaining of pain in the left groin and buttock area. He initially was referred to Dr. Suchy by Dr. Weaver; however he saw his own orthopedic surgeon Dr. Grear, who treated petitioner in the past, on March 25, 2016. Petitioner did not specify the nature of the prior treatment from Dr. Grear for himself; however on cross examination he stated that his wife had knee surgery with Dr. Grear. Petitioner denied a prior history of hip pain. On physical examination, Dr. Suchy noted Petitioner was 6 feet tall and 395 pounds. He has a positive Faber test, and examination of his left hip revealed restrictions of range of motion in all planes. X-rays of the left hip demonstrated degenerative changes with loss of articular cartilage, osteophyte formation. Dr. Suchy's impression was left [wrist] (assuming this is a typographical error and he meant hip) strain with exacerbation of preexisting osteoarthritis. Dr. Suchy ordered a MRI to determine if there were any acute problems. Dr. Suchy opined this was a temporary

exacerbation of his preexisting arthritis, and Petitioner's substantial morbid obesity was a contributing factor. Dr. Suchy opined that Petitioner should continue to follow up with Dr. Grear. (PX 1)

The MRI of the left hip completed on March 29, 2016 revealed: (1) no acute fracture, dislocation or destructive process (2) no discrete soft tissue mass or intramuscular lesion and (3) degenerative changes in the lumbosacral spine. (PX 2).

Dr. Grear re-examined Petitioner on April 8, 2016 and noted intermittent discomfort and pain in the left groin, point tenderness over the left pubic rami and limited range of motion in the left hip. Dr. Grear also noted that the MRI did not demonstrate significant pathologic changes of the hip or pelvis. (PX 2) Dr. Grear continued to restrict Petitioner from all work activity and prescribed Relafen, Flexeril and Norco. (PX 2).

Petitioner testified at the hearing that in April he just experienced hip and groin pain; he did not experience any back pain.

The Petitioner's last follow-up appointment with Dr. Grear appears to have been on May 5, 2016. The chief complaint on that visit was abductor tendinitis of the left hip. Petitioner complained of moderate discomfort and pain that persisted in the groin of his left hip. A pelvic x-ray demonstrated a highly questionable stress fracture of the superior and inferior pubic rami on the left with no evidence of any healing. It noted the callus technique was compromised by his obesity. Dr. Grear noted that the previous MRI suggested the possibility of a stress fracture of the left pubic rami but was not confirmed by plain films and that objectively, Petitioner had pain at the extremes of rotation and ambulated with a slight antalgic gait. The assessment was hip joint pain. Dr. Grear recommended physical therapy, including aquatic exercises. Dr. Grear also referred Petitioner to Dr. Berger at Rush for an evaluation. He continued the Petitioner's off work status until his next appointment, which was unspecified. (PX 2)

Petitioner stated that he wishes to have a follow-up appointment with Dr. Richard Berger at Rush however he is unable to attend that appointment without approval from workers' compensation. He testified further that Dr. Berger does not do worker's compensation cases anymore. Petitioner testified that he continued to be restricted and if approved, he would like to attend the additional physical therapy recommended by Dr. Grear.

Petitioner described his current issues as limping, discomfort in his hip and groin. Petitioner stated if he walked around a lot he would experience pain in his hip and groin. Petitioner also stated he could not sleep through the night as he would sleep on his side. Petitioner also stated that he has trouble driving, he took the train to the hearing the morning of May 13. He stated that he sits around the house with a heating pad doing nothing all day.

Petitioner also testified that he was experiencing financial difficulties since sustaining the work injury.

Petitioner offered exhibits five through nine which were copies of his checks for the time periods ending February 27, 2016, March 5, 2016, March 12, 2016, March 19, 2016, which were for his light duty work, and March 26, 2016 which included vacation pay with the light duty pay. March 22, 2016 was actually the last day he worked light duty, he saw Dr. Grear on March 25,

2016 who took him off of work completely at that visit. The Petitioner testified that he did not receive any worker's compensation benefits when he was working light duty with respect to the difference in pay from light duty to his regular pay, or after he had been taken off of work completely. He stated that he hired his attorney when he did not get TTD benefits from his employer. He admitted on cross-examination, that he did not tender copies of the medical records with the off work slips that he tendered to his employer, to the insurance company. Petitioner testified that he did receive a check on May 1, 2016, in the amount of $2,965.25.

Prior to proceeding to hearing on May 13, 2016, the Respondent requested a continuance arguing that they had not been provided with any treating medical records supporting Petitioner's claim for temporary total disability benefits. Respondent's attorney advised that if they were provided with the treating records, she would direct their client to issue benefits. Respondent indicated that they had not issued benefit checks to date as Petitioner had failed to provide evidence supporting his claim, namely medical treatment records, arguing that off-work notes without corresponding medical documentation are not sufficient to require Respondent to issue temporary total disability benefits. The Petitioner objected to any continuance. The Arbitrator denied the request for continuance but agreed to bifurcate the trial. The hearing was recessed until June 8, 2016, after the Petitioner's testimony to provide the Respondent time to prepare their response for presentation and obtain the witnesses necessary to support the position with respect to the denial of benefits. The Arbitrator suggested to Petitioner's attorney that he provide opposing counsel with his exhibits, including the medical documentation that he indicated he was prepared to offer at the hearing so that Respondent would have the necessary documentation to begin paying benefits.

On June 8, 2016, the parties appeared for hearing. The Respondent declined to call any witnesses. Exhibits for each party were offered and ruled upon and proofs were closed.

CONCLUSIONS OF LAW

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

Longstanding Illinois law mandates a claimant must show that the injury is due to a cause connected to the employment to establish it arose out of employment. *Elliot v. Industrial Commission*, 153 Ill. App. 3d 238, 242 (1987).

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

The burden of proving disablement and the right to temporary total disability benefits lies with the Petitioner who must show this entitlement by a preponderance of the evidence. *J.M. Jones Co. v. Industrial Commission*,71 Ill.2d 368, 375 N.E.2d 1306 (1978)

In support of the Arbitrator's decision with regard to whether Petitioner's current condition of ill-being causally related to the injury, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Arbitrator finds that Petitioner proved that his current condition of ill-being as of June 8, 2016, is causally connected to the work injury. There is no dispute that Petitioner sustained an injury on February 17, 2016 arising out of and in the course of his employment. Petitioner testified that he slipped and fell on ice landing on his left hip while walking from the cab of his truck to the back of the truck to close the trailer doors following a delivery. Petitioner's testimony was not contradicted. The medical records are consistent with Petitioner's testimony at trial.

Petitioner initially sought medical treatment a few days after the injury on February 24, 2016. Petitioner treated at Concentra Medical Center, the employer's clinic. He consistently reported left hip and groin pain as a result of his slip and fall. The medical records provided do not record an alternative source of pain. Nothing in the medical records suggests that Petitioner's complaints of pain are the result of an injury other than the work accident. Petitioner denied any injury prior to or after the accepted accidental injury sustained on February 17, 2016.

At the time of the hearing on June 8, 2016, the Arbitrator finds that the preponderance of the evidence demonstrates that Petitioner's current condition of ill being is causally connected to the work accident of February 17, 2016.

In support of the Arbitrator's decision with regard to what the Petitioner's average weekly wage was calculated pursuant to Section 10 of the Act, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Petitioner testified that he regularly worked overtime and that it was mandatory. According to the Petitioner he had to complete his deliveries, even if it meant that he worked longer than eight hours because you could not quit in the middle of a delivery to leave if you were close to your eight hours. That testimony was not contradicted, and was actually supported by Respondent's exhibit number 1 which shows that Petitioner worked overtime every one of the thirty one weeks that he was working for Respondent. Additionally there were numerous weeks where he worked slightly less than forty hours of regular time but was still paid overtime that week. The Arbitrator finds that overtime was mandatory, and that the overtime hours should be included in the Petitioner's salary, at the hourly rate, not at the premium pay rate.

Between July 20, 2015 and January 3, 2016, the Petitioner worked a total of 952.7 hours of regular time at the rate of $18.25 per hour totaling $17,386.77. During that same time period he worked a total of 231.85 hours of overtime. Calculating his wages at the straight time rate of

$18.25 per hour the Petitioner earned a total of $4,231.26 for his overtime hours, giving him a total of $21,618.03, for that time period. (RX 1)

Petitioner's hourly rate was raised to $18.88 per hour beginning with the pay check that he received covering January 4, 2016 to January 10, 2016. Between January 4, 2016 and February 21, 2016, the Petitioner worked a total of 277.36 hours regular time, at the rate of $18.88 per hour his total salary was $5,236.56. During that time period he also worked a total of 36.81 hours of overtime, which at the straight time rate of $18.88 amounts to $694.97. During this time period the Petitioner earned a total of $5,931.53.

The Petitioner's total salary for regular and overtime worked, all at straight time rates, was $27,549.56. (RX 1). The total income divided by the 31 weeks that Petitioner worked for the Respondent before the injury amounts to an average weekly wage of $888.70; two- thirds of the average weekly wage amounts to a TTD rate of $592.47.

In support of the Arbitrator's decision with regard to whether the medical services provided to Petitioner were reasonable and necessary and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The parties stipulated that the Petitioner sustained injuries to his left hip and groin as a result of the February 17, 2016 fall at work. The Petitioner is entitled to medical treatment for those injuries. No challenge was raised regarding the reasonableness or the necessity of the medical treatment Petitioner received for the injuries he sustained in the accident at work. Having found that the current condition of ill-being of the Petitioner is causally related to the injuries sustained on February 17, 2016, the Respondent is liable for the reasonable and necessary costs of the medical treatment petitioner received. Based upon the medical records and bills admitted into evidence and the Petitioner's testimony the Arbitrator finds that Respondent shall pay Petitioner the reasonable and necessary medical expenses (PX 3 and 4) incurred in the care and treatment of petitioner's left hip/leg pursuant to the medical fee schedule and Section 8 and 8.2 of the Act. Respondent is entitled to a credit for all amounts previously paid.

In support of the Arbitrator's decision with regard to what temporary benefits are in dispute, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

On March 25, 2016, Dr. Grear took Petitioner off of work entirely. As of the date of the hearing, Dr. Grear has not released Petitioner to return to work. Therefore, Petitioner is entitled to temporary total disability benefits during the time period from March 25, 2016 through June 8, 2016, at a rate of $592.47 per week for a period of 10-6/7 weeks. Respondent is given credit for

all benefits paid. Petitioner is not entitled to collect temporary total disability benefits for the same time period more than once.

Petitioner initially treated at Concentra Medical Center and was given light duty restrictions from February 27, 2016 through March 19, 2016. Respondent was able to accommodate the restrictions of no lifting more than 20 pounds. While working light duty, Petitioner earned a lesser rate of pay at $16.05 per hour. As such Petitioner is entitled to two-thirds the difference of his average weekly wage of $888.70 and what he earned while working light duty. Pursuant to Section 8(a) of the Act Petitioner is entitled to temporary partial disability benefits as follows:

The Arbitrator calculates Petitioner's temporary partial disability benefit as follows:

The pay check from 2/27/2016, totaled $789.26, which included $90.25 overtime and $151.04 personal. Petitioner is entitled to an additional $66.27. (PX 5) On 3/5/2016 Petitioner received $642.00, leaving a difference of $164.45. (PX 6) On 3/12/2016 the Petitioner was paid $637.99, leaving a difference of $167.12 (PX 7) and on 3/19/2016, the Petitioner was paid $353.42, leaving a balance of $356.83. (PX 8) On 3/26/2016 the Petitioner was paid $712.12, which included $453.12, in vacation pay for three days at his regular rate of pay of $18.88 per hour. (PX 9) $880.70 minus the vacation pay of $453.12, leaves a balance for the week of $437.62 times two-thirds is $291.74, Petitioner was paid $264.00 leaving a balance of $27.75.

Petitioner is entitled to an additional $782.42 in TPD benefits.

In support of the Arbitrator's decision with regard to whether the Petitioner is entitled to prospective medical treatment, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Arbitrator finds that Petitioner's medical treatment through the date of hearing was reasonable and necessary. Petitioner initially sought treatment at Concentra Medical Center in Elk Grove, where he was referred by his employer. Dr. Weaver examined Petitioner and prescribed therapy on February 24, 2016. Thereafter, Petitioner began a course of physical therapy and continued to follow up with Dr. Weaver. Dr. Weaver referred Petitioner to Dr. Suchy for an orthopedic evaluation. Petitioner also sought treatment with Dr. Grear, an orthopedic physician of his choice. Dr. Grear evaluated Petitioner, ordered a MRI and prescribed physical therapy, include aquatic therapy.

There is no indication in the medical records that Petitioner's treatment was unreasonable or unnecessary. Respondent did not provide any evidence disputing Petitioner's treatment through the date of the hearing. As such, Respondent is ordered to pay the medical expenses per the fee schedule.

In support of the Arbitrator's decision with regard to the whether penalties and fees be imposed upon Respondent, Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

In support of the Arbitrator's decision with regard to whether Respondent is entitled to credit for payments already made, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

On February 24, 2016 Petitioner was issued light duty work restrictions. Respondent accommodated Petitioner's work restrictions but decreased his hourly compensation while working light duty from February 24, 2016 through March 22, 2016.

Copies of Petitioner's payroll checks were sent to Respondent requesting Petitioner's temporary partial disability benefits (PX 13 & 14). Respondent failed to respond to the request for benefits or issue Petitioner's temporary partial disability benefits. Consequently, Petitioner filed a petition for penalties and fees on April 19, 2016.

Thereafter, Petitioner continued to demand Petitioner's temporary partial disability benefits. (PX 15 - 22). Respondent failed to issue Petitioner's temporary partial disability benefits.

Respondent also failed to issue Petitioner his temporary total disability benefits despite Petitioner's repeated request for the outstanding benefits. (PX 11, 12, 15 - 22). Respondent continued to deny payment of Petitioner's temporary total disability benefits in the absence of any medical opinion supporting the denial of benefits.

Respondent's attorney argued that the Petitioner did not send any medical documents supporting the recommended treatment and the light duty restrictions and eventual totally off of work restrictions. No letters or documents responding to the Petitioner's multiple requests for benefits indicating that additional paperwork was needed were offered or admitted by Respondent. No requests for evaluation pursuant to Section 12 of the Act were offered either. No testimony was provided indicating that these documents were requested from the Petitioner either. The record is devoid of any evidence explaining or providing a reasonable explanation for the Respondent's lack of action. However, the letters requesting benefits which were sent by the Petitioner appear to be the off work slips with no medical records and bills with no explanation for what the injury was that was being treated.

Pursuant to Section 19(l) "If an employee has made a written demand for payment of benefits under Section 8(a) or 8(b) the employer shall have 14 days from the date 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 payment of benefits under Section 8(a)... The Arbitrator or Commission shall allow to the employee additional compensation in the sum of $30 per day for each day that the benefits under Section 8(a) have been so withheld or refused, not to exceed $10,000.00". Pursuant to Section 19(l) "A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable

delay." 826 ILCS 305/19(l). Respondent has denied Petitioner his temporary partial disability benefits since February 24, 2016. Respondent failed to respond in writing within 14 days the reasons for the denial, therefore, Petitioner is entitled to 19(l) penalties of **$3,180.00** for Respondents' delay in payment of temporary partial disability benefits. (2/24/16 – 6/8/16 = 106 days x $30 = $3,180.00)

Petitioner is also entitled to 19(l) penalties for respondent's delay in issuing temporary total disability benefits for the period March 25, 2016 through the 19(b) hearing on June 8, 2016. Again the Respondent failed to respond in writing within fourteen days of the written demand the reasons for the denial, therefore, Petitioner is entitled to 19(l) penalties of **$2,880.00** for Respondent's delay in payment of temporary total disability benefits. (3/25/16 – 6/8/16 = 76 days x $30 = $2,880.00)

Petitioner argues that Respondent has unreasonably and vexatiously refused to issue Petitioner's temporary partial and temporary total disability benefits in the absence of any medical opinion in support of the denial of benefits, in violation of §19(k) *McMahan v. Industrial Commission, et al.*, Ill.Sup.Ct. Docket No. 84057, 183 Ill.2d 499, 702 N.E.2d 545, 234 Ill.Dec. 205 (1998). The documentation that Petitioner offered in support of this petition clearly includes requests for payments and off work slips, however there is no information informing the Respondent of the medical basis or reason for taking the Petitioner off of work. The Arbitrator finds that given the incomplete information Petitioner provided to the Respondent the actions of the Respondent cannot be found to be unreasonable and vexatious. Penalties pursuant to Section 19(k) and Section 16 of the Act are denied.

ORDER OF THE ARBITRATOR

Respondent shall pay Petitioner temporary total disability benefits of **$592.47**/week for **10-6/7** weeks, commencing March 25, 2016 through June 8, 2016, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of **$782.42** for light duty work from February 27, 2016 through March 24, 2016, per Section 8(a) of the Act.

Respondent shall pay for medical expenses Petitioner incurred through June 8, 2016, per Section 8.2 of the Act, the Medical Fee Schedule.

Respondent shall authorize and pay for the Aqua therapy ordered by Dr. Grear.

Because Respondent failed to respond in writing to the Petitioner's demands for benefits within the 14 days prescribed by the Act explaining the basis for denying benefits, Respondent shall pay penalties pursuant to Section 19(l) in the amount of **$3,180.00** for Respondents' delay in payment of temporary partial disability benefits and **$2,880.00** for Respondent's delay in payment of temporary total disability benefits.

Petitioner is not entitled to penalties or attorneys' fees per Sections 19(k) or 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.

Signature of Arbitrator

September 30, 2016
Date

STATE OF ILLINOIS	)	☒ Affirm and adopt	☐ 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

Eunice Cummings,
Petitioner,

vs.

17IWCC0815

NO: 11 WC 35602

Champaign School District #4,
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 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 11, 2017 is hereby affirmed and adopted.

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

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

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: DEC 19 2017
KWL/vf
O-11/21/17
42

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0815

CUMMINGS, EUNICE
Employee/Petitioner

Case# **11WC035602**

09WC003765
13WC016262

CHAMPAIGN SCHOOL DISTRICT #4
Employer/Respondent

On 5/11/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 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
MICHAEL BRANDOW
3100 N KNOXVILLE AVE
PEORIA, IL 61603

0522 THOMAS MAMER & HAUGHEY LLC
EROC CHOVANEC
30 E MAIN ST SUITE 500
CHAMPAIGN, IL 61824

STATE OF ILLINOIS)

)SS.

COUNTY OF CHAMPAIGN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 17IWCC0815

Eunice Cummings
Employee/Petitioner

v.

Champaign School District # 4
Employer/Respondent

Case # 11WC 35602

Consolidated cases: 09 WC 3765 & 13 WC 16262

An *Application for Adjustment 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 **Nancy Lindsay** of the Commission, in the city of **Urbana** on **March 9, 2017.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **3/31/09**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$19,689.64**; the average weekly wage was **$410.20**.

On the date of accident, Petitioner was **59** years of age, ***single*** with **no** dependent children.

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

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

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and $0.00 for other benefits, for a total credit of $0.

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

ORDER

PETITIONER FAILED TO PROVE THAT HER CURRENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO HER ACCIDENT OF MARCH 31, 2009. PETITIONER SUSTAINED, AT MOST, AN INJURY TO HER RIGHT ANKLE, BUT FAILED TO PROVE ONGOING CAUSATION FOR THAT CONDITION AFTER APRIL 30, 2009.

RESPONDENT SHALL PAY PETITIONER REASONABLE AND NECESSARY MEDICAL EXPENSES IN THE AMOUNT OF **$190.00** SUBJECT TO THE MEDICAL FEE SCHEDULE, AS PROVIDED IN SECTIONS 8(A) AND 8.2 OF THE ACT.

RESPONDENT SHALL PAY PETITIONER PERMANENT PARTIAL DISABILITY BENEFITS OF **$246.12/WEEK** FOR **4.175 WEEKS**, BECAUSE THE INJURIES SUSTAINED CAUSED **2.5% LOSS OF THE RIGHT FOOT**, AS PROVIDED IN SECTION 8(E) OF THE ACT.

RESPONDENT SHALL PAY PETITIONER COMPENSATION THAT HAS ACCRUED BETWEEN **MARCH 31, 2009** AND **MARCH 9, 2017** AND SHALL PAY THE REMAINDER OF THE AWARD, IF ANY, IN WEEKLY INSTALLMENTS.

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

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

Nancy Lindsay
Signature of Arbitrator

May 7, 2017
Date

Eunice Cummings v. Champaign School District #4, 11 WC 035602

Petitioner has three claims on file against Respondent. All three cases were consolidated for purposes of the arbitration hearing; however, the parties understood that separate decisions would issue.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

The triage records from Provena Emergency Room dated September 9, 2008 indicate that Petitioner was there due to a fall. The medical records further indicate that she was not examined on that date as she had another appointment. (PX 11)

On September 11, 2008, Petitioner returned to the emergency room at Provena Covenant Medical Center reporting that she had fallen down four steps the day before and landed on her right side. She noticed pain in her lumbar back into the sacral area. She further complained of right ankle pain and right shoulder pain. X-rays were taken of her right wrist, right shoulder and right ankle. No fracture or dislocation was seen. It was noted that the findings from the right ankle indicated plantar spur calcis and generalized soft tissue swelling. She was advised she could return to work the next day. (PX 11)

Petitioner followed up with her primary care doctor, Dr. Raman, on September 29, 2008, reporting she had fallen down on the staircase about four steps (at work) and hurt her right foot and lower back. She described the pain in both places as "intense." The physical examination indicated all movement of Petitioner's right ankle was painful. Petitioner further had bilateral paraspinal muscle tenderness in the lumbar region, right greater than left. The straight leg raising test was negative. Dr. Raman's assessment was low back pain and right foot swelling and pain. Petitioner was referred to Dr. Muscatella for further evaluation of her right foot and to Carle Spine Institute for the low back pain. (PX 7)

On October 1, 2008, Petitioner was examined by Dr. Muscatella. Petitioner gave a history of "trip[ping] and [falling] down 4 steps at work" to Dr. Muscatella regarding the accident. The doctor noted that Petitioner had been taken off work since Monday, September 29, 2008 by Dr. Raman. An examination took place with the assessment being Grade I ankle sprain, on the right. The treatment plan was to place her in a cam walker, limit her activity, continue her on Tramadol and place her off work for a week. Petitioner was to follow up with the doctor in a week. (PX 4)

On October 8, 2008, Petitioner followed up with Dr. Muscatella. She indicated that if she wore the cam walker, she felt good. Without it, she noticed pain especially going up and down stairs. The physical examination indicated that she was tender over the anterior talofib ligament. The right ankle edema had decreased. She had good range of motion and she was tender with aversion but no tenderness with dorsiflexion or plantar flexion. The treatment plan was to continue the cam walker and place Petitioner in physical therapy. Petitioner was released to light duty. (PX 4)

As of October 20, 2008 Dr. Muscatella noted that Petitioner was doing well but still had not begun physical therapy. (PX 4)

Petitioner returned to see Dr. Raman on November 3, 2008 for follow up regarding her medical problems and to discuss blood work. She reported "doing fine" and had no particular complaints. No mention of her ankle or low back was otherwise made. (PX 7)

On November 19, 2008, Petitioner had a follow-up appointment with Dr. Muscatella at which time she reported that her ankle was worse and physical therapy was not helping. Petitioner was tender along the lateral aspect of her right ankle and had pain along the baronial tendons and she also had pain with inversion. She was directed to finish out physical therapy and she was told to limit her activities and to stay off work. (PX 4)

On December 4, 2008, Petitioner returned to see Dr. Muscatella as she had finished her therapy. She indicated that she was still having some pain but it was better. On examination Petitioner indicated pain on palpation of the anterior talofib ligament of the right ankle. She was still tender with inversion. The doctor applied a taping and padding to the foot and told Petitioner to return in one week. (PX 4)

When Petitioner returned to see Dr. Muscatella on December 11, 2008, she still had some swelling she attributed to being on her feet but she was, otherwise, doing okay. Dr. Muscatella ordered a pair of diabetic orthotics to stabilize her foot and to prevent excessive pronation and to prevent recurrent ankle sprains. Petitioner was provided a taping and padding to wear in the interim. (PX 4)

On January 5, 2009, Petitioner returned to Dr. Muscatella's office for dispensing of the diabetic orthotics. (PX 4)

On January 20, 2009, Petitioner followed up with Dr. Muscatella reporting that she was still having pain in the right ankle, which was aggravated by activity. The examination indicated tenderness over the lateral aspect of the right ankle and pain with inversion. He prescribed Relafen to take as directed. They discussed the etiology of her symptoms. (PX 4)

Petitioner's Application for Adjustment of Claim in case # 09 WC 03765 was filed on January 28, 2009. She alleged injuries to her right foot and leg when she "fell down wet [crossed out] stairs on September 9, 2008. (PX 1)

On February 3, 2009, Dr. Muscatella re-examined Petitioner who was still having pain especially with increased activity and stairs. The assessment was a chronic right ankle sprain. They discussed the possibility of a corticosteroid injection in which Petitioner deferred upon. She was placed on Indocin SR for one week. (PX 4)

When Petitioner returned to see Dr. Muscatella on February 23, 2009, she indicated she was ready for an injection. It was provided and she was told to return in two weeks. (PX 4)

When Petitioner returned to see the doctor on March 9, 2009, she indicated that she had good relief from the injection. The assessment at this point was diabetes mellitus with diabetic peripheral neuropathy, hypertrophy, chronic ankle sprain with possible capsulitis and synovitis of the ankle with a possible tear of the anterior talofib ligament. The doctor recommended an MRI of the right ankle at that time. (PX 4)

Petitioner underwent a right ankle MRI on March 10, 2009 due to "pain related to a fall at work 9/08" The radiologist's impression was mild peroneal brevis and longus tendinopathy without tearing, mild stress reaction in the proximal fourth metatarsal and a normal anterior talofibular ligament. (PX 4)

Petitioner failed to keep her appointment with Dr. Muscatella scheduled for March 16, 2009. (PX 4)

Petitioner called Dr. Muscatella's office on March 18, 2009 reporting she was going on a trip and wanted a refill on her Tramadol. (PX 4)

Petitioner was seen at Provena Covenant Medical Center on March 31, 2009 reporting that she was going to sit down at work and the chair broke when she sat on it. Her right knee, right shoulder and lower back all hurt. She was diagnosed with contusions of the hip, shoulder, and ankle. It was noted that she had fallen down steps at school in September and hurt her ankle. Petitioner was discharged with instructions and prescriptions. (PX 10)

On April 8, 2009, Dr. Muscatella reviewed Petitioner's right ankle MRI and indicated that there were no signs of ligament rupture. Petitioner reported feeling better and was at work the week before when a chair broke and she fell back landing on her foot and right ankle. She reported it was now tender "again" and stairs were reportedly difficult. On exam, Petitioner displayed no edema but was tender over the anterior talofib ligament again. The assessment was that she had re-injured the ankle following the second fall at work. The treatment plan was for her to go back into the 3D walker, limit her activity and he gave her a prescription for Tramadol. (PX 4)

Petitioner saw Dr. Muscatella again for her right ankle on April 16, 2009. She still was tender and had minimal edema. She was asked to wear a boot for two more weeks. (PX 4)

Petitioner saw her family doctor, Dr. Raman on April 21, 2009 regarding blurring vision and painful red eyes. If was felt she might have conjunctivitis or cataracts or glaucoma. Eye drops were dispensed and an appointment with an eye doctor made. (PX 7)

On April 30, 2009, at her re-check visit with Dr. Muscatella, Petitioner indicated that she was wearing the cam walker. She stated she did not have any pain while using the cam walker. Objectively, she had minimal pain on palpation of the interior talofib ligament but there was still minimal edema. She was told to transition back to her shoe gear and to return as needed. (PX 4)

Petitioner saw Dr. Raman on May 1, 2009 regarding a sore throat. (PX 7)

Petitioner underwent cataract surgery on June 22, 2009. In her pre-op exam with Dr. Raman she had no complaints otherwise and was doing fine. (PX 7)

Dr. Muscatella's medical records indicate that he received a phone call from Petitioner on June 30, 2009 requesting a refill for the Tramadol. (PX 4)

On September 10, 2009, Petitioner called Dr. Muscatella's office stating that she was having problems with her ankle and she wanted an evaluation. (PX 4)

Petitioner came in and saw Dr. Muscatella on September 17, 2009. The medical records indicate that she was still having pain in her ankle and it was swollen. She was taking Tramadol but she did not like it. The assessment was right ankle pain secondary to previous sprain. Dr. Muscatella recommended a diagnostic and surgical arthroscopy of her ankle due to the continued pain and swelling. Petitioner did not want surgery at that time. (PX 4)

The next time that Petitioner saw Dr. Muscatella was on October 13, 2009. She indicated that she was having quite a bit of pain, especially with stairs. She had pain on palpation of the lateral aspect of the right ankle pain with conversion and eversion. The assessment was capsulitis, synovitis of the right ankle joint. They discussed the treatment and concluded that since she had exhausted all conservative treatment that she would undergo the arthroscopy that was previously recommended. (PX 4)

Dr. Raman examined Petitioner on October 23, 2009 for a variety of her ongoing health issues as well as a pre-op visit before ankle surgery. No back complaints were noted. Pre-op clearance form her cardiologist was needed. (PX 7)

On November 13, 2009, Petitioner underwent a diagnostic and surgical arthroscopy of the right ankle at Provena Covenant under general anesthesia. Dr. Muscatella's History and Physical noted that she had chronic synovitis with chronic ankle pain post previous right ankle sprain. Petitioner was prescribed Vicodin following the surgery. (PX 4; PX 11)

On November 25, 2009, Petitioner was referred for physical therapy. She was doing well with no pain or problems. (PX 4; PX 10)

When Petitioner went to see Dr. Muscatella on December 9, 2009, she indicated that she still had some discomfort but she was anxious to get back to work. Minimal pain with range of motion and minimal edema was noted. The treatment was to continue physical therapy and use of a cam walker. She was released to return to work light duty as long as she wore the cam walker. (PX 4)

On December 23, 2009 Dr. Muscatella re-examined Petitioner noting she was doing well with good improvement and no pain with stairs. (PX 4)

Petitioner did not show up for her January 4th appointment with Dr. Muscatella. (PX 4)

Petitioner was discharged from therapy for her ankle on January 18, 2010. She had improved in strength and flexibility and range of motion. Prolonged walking was still painful. She was still wearing the cam walker boot. (PX 10)

Petitioner was seen by Dr. Raman on January 18, 2010. Her complaints included right hand tingling and numbness along with left foot tingling and numbness. It was "paralyzing" and made her stop what she was doing. Petitioner mentioned seeing a neurologist. Lab work was ordered. (PX 7)

On January 25, 2010, Petitioner returned to Dr. Muscatella stating she was still having pain along the lateral aspect of her ankle but she believed that she was doing well with therapy. She was tender over the lateral incision on the ankle and there was induration consistent with scar tissue. She was given an injection with Decadron and Kenalog and Lidocaine. (PX 4)

At the request of Respondent, a records review was prepared by Dr. Vinci on February 4, 2010. His report is limited to the accident date of September 9, 2008. He stated that after his review of the medical records, it was his opinion that all of Petitioner's problems were subjective in nature and there was very little clinical abnormalities to support the recommendation of the surgical arthroscopy. He did not dispute that Petitioner's accident occurred but a lengthy amount of time had transpired since then. He further did not believe that the surgery would benefit her at all. Therefore, he felt it was unwarranted. (RX 1)

On February 10, 2010, Petitioner saw Dr. Muscatella and she reported she was doing well and had a great relief of symptoms. Petitioner requested a refill of the Tramadol. She also reported that she was doing better with her diabetes and neuropathy. Objectively, the examination showed no pain on palpation or range of motion. She still had minimal edema. She was released from Dr. Muscatella's care and was told to return as needed and to resume her normal activities. (PX 4)

Dr. Raman examined Petitioner on February 19, 2010. Petitioner's complaints included weakness in both her legs and a sensation of numbness in her arms and legs. A history of heart problems was noted and discussed. A possible transient ischemic attack was noted. She was advised to go to the emergency room immediately if it happened again. (PX 7)

An MRI of Petitioner's lumbar spine was ordered by Dr. Wang and took place on March 11, 2010 at Provena. The radiologist's impression was desiccation of discs, some degenerative changes at L4-5 and L5-S1 in the facet joints, slight narrowing of the intervertebral neural foramina at L5-S1. (PX 9)

On May 11, 2010 Petitioner returned to see Dr. Raman in follow up on a variety of medical problems. However, she specifically mentioned pain in her whole right leg and lower back. He planned to refer her to Dr. Kohlmann for her back. (PX 7)

Dr. Kohlmann saw Petitioner on a referral from her primary care doctor, Dr. Raman, on May 19, 2010. Petitioner reported having right leg pain two to three months earlier but it had been noticed most recently in the past three months or so. She described it as going through the

buttock on her right side, down the lateral thigh, and into the lateral calf and ankle. It had been "very, very bad." Petitioner's pertinent history included back surgery in 2003 or 2004 for a herniated disc at L5-S1 on the right side and she had done well after that. Petitioner reported falling at work and hurting her right ankle and having surgery but she was now a lot better but still had the pain down her leg that had been ongoing for three months. Dr. Kohlmann wrote: "The patient told me but I did not write it and I do not remember it just a few minutes after I saw her if she did or did not have it immediately after the fall." Her current complaint was leg pain although there was some back pain. Dr. Kohlmann noted that Petitioner could stand and walk fairly well but limped a little. Both of her feet had arches which became very depressed with collapse of the midfoot when she stood. He described it as being similar to tibialis posterior insufficiency in both feet. On examination of her back she lacked any significant spinal tenderness and there was no palpable deformity. Sitting straight leg raise testing was positive on the right and negative on the left. The doctor reviewed her lumbar spine MRI noting it showed a definite sub articular spinal stenosis at L4, L5 on the right side that is caused primarily by joint arthritis and a little bit of bulging discs, minimal but some similar stenosis at L4, L5 level. There was no spondylolisthesis. The L 5, S1 level did not show any significant changes. The radiologist was noted to have seen some degenerative changes at L4, L5 and L5, S1 and narrowing at L5, S1.

Overall, Dr. Kohlmann did not think there was a whole lot of findings. Dr. Kohlmann's impression was that Petitioner had some mild to moderate spinal stenosis at L4, L5 causing L5 radiculitis. Treatment options were discussed including a lumbar epidural steroid injection. They also discussed weight loss and how it could help her back, knees, diabetes, and hypertension. Petitioner expressed interest in weight loss surgery. She was to be referred for a lumbar epidural steroid injection. (PX 9)

Petitioner returned to see Dr. Raman on June 22, 2010 regarding her various medical problems. Her back and ankle were not mentioned in his notes. (PX 7)

Petitioner presented to the Millennium Pain Center on July 7, 2010 per the referral of Dr. Raman. Petitioner's chief complaint was of lower back pain with pain going down her right leg to her foot. She also mentioned her right arm and occasional numbness in her right hand. Petitioner told the doctor her pain had begun 8 -9 months earlier and she had gone to Dr. Wang 4-5 months earlier who put her on Tramadol. She had also been seen by Dr. Kohlmann three months earlier and he agreed with Dr. Wang that she had a bulging disc. Petitioner reported more leg pain than back pain. She had never previously undergone any injections. The doctor noted she was a teacher's assistant and off for the summer. Petitioner also referenced ankle pain in a "Follow Up Questionnaire" completed the same day. A caudal injection was recommended and that was given on July 15, 2010. (PX 8)

On August 3, 2010 Dr. Raman examined Petitioner concerning her peripheral neuropathy secondary to diabetes and possible carpal tunnel syndrome. No back or ankle concerns were noted. (PX 7)

Petitioner returned to see Dr. Muscatella on August 17, 2010 having last seen him in February of 2010. This was part of an annual diabetic check- up and she reported her right foot

was painful. The doctor diagnosed her with extensor tendonitis of the right foot and diabetic neuropathy. (PX 4)

Petitioner followed up with Dr. Kohlmann's assistant on January 17, 2011, reporting problems with her right knee for about a year. She indicated that she did not have any trauma but that she has pain in her knee that gradually got worse over the past several months. She was taking Tramadol every 6 hours. It should be noted that she was looking forward to having a total hip replacement done in June of 2011. A right antalgic limp was noted and her knee was enlarged but not hot or red. It was stable to stressing of the LCL and MCL. Crepitation was noted with passive range of motion. X-rays showed marked patellofemoral arthritis as well as notch arthritis with medial joint space narrowing and some large-sized marginal osteophytes. Dr. Kohlmann felt Petitioner had osteoarthritis of the right knee. Petitioner was given an injection into the right knee at that time and told she could get one every three months. Petitioner also mentioned she was undergoing hip surgery in the future. (PX 9)

Petitioner returned to see Dr. Kohlmann on March 2, 2011. She updated some forms for the doctor which included a statement indicating her visit was not the result of a work accident. She was there for her ongoing right knee pain. Petitioner was "hurting badly" and the doctor noted she had problems with both knees. Petitioner had decided she wanted a knee replacement and the doctor gave her various options but she wished to proceed with the replacement. Petitioner wished to proceed with the surgery when school was out. (PX 9)

On June 14, 2011, Petitioner saw Dr. Moran who is with the Department of Orthopedics at Carle Clinic. He ordered bilateral knee x-rays that were taken that day. It was noted that Petitioner had been complaining of right knee pain for the past year. She indicated that she was told by another doctor that she needed a knee replacement. Dr. Moran examined the right knee and his impression was severe osteoarthritis. He scheduled her for a right total knee replacement. (PX 6)

On June 24, 2011 Petitioner was cleared for surgery by her cardiologist. (PX 6)

The total right knee replacement took place at Carle Foundation Hospital on July 11, 2011. On the Admission History Petitioner denied any other musculoskeletal problems beyond her right knee. According to the Discharge Summary, Petitioner had reported right knee pain for the past several years and she had been unable to walk more than one block. Petitioner was in the hospital through July 14, 2011. (PX 6; PX 10)

Petitioner called Dr. Muscatella's office on July 27, 2011 stating that she had undergone a knee replacement but was now having some ankle pain and trouble with walking rehab on the right knee. (PX 6)

After her discharge, Petitioner had a short stay in a rehabilitation facility. On July 29, 2011 the nurse practitioner noted that Petitioner was being discharged to go home with a prescription for a quad cane and instructions to continue outpatient therapy and follow up with the doctors as noted in her discharge instructions. (PX 6)

Petitioner began undergoing physical therapy on August 5, 2011. (PX 10)

Petitioner was also seen by Dr. Uloza on August 5, 2011 for her chronic kidney disease. She reported doing alright at home after her knee surgery despite having steps there. (PX 6)

Petitioner returned to see Dr. Muscatella on August 9, 2011. Dr. Muscatella arrived at an assessment of lateral ankle pain status post knee replacement. An ankle brace was dispensed and she was placed at Medrol dose pack to decrease the inflammation. (PX 4)

Petitioner saw Dr. Moran post TKR on August 9, 2011 who noted gradual progress and that Petitioner was using a cane. (PX 6)

On August 18, 2011, Petitioner reported that she was doing well. Objectively, she was tender along the lateral aspect of the right ankle over the anterior talofib ligament and was tender with inversion. The assessment was arthritis in the right ankle and she was given an injection and sent to physical therapy. (PX 4)

Petitioner was seen in Physical Therapy on August 23, 2011. She gave a history of falling down stairs on September 23, 2008. Petitioner reported difficulty with walking, turning when walking, and going upon and down stairs. She was to undergo therapy two times a week for four weeks. Petitioner continued with therapy through August 31, 2011. (PX 10)

On September 1, 2011 Petitioner signed her Application for Adjustment of Claim in case # 11 WC 35602 alleging injuries to her legs, arms, feet and "MAW" when she fell on March 31, 2009. (PX 2)

When Petitioner returned to see Dr. Muscatella on October 4, 2011, she reported that she was doing well as she had good improvement with her symptoms with the therapy and the bracing. She was asked to go back to orthotics in order to prevent excessive pronation in the future. (PX 4)

Petitioner saw Dr. D'Souza on December 15, 2011 for a second opinion of her right ankle. Petitioner told the doctor that her ankle had been doing very well following her surgery on it but it had flared up temporarily after she underwent a knee replacement. Her current pain was "0/10." Petitioner told the doctor that when she notices pain it is along the medial side of her joint. She lacked any mechanical symptoms. The amount of swelling noted in her ankle has been constant for many years. She is diabetic. Petitioner indicated to the doctor that she still had pain inside the joint but not feeling any pain on this day. Because Petitioner was not having any symptoms at that time the doctor felt that she probably just needed periodic injections in the future and use of a brace. (PX 5)

The medical records indicated that Petitioner returned to see Dr. Muscatella on October 23, 2012 for a recheck. The assessment was "other rheumatoid arthritis." Apparently, she had increased pain that was being aggravated by the shoe gear. (PX 4)

On November 5, 2012, Petitioner returned to Dr. Muscatella for a recheck of the right foot. She indicated that she was getting worse and it would get worse with activity. The assessment was tenosynovitis of the right ankle and arthritis of the lower leg. (PX 4)

On November 12, 2012 Dr. Muscatella's diagnoses were tenosynovitis of the foot/ankle and osteoarthritis of the lower leg. (PX 4)

Petitioner went to the emergency room at Carle Clinic on March 4, 2013 where she was seen in Occupational Medicine indicating that she missed the last four steps and fell backwards and struck her head and injured her shoulder. Petitioner reported feeling tightness and pain in her right shoulder girdle region and right scapular area as well as right neck pain. She also reported right knee pain and discomfort. Stiffness and soreness was confirmed on physical examination. Range of motion of her cervical spine was limited but that was felt to possibly be due to body habitus, in part, and pain. She was assessed with contusions of the right shoulder region and, possibly, the occipital region of her head, mild right knee pain and discomfort and right-sided neck pain. She was given a trial of Tramadol and told to use ice. She was to return in one week. (PX 12)

Beverly Lacy completed a witness statement on March 4, 2013. She indicated that she heard Petitioner fall and saw her sliding down the stairs. She dropped her purse and coffee cup. Petitioner reported hitting her head. She also said she was somewhat dizzy. She did not complain of any pain. When asked to describe what Petitioner was doing at the time of the accident, Ms. Lacy wrote, "She was walking down the stairs." In response to the question, "Could this accident have been prevented?" Ms. Lacy wrote, "I didn't see it." (PX 12)

Joel Wright also completed a witness statement on March 4, 2013. He saw the accident occur and described a head injury. She fell and hurt herself on the stairs. He didn't see any cuts or bruises. Petitioner did complain of head pain. Mr. Wright also wrote that Petitioner was carrying work materials (books, papers, pencils) and so both hands were occupied so she couldn't grab the handrail. (PX 12)

Petitioner completed an accident report on March 4, 2013 indicating she fell going down the stairs and hit her head and right shoulder. (PX 12)

On March 5, 2013 Petitioner's Supervisor completed a "Supervisor's Injury Report." The supervisor noted he did not question the legitimacy of the injury as witnesses backed it up. (PX 12)

On March 7, 2013, Petitioner returned to Occupational Medicine at Carle as previously instructed. By history, she had slipped on the steps and had a right shoulder contusion and neck strain. There was no head injury. Petitioner indicated that she was still a little sore from the fall and could return to work without restrictions. She was allowed to do so. (PX 12)

Petitioner signed her Application for Adjustment of Claim in case # 13 WC 16262 on April 30, 2013 alleging injuries to her head, neck, back, both arms and "MAW" when she fell on March 4, 2013 and struck her head on stairs. (PX 3)

Petitioner followed up at Carle on May 6, 2013 and saw Dr. William Scott. At that time, Petitioner reported that she had significantly improved about a week following the initial accident on March 4, 2013, but that a couple of weeks ago, she began to notice ongoing chronic right shoulder pain. The doctor's records indicated that Petitioner did not know what caused this. She did report that she remembered tripping and falling. The doctor stated that he did not know whether or not these symptoms were related to the prior incident. She had been taking Tramadol that she had for other conditions and was requesting a refill. She didn't know why she hurt. Dr. Scott noted that Petitioner had many medical problems and needed to be careful as to the pain medications she used because they could be hard on her kidneys and lead to kidney disease. He felt she had multiple medical problems and had now developed right shoulder pains and stiffness which seemed to be myofascial in origin. He wrote, "No red flags are discovered during this evaluation." He was willing to try Tramadol but not on a long-term basis. He also recommended ThermaCare and heat wraps. He concluded, "Overall, I am not clear on the work relatedness of this condition, given the fact that she did recover and now this seems to be relatively new." (PX 12)

On May 30, 2013, Petitioner returned to Carle's Occupational Medicine Department and was released from the doctor's care from the March 4, 2013 accident to return as needed. She was still complaining of left-sided soft tissue pain over her left shoulder and could reproduce the pain by pressing and touching the left trapezius muscle. It was felt she was approaching maximum medical improvement for the soft tissue pain and he thought it would go away on its own. (PX 12)

Petitioner returned to see Dr. Muscatella on August 15, 2013 regarding her left ankle pain and swelling. X-rays were taken indicating a non-displaced fracture of the tibia and fibula. She was dispensed a 3D walker and was told to return in 3 weeks. She returned a couple of times for a stress fracture. It was noted that on September 11, 2013, Petitioner had a stress fracture of the left ankle. Some right foot swelling was noted in September of 2013; however, it was attributed to Petitioner's not using certain medications. (PX 4; PX 14)

Since that visit, Petitioner has continued to treat with Dr. Muscatella in 2013 and 2014 but the records clearly reflect that treatment was either for her left foot or for a refill of medication. (PX 14)[1]

Due to Petitioner's complaints of leg weakness Dr. Muscatella had Petitioner undergo an EMG on December 9, 2013, the results of which suggested severe diffuse polyneuropathy and superimposed carpal tunnel syndrome. (PX 4)

The Arbitration Hearing

Petitioner's case proceeded to arbitration on March 9, 2017. Petitioner was the sole witness testifying. The disputed issues were causal connection, medical bills, and the nature and extent of any injury. (AX 2)

[1] The doctor's bills found in PX 14 also suggest visits in 2015 but no records were included with the exhibit.

Petitioner testified that she was hired by Respondent in 1988 as a teacher's assistant. Petitioner testified that on September 9, 2008, she fell down some steps. She explained that the steps were "kind of misty" or "damp" and she just slipped and fell down the steps. She testified that "misty" wasn't really a good word to use as the steps "were just – and I slipped and I fell and I –." The steps were not wet. Petitioner was going down the steps from her classes upstairs to her classes on the second floor. She did not have anything in her hands. After she slipped several teachers and a student came to see if she was okay and they took her to the office and she wrote out a statement. Petitioner further testified that she noticed both her right foot and low back hurt.

Petitioner testified that after accident, she went to Provena Emergency Room on September 10, 2008 and she underwent right wrist, shoulder and ankle x-rays. She then followed up with her primary care doctor, Dr. Raman, who, in turn, referred her to Dr. Muscatella.

Petitioner testified that Dr. Muscatella treated her with pain medication, a cam walker boot, and physical therapy. She attended physical therapy through December 4, 2008 and described her progress in therapy as "okay."

Petitioner returned to work on December 8, 2008. She returned to work in the same position. She proceeded to follow up with Dr. Muscatella several more times over the next couple of months and underwent an injection to her ankle at one point. Petitioner testified that Dr. Muscatella eventually ordered an MRI of her ankle because she was still having problems. That took place on March 10, 2009.

Petitioner testified that she had another accident on March 31, 2009 at work when a chair she was sitting on gave way and she fell and her foot "kind of like went under her." She testified that, as a result, her right foot hurt a little bit more. She also noticed back pain. When asked about whether she hurt her knee, she replied, "I am thinking yes, it was."

Petitioner then followed up with Dr. Muscatella who put her back in the cam boot until April 30, 2009 when he advised her she could proceed into regular shoes. He then released her to return as needed.

Petitioner testified that when she resumed shoe gear she was in a lot of pain and when she increased her activities her ankle hurt more. Petitioner testified that during the summer she called Dr. Muscatella's office requesting pain medication. She then returned to work in August of 2009 at which point she noticed a certain amount of ankle pain leading her to return to see Dr. Muscatella. At that point he recommended ankle surgery and she underwent surgery on November 13, 2009.

Petitioner further testified that after her surgery the doctor had her undergo physical therapy which she did through January 8, 2010. While she was doing well, the doctor injected her ankle in late January of 2010 and she was released from his care as of February 10, 2010.

Petitioner also testified that after she had been released by Dr. Muscatella she underwent an MRI of her low back but she didn't recall who ordered it, maybe Dr. Kohlmann. He then injected her back in July of 2010.

Petitioner indicated that following the initial treatment of her back that she did not receive any additional treatment until 2016 when she began undergoing water therapy. She just took medication.

Petitioner testified to seeing Dr. Kohlmann's assistant in January of 2011 for right knee pain. She did not recall when her right knee began to hurt. When asked if it was from one of the two accidents, she replied "Yeah, I think it was when I fell down the steps." She was then asked if it was the fall in 2008 and she replied, "Yeah, initially." She received a knee injection in January of 2011 and she underwent the knee replacement in July of 2011. Petitioner testified that after she had a knee replacement she followed up with Dr. Muscatella in July of 2011 and he treated her for a short period of time. In October of 2011 she was placed back in an orthotic for her ankle per Dr. Muscatella. She could not remember when she stopped using it but she no longer does.

Petitioner testified to falling down some steps on March 4, 2013. She was coming down steps from the third floor to the second floor and she slipped. She had books in her hands but she could see. She could not recall if the steps were "misty" or not. After falling, Petitioner felt pain in her shoulder, foot and back. She went to the emergency room that day and gave them a history of missing the last four steps. She then proceeded to treat at Carle for the next few months and primarily for her shoulder. She was released from Carle as of May 30, 2013.

Petitioner further testified that she had no further ankle problems after October of 2011 until about a year ago when it began hurting and swelling up again. She returned to Dr. Muscatella. According to Petitioner he ordered Neurontin for her to take and she does so.

Petitioner testified to pain and swelling in her right ankle and that it "sometimes works and sometimes it doesn't." She has trouble walking more than half a mile before she notices problems with pain.

Petitioner also notices back pain when walking half a mile and she takes prescription medication for it as prescribed by Dr. Hoffman, her primary care doctor. She indicated that she was diagnosed with degenerative disc disease and she underwent therapy at that time. Petitioner acknowledged having back surgery in 2003 or 2004. The therapy helps her back but in just the last few weeks Petitioner has been having problems with walking due to her back and leg pain.

Petitioner further testified at the hearing that she was not having any problems with her right knee. It was okay.

Petitioner is still working for Respondent and earning more than before. She has, however, pain.

Petitioner denied any other accidents than the three she testified to.

Petitioner testified to a painful right shoulder and no range of motion. She has recently gone to Sports Medicine and has been told it's where it was hurt when she fell at school because she has a degenerative condition that "opened up" and is now more painful. She has to get steroid injections now. Up until then she had undergone no shoulder treatment since being released in 2013.

On cross-examination Petitioner was asked about each of the accidents. With regard to the 2008 accident Petitioner agreed there were no chips, cracks or defects in the stairs. She denied the presence of any standing water. It was just "misty." She clarified that the steps she was going down were the ones from the second floor going out to the playground. Some students were with her when she fell.

Petitioner was asked about how she fell when the chair broke on March 31, 2009 and she explained that the chair cracked and she fell like sideways and maybe backwards but it had happened a long time ago and she couldn't remember.

Petitioner also testified that when she fell down the stairs on March 4, 2013 she had books in her hands but she could see the stairs in front of her.

Petitioner agreed that she saw Dr. Moran on June 4, 2011 regarding her knee. When asked about the doctor who had previously recommended a knee replacement she thought it was Dr. Kohlmann; however, she could not recall when he told her that.

Petitioner acknowledged having diabetes and being insulin dependent now; however, she wasn't on insulin before the first accident in 2008.

On redirect examination Petitioner explained that the steps she fell down in 2008 led to the outdoors. There wasn't a door at the bottom of the steps; rather, there was a small landing and then there was a door. That was the area that was "misty."

Proofs were closed.

The Arbitrator concludes:

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

Respondent stipulated that Petitioner was injured in a work-related accident on March 31, 2009. On that day, Petitioner testified that she was sitting in a chair that had loose screws. The chair broke and she fell to the ground. Petitioner testified that when she fell to the ground, her right foot hurt "a little bit more" and she noticed some back pain. Petitioner had to be asked by her attorney if she hurt her knee and she replied, "I am thinking yes, it was."

The Arbitrator did not find Petitioner's testimony about injuring her right knee at the time

of the accident to be credible. First, she didn't volunteer that she hurt it at that time. Second, even when asked by her attorney, she didn't answer definitively. The Arbitrator was present and observed Petitioner when she spoke those words and they were spoken with uncertainty. Most importantly, there is a complete lack of medical treatment for her right knee immediately after the accident. Petitioner's medical records don't reveal any treatment for right knee complaints until May of 2010 at the very least. Even then her complaints to Dr. Kohlmann were centered around back and leg complaints rather than specific knee complaints. It is not until January of 2011 one finds a reference to right knee complaints. That is almost two years after the accident and Petitioner did not even mention the accident in her history to the doctor. Alternatively, even if one believes Petitioner did injure her right knee at the time of the accident, she failed to prove that any treatment she received to her right knee (the injections or the replacement) were causally related to the March 31, 2009 accident. No doctor testified to that nor would a chain of events support such a finding, given he two year gap in treatment between the accident and the seeking of care for knee complaints.

While Petitioner may have had some back pain associated with the accident, she failed to seek any immediate medical treatment for it. The first mention of back treatment is found in PX 9 wherein Dr. Wang had Petitioner undergo an MRI on March of 2010. Dr. Wang's records were not admitted into evidence. It is unclear why or when Petitioner saw him. She provided no testimony on the subject. Petitioner then presented to Dr. Kohlmann. She did not attribute her back or leg complaints to the work accident. She gave a history in May of 2010 of experiencing right leg pain for the last two to three months. She mentioned mentioned falling at work but did not mention the chair incident. Petitioner failed to prove that any back problems or treatment she has undergone was caused by the work accident of March 4, 2009.

As for the right ankle, it is clear from the records that Petitioner was having problems with her right ankle prior to this accident. She had been treating with Dr. Muscatella. When he examined her on April 8, 2009 after the accident he felt she had "re-injured" her right ankle after a second fall at work. He had her go back into the cam walker boot, limit activity and take Tramadol. Thereafter, Petitioner improved and as of April 30, 2009 she was released to return as needed. At that point she was to transition back to regular shoes. Petitioner did not return to see Dr. Muscatella for five months who then diagnosed her with a "right ankle sprain secondary to previous strain." It is not clear if he was referring to the first strain in 2008 or the "re-injury" in 2009. The doctor recommended ankle surgery at that time but it is unclear why it was needed. Dr. Muscatella was not deposed nor did he render a causation opinion between the March 31, 2009 accident and Petitioner's need for ankle surgery. Given the gap in treatment after being released on April 30, 2009, the prior ankle strain in 2008, and the lack of expert opinion on causation, the Arbitrator is unable to conclude that Petitioner's need for her ankle surgery was on account of this accident. Petitioner failed to prove that her condition of ill-being in her ankle after September 10, 2009 was causally connected to the March 31, 2009 accident.

Finally, the Arbitrator notes that Petitioner's Application for Adjustment of Claim in this case alleges bilateral injuries to Petitioner's legs, arm and feet. Petitioner failed to prove she sustained any injuries to her left foot, left leg, or left arm at the time of the accident or that any alleged injuries to these body parts is causally connected to her work accident of March 31, 2009.

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

Petitioner is awarded her medical bills for treatment with Dr. Muscatella from April 8, 2009 through April 31, 2009. These bills total $190.00. All other bills are denied consistent with the Arbitrator's causation determination set forth above and incorporated herein by reference.

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

Section 8.1(b) of the Act establishes the criteria for determining permanent partial disability. It states:

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.

Pursuant to §8.1b (b) the Arbitrator bases her determination of permanent partial disability on the following factors:

i) The reported level of impairment. Neither party submitted an impairment report/rating. Therefore, the Arbitrator gives this factor no weight.

ii) The occupation of the injured employee. Petitioner is a teacher's assistant and has remained in that position. The Arbitrator gives this factor some weight in that it indicates, despite her injury, she has remained in her job.

iii) The age of employee at the time of the injury was 59 years old. Given Petitioner's age, the Arbitrator reasonably infers that Petitioner will have to live with the effects of his injury for a shorter time than that of a younger worker. The Arbitrator gives some weight to this factor.

iv) The employee's future earning capacity. No evidence was presented as to how Petitioner's injury has affected her future earning capacity. As such, the Arbitrator gives no weight to this factor.

(v) Evidence of disability as corroborated by the treating medical records.

Petitioner underwent conservative care for a "re-injury" to her ankle sustained on March 31, 2009. She was placed in a cam walker boot and used Tramadol for a short time period before being released to return as needed in late

April of 2009. She lost no time from work nor did she have to work with any restrictions. While Petitioner did go on to have further treatment to her right ankle, that treatment was not found causally connected to the work accident herein. While Petitioner testified to ongoing pain in her ankle she also testified to a number of other health issues causing difficulties with activities, such as walking and standing. Petitioner's testimony regarding pain after being released by the doctor in April of 2009 was somewhat corroborated by the medical records.

Based upon the foregoing factors, the Arbitrator finds that Petitioner was permanently partially disabled to the extent of 2.5% loss of use of the right foot as a result of the March 31, 2009 accident.

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Eunice Cummings,

Petitioner,

17IWCC0816

vs. NO: 09WC 3765

Champaign School District #4,

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 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 11, 2017 is hereby affirmed and adopted.

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

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

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: DEC 19 2017
KWL/vf
O-11/21/17
42

Kevin W. Lamborn

Michael J. Brennan

DISSENT

I respectfully dissent from three of the arbitrator's findings now adopted by the majority. I would find that (1) Petitioner's September 9, 2008, accident was work-related; (2) Petitioner's continued ankle problems after April 31, 2009, are related to her workplace accident or accidents; and (3) Petitioner is entitled to a PPD award representing 7.5%, not 2.5%, of her right foot. I address each point in turn.

Regarding Petitioner's September 9, 2008, accident, the arbitrator found her fall down the stairs at work not to have arisen out of and in the course of her employment because it involved an unremarkable staircase. Thus, the arbitrator reasoned, Petitioner's fall was triggered by a neutral risk to which the public was equally exposed. To employ this reasoning, the arbitrator discounts Petitioner's testimony that the staircase was "misty" at the time she slipped on it, a feature that distinguishes it readily from neutral public risks. The arbitrator discounts Petitioner's testimony regarding the misty condition of the staircase largely because Petitioner offered "[n]o explanation as to why the steps were like that." Quite to the contrary, Petitioner pointed out that the staircase led directly from the exterior and was used by students; this raises a strong inference that foot traffic had carried moisture from outside onto the stairs. Even if that inference were not so strong, though, an injured worker is not required to investigate and prove the source of the risky employment condition that caused her injury; as Petitioner aptly points out in her brief, it should be enough that the employee proves that the risky condition exists. For that reason and based on the evidence presented, I would find that Petitioner's September 2008 fall arose out of and in the course of her employment, so that her ensuing condition and treatment were work-related.

My second point of disagreement with the majority is its adoption of the arbitrator's finding that Petitioner's post-April 2009 ankle condition was not related to a workplace accident. While accepting that Petitioner's ankle condition was attributable to her work at least initially, the arbitrator set an April 31, 2009, cut-off date because it represents the point that Dr. Muscatella told her to transition from her ankle boot into normal shoes, and released her to return as needed. The arbitrator noted that Petitioner did not return for further treatment until August 2009, and she cited this "gap in treatment" as a major part of her reason for finding a break in causation. That "gap in treatment," however, did not really exist. As Petitioner explained in her testimony, on Dr.

17IWCC0816

Muscatella's orders, she tried to transition to a normal shoe following her April 2009 visit, but she noticed increased pain and in fact called Dr. Muscatella to request pain medication, before returning for treatment in August. Even if these facts established a gap in treatment, though, the record amply explains it. Petitioner testified that her pain increased as she tried to transition out of her boot and, crucially, as she returned to work in August. Petitioner's actions, in seeking pain medication as she transitioned, and seeking treatment when the work-related demands on her ankle returned, are entirely consistent with the presence of a continued ankle condition. The same evidence also demonstrates that her condition was not stable as of April 2009; as of that time, she was still progressing in her treatment by attempting to transition out of her ankle boot.

Accordingly, I find no support in the record for a finding terminating the causal link in her ankle condition as of April 31, 2009, and I would find that her ankle condition after that date continued to be caused by a workplace accident. Petitioner's August 2009 treatment visit for her continued ankle condition led to Dr. Muscatella's recommending ankle surgery, which revealed synovitis of the ankle. I would find that surgery and related treatment, and Petitioner's ongoing condition as a result, to be, reasonable, necessary, and causally related to a workplace accident.

My final point of disagreement with the majority's decision relates to the PPD award to be given to Petitioner for the loss of her ankle. In weighing the statutory factors, the arbitrator weighed the second factor—Petitioner's occupation—against her, because "despite her injury, she has remained in her job." That approach would unfairly penalize the employee for working through injuries, and for accepting accommodations. While it is true that Petitioner is able to continue her work, it is also true that the work involves a fair amount of walking that includes stairs, and standing. Those demands would toll on a person whose ankle flares to the point that she cannot walk more than one-half mile without experiencing pain. I would therefore weigh that factor in Petitioner's favor. I would also weigh the last factor—the corroboration of medical records—in Petitioner's favor, since her surgery record documents an ankle condition. For those reasons, I would award Petitioner an award that represents the 7.5% loss of use of her right foot.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0816

CUMMINGS, EUNICE
Employee/Petitioner

Case# **09WC003765**

11WC035602
13WC016262

CHAMPAIGN SCHOOL DSTRICT #4
Employer/Respondent

On 5/11/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 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
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CHAMPAIGN, IL 61824

STATE OF ILLINOIS)

)SS.

COUNTY OF CHAMPAIGN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

17IWCC0816

Eunice Cummings
Employee/Petitioner

v.

Champaign School District # 4
Employer/Respondent

Case # 09WC 03765

Consolidated Cases: 11 WC 35602 & 13 WC 16262

An *Application for Adjustment 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 **Nancy Lindsay** of the Commission, in the city of **Urbana** on **March 9, 2017.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ 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 **9/9/2008**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$19,689.64**; the average weekly wage was **$410.20**.

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

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

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

Respondent shall be given a credit of **$1,289.23** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$1,211.09** for other benefits, for a total credit of **$2500.32**.

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

ORDER

Petitioner failed to prove she sustained an accident on September 9, 2008 that arose out of and in the course of her employment with Respondent. Petitioner's claim for compensation is denied. 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.

Nancy Lindsay
Signature of Arbitrator

May 7, 2017
Date

MAY 11 2017

Eunice Cummings v. Champaign School District #4, 09 WC 003765

Petitioner has three claims on file against Respondent. All three cases were consolidated for purposes of the arbitration hearing; however, the parties understood that separate decisions would issue.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

The triage records from Provena Emergency Room dated September 9, 2008 indicate that Petitioner was there due to a fall. The medical records further indicate that she was not examined on that date as she had another appointment. (PX 11)

On September 11, 2008, Petitioner returned to the emergency room at Provena Covenant Medical Center reporting that she had fallen down four steps the day before and landed on her right side. She noticed pain in her lumbar back into the sacral area. She further complained of right ankle pain and right shoulder pain. X-rays were taken of her right wrist, right shoulder and right ankle. No fracture or dislocation was seen. It was noted that the findings from the right ankle indicated plantar spur calcis and generalized soft tissue swelling. She was advised she could return to work the next day. (PX 11)

Petitioner followed up with her primary care doctor, Dr. Raman, on September 29, 2008, reporting she had fallen down on the staircase about four steps (at work) and hurt her right foot and lower back. She described the pain in both places as "intense." The physical examination indicated all movement of Petitioner's right ankle was painful. Petitioner further had bilateral paraspinal muscle tenderness in the lumbar region, right greater than left. The straight leg raising test was negative. Dr. Raman's assessment was low back pain and right foot swelling and pain. Petitioner was referred to Dr. Muscatella for further evaluation of her right foot and to Carle Spine Institute for the low back pain. (PX 7)

On October 1, 2008, Petitioner was examined by Dr. Muscatella. Petitioner gave a history of "trip[ping] and [falling] down 4 steps at work" to Dr. Muscatella regarding the accident. The doctor noted that Petitioner had been taken off work since Monday, September 29, 2008 by Dr. Raman. An examination took place with the assessment being Grade I ankle sprain, on the right. The treatment plan was to place her in a cam walker, limit her activity, continue her on Tramadol and place her off work for a week. Petitioner was to follow up with the doctor in a week. (PX 4)

On October 8, 2008, Petitioner followed up with Dr. Muscatella. She indicated that if she wore the cam walker, she felt good. Without it, she noticed pain especially going up and down stairs. The physical examination indicated that she was tender over the anterior talofib ligament. The right ankle edema had decreased. She had good range of motion and she was tender with aversion but no tenderness with dorsiflexion or plantar flexion. The treatment plan was to continue the cam walker and place Petitioner in physical therapy. Petitioner was released to light duty. (PX 4)

As of October 20, 2008 Dr. Muscatella noted that Petitioner was doing well but still had not begun physical therapy. (PX 4)

Petitioner returned to see Dr. Raman on November 3, 2008 for follow up regarding her medical problems and to discuss blood work. She reported "doing fine" and had no particular complaints. No mention of her ankle or low back was otherwise made. (PX 7)

On November 19, 2008, Petitioner had a follow-up appointment with Dr. Muscatella at which time she reported that her ankle was worse and physical therapy was not helping. Petitioner was tender along the lateral aspect of her right ankle and had pain along the baronial tendons and she also had pain with inversion. She was directed to finish out physical therapy and she was told to limit her activities and to stay off work. (PX 4)

On December 4, 2008, Petitioner returned to see Dr. Muscatella as she had finished her therapy. She indicated that she was still having some pain but it was better. On examination Petitioner indicated pain on palpation of the anterior talofib ligament of the right ankle. She was still tender with inversion. The doctor applied a taping and padding to the foot and told Petitioner to return in one week. (PX 4)

When Petitioner returned to see Dr. Muscatella on December 11, 2008, she still had some swelling she attributed to being on her feet but she was, otherwise, doing okay. Dr. Muscatella ordered a pair of diabetic orthotics to stabilize her foot and to prevent excessive pronation and to prevent recurrent ankle sprains. Petitioner was provided a taping and padding to wear in the interim. (PX 4)

On January 5, 2009, Petitioner returned to Dr. Muscatella's office for dispensing of the diabetic orthotics. (PX 4)

On January 20, 2009, Petitioner followed up with Dr. Muscatella reporting that she was still having pain in the right ankle, which was aggravated by activity. The examination indicated tenderness over the lateral aspect of the right ankle and pain with inversion. He prescribed Relafen to take as directed. They discussed the etiology of her symptoms. (PX 4)

Petitioner's Application for Adjustment of Claim in case # 09 WC 03765 was filed on January 28, 2009. She alleged injuries to her right foot and leg when she "fell down wet [crossed out] stairs on September 9, 2008. (PX 1)

On February 3, 2009, Dr. Muscatella re-examined Petitioner who was still having pain especially with increased activity and stairs. The assessment was a chronic right ankle sprain. They discussed the possibility of a corticosteroid injection in which Petitioner deferred upon. She was placed on Indocin SR for one week. (PX 4)

When Petitioner returned to see Dr. Muscatella on February 23, 2009, she indicated she was ready for an injection. It was provided and she was told to return in two weeks. (PX 4)

When Petitioner returned to see the doctor on March 9, 2009, she indicated that she had good relief from the injection. The assessment at this point was diabetes mellitus with diabetic peripheral neuropathy, hypertrophy, chronic ankle sprain with possible capsulitis and synovitis of the ankle with a possible tear of the anterior talofib ligament. The doctor recommended an MRI of the right ankle at that time. (PX 4)

Petitioner underwent a right ankle MRI on March 10, 2009 due to "pain related to a fall at work 9/08" The radiologist's impression was mild peroneal brevis and longus tendinopathy without tearing, mild stress reaction in the proximal fourth metatarsal and a normal anterior talofibular ligament. (PX 4)

Petitioner failed to keep her appointment with Dr. Muscatella scheduled for March 16, 2009. (PX 4)

Petitioner called Dr. Muscatella's office on March 18, 2009 reporting she was going on a trip and wanted a refill on her Tramadol. (PX 4)

Petitioner was seen at Provena Covenant Medical Center on March 31, 2009 reporting that she was going to sit down at work and the chair broke when she sat on it. Her right knee, right shoulder and lower back all hurt. She was diagnosed with contusions of the hip, shoulder, and ankle. It was noted that she had fallen down steps at school in September and hurt her ankle. Petitioner was discharged with instructions and prescriptions. (PX 10)

On April 8, 2009, Dr. Muscatella reviewed Petitioner's right ankle MRI and indicated that there were no signs of ligament rupture. Petitioner reported feeling better and was at work the week before when a chair broke and she fell back landing on her foot and right ankle. She reported it was now tender "again" and stairs were reportedly difficult. On exam, Petitioner displayed no edema but was tender over the anterior talofib ligament again. The assessment was that she had re-injured the ankle following the second fall at work. The treatment plan was for her to go back into the 3D walker, limit her activity and he gave her a prescription for Tramadol. (PX 4)

Petitioner saw Dr. Muscatella again for her right ankle on April 16, 2009. She still was tender and had minimal edema. She was asked to wear a boot for two more weeks. (PX 4)

Petitioner saw her family doctor, Dr. Raman on April 21, 2009 regarding blurring vision and painful red eyes. If was felt she might have conjunctivitis or cataracts or glaucoma. Eye drops were dispensed and an appointment with an eye doctor made. (PX 7)

On April 30, 2009, at her re-check visit with Dr. Muscatella, Petitioner indicated that she was wearing the cam walker. She stated she did not have any pain while using the cam walker. Objectively, she had minimal pain on palpation of the interior talofib ligament but there was still minimal edema. She was told to transition back to her shoe gear and to return as needed. (PX 4)

Petitioner saw Dr. Raman on May 1, 2009 regarding a sore throat. (PX 7)

Petitioner underwent cataract surgery on June 22, 2009. In her pre-op exam with Dr. Raman she had no complaints otherwise and was doing fine. (PX 7)

Dr. Muscatella's medical records indicate that he received a phone call from Petitioner on June 30, 2009 requesting a refill for the Tramadol. (PX 4)

On September 10, 2009, Petitioner called Dr. Muscatella's office stating that she was having problems with her ankle and she wanted an evaluation. (PX 4)

Petitioner came in and saw Dr. Muscatella on September 17, 2009. The medical records indicate that she was still having pain in her ankle and it was swollen. She was taking Tramadol but she did not like it. The assessment was right ankle pain secondary to previous sprain. Dr. Muscatella recommended a diagnostic and surgical arthroscopy of her ankle due to the continued pain and swelling. Petitioner did not want surgery at that time. (PX 4)

The next time that Petitioner saw Dr. Muscatella was on October 13, 2009. She indicated that she was having quite a bit of pain, especially with stairs. She had pain on palpation of the lateral aspect of the right ankle pain with conversion and eversion. The assessment was capsulitis, synovitis of the right ankle joint. They discussed the treatment and concluded that since she had exhausted all conservative treatment that she would undergo the arthroscopy that was previously recommended. (PX 4)

Dr. Raman examined Petitioner on October 23, 2009 for a variety of her ongoing health issues as well as a pre-op visit before ankle surgery. No back complaints were noted. Pre-op clearance form her cardiologist was needed. (PX 7)

On November 13, 2009, Petitioner underwent a diagnostic and surgical arthroscopy of the right ankle at Provena Covenant under general anesthesia. Dr. Muscatella's History and Physical noted that she had chronic synovitis with chronic ankle pain post previous right ankle sprain. Petitioner was prescribed Vicodin following the surgery. (PX 4; PX 11)

On November 25, 2009, Petitioner was referred for physical therapy. She was doing well with no pain or problems. (PX 4; PX 10)

When Petitioner went to see Dr. Muscatella on December 9, 2009, she indicated that she still had some discomfort but she was anxious to get back to work. Minimal pain with range of motion and minimal edema was noted. The treatment was to continue physical therapy and use of a cam walker. She was released to return to work light duty as long as she wore the cam walker. (PX 4)

On December 23, 2009 Dr. Muscatella re-examined Petitioner noting she was doing well with good improvement and no pain with stairs. (PX 4)

Petitioner did not show up for her January 4th appointment with Dr. Muscatella. (PX 4)

Petitioner was discharged from therapy for her ankle on January 18, 2010. She had improved in strength and flexibility and range of motion. Prolonged walking was still painful. She was still wearing the cam walker boot. (PX 10)

Petitioner was seen by Dr. Raman on January 18, 2010. Her complaints included right hand tingling and numbness along with left foot tingling and numbness. It was "paralyzing" and made her stop what she was doing. Petitioner mentioned seeing a neurologist. Lab work was ordered. (PX 7)

On January 25, 2010, Petitioner returned to Dr. Muscatella stating she was still having pain along the lateral aspect of her ankle but she believed that she was doing well with therapy. She was tender over the lateral incision on the ankle and there was induration consistent with scar tissue. She was given an injection with Decadron and Kenalog and Lidocaine. (PX 4)

At the request of Respondent, a records review was prepared by Dr. Vinci on February 4, 2010. His report is limited to the accident date of September 9, 2008. He stated that after his review of the medical records, it was his opinion that all of Petitioner's problems were subjective in nature and there was very little clinical abnormalities to support the recommendation of the surgical arthroscopy. He did not dispute that Petitioner's accident occurred but a lengthy amount of time had transpired since then. He further did not believe that the surgery would benefit her at all. Therefore, he felt it was unwarranted. (RX 1)

On February 10, 2010, Petitioner saw Dr. Muscatella and she reported she was doing well and had a great relief of symptoms. Petitioner requested a refill of the Tramadol. She also reported that she was doing better with her diabetes and neuropathy. Objectively, the examination showed no pain on palpation or range of motion. She still had minimal edema. She was released from Dr. Muscatella's care and was told to return as needed and to resume her normal activities. (PX 4)

Dr. Raman examined Petitioner on February 19, 2010. Petitioner's complaints included weakness in both her legs and a sensation of numbness in her arms and legs. A history of heart problems was noted and discussed. A possible transient ischemic attack was noted. She was advised to go to the emergency room immediately if it happened again. (PX 7)

An MRI of Petitioner's lumbar spine was ordered by Dr. Wang and took place on March 11, 2010 at Provena. The radiologist's impression was desiccation of discs, some degenerative changes at L4-5 and L5-S1 in the facet joints, slight narrowing of the intervertebral neural foramina at L5-S1. (PX 9)

On May 11, 2010 Petitioner returned to see Dr. Raman in follow up on a variety of medical problems. However, she specifically mentioned pain in her whole right leg and lower back. He planned to refer her to Dr. Kohlmann for her back. (PX 7)

Dr. Kohlmann saw Petitioner on a referral from her primary care doctor, Dr. Raman, on May 19, 2010. Petitioner reported having right leg pain two to three months earlier but it had been noticed most recently in the past three months or so. She described it as going through the

buttock on her right side, down the lateral thigh, and into the lateral calf and ankle. It had been "very, very bad." Petitioner's pertinent history included back surgery in 2003 or 2004 for a herniated disc at L5-S1 on the right side and she had done well after that. Petitioner reported falling at work and hurting her right ankle and having surgery but she was now a lot better but still had the pain down her leg that had been ongoing for three months. Dr. Kohlmann wrote: "The patient told me but I did not write it and I do not remember it just a few minutes after I saw her if she did or did not have it immediately after the fall." Her current complaint was leg pain although there was some back pain. Dr. Kohlmann noted that Petitioner could stand and walk fairly well but limped a little. Both of her feet had arches which became very depressed with collapse of the midfoot when she stood. He described it as being similar to tibialis posterior insufficiency in both feet. On examination of her back she lacked any significant spinal tenderness and there was no palpable deformity. Sitting straight leg raise testing was positive on the right and negative on the left. The doctor reviewed her lumbar spine MRI noting it showed a definite sub articular spinal stenosis at L4, L5 on the right side that is caused primarily by joint arthritis and a little bit of bulging discs, minimal but some similar stenosis at L4, L5 level. There was no spondylolisthesis. The L 5, S1 level did not show any significant changes. The radiologist was noted to have seen some degenerative changes at L4, L5 and L5, S1 and narrowing at L5, S1.

Overall, Dr. Kohlmann did not think there was a whole lot of findings. Dr. Kohlmann's impression was that Petitioner had some mild to moderate spinal stenosis at L4, L5 causing L5 radiculitis. Treatment options were discussed including a lumbar epidural steroid injection. They also discussed weight loss and how it could help her back, knees, diabetes, and hypertension. Petitioner expressed interest in weight loss surgery. She was to be referred for a lumbar epidural steroid injection. (PX 9)

Petitioner returned to see Dr. Raman on June 22, 2010 regarding her various medical problems. Her back and ankle were not mentioned in his notes. (PX 7)

Petitioner presented to the Millennium Pain Center on July 7, 2010 per the referral of Dr. Raman. Petitioner's chief complaint was of lower back pain with pain going down her right leg to her foot. She also mentioned her right arm and occasional numbness in her right hand. Petitioner told the doctor her pain had begun 8 -9 months earlier and she had gone to Dr. Wang 4-5 months earlier who put her on Tramadol. She had also been seen by Dr. Kohlmann three months earlier and he agreed with Dr. Wang that she had a bulging disc. Petitioner reported more leg pain than back pain. She had never previously undergone any injections. The doctor noted she was a teacher's assistant and off for the summer. Petitioner also referenced ankle pain in a "Follow Up Questionnaire" completed the same day. A caudal injection was recommended and that was given on July 15, 2010. (PX 8)

On August 3, 2010 Dr. Raman examined Petitioner concerning her peripheral neuropathy secondary to diabetes and possible carpal tunnel syndrome. No back or ankle concerns were noted. (PX 7)

Petitioner returned to see Dr. Muscatella on August 17, 2010 having last seen him in February of 2010. This was part of an annual diabetic check- up and she reported her right foot

was painful. The doctor diagnosed her with extensor tendonitis of the right foot and diabetic neuropathy. (PX 4)

Petitioner followed up with Dr. Kohlmann's assistant on January 17, 2011, reporting problems with her right knee for about a year. She indicated that she did not have any trauma but that she has pain in her knee that gradually got worse over the past several months. She was taking Tramadol every 6 hours. It should be noted that she was looking forward to having a total hip replacement done in June of 2011. A right antalgic limp was noted and her knee was enlarged but not hot or red. It was stable to stressing of the LCL and MCL. Crepitation was noted with passive range of motion. X-rays showed marked patellofemoral arthritis as well as notch arthritis with medial joint space narrowing and some large-sized marginal osteophytes. Dr. Kohlmann felt Petitioner had osteoarthritis of the right knee. Petitioner was given an injection into the right knee at that time and told she could get one every three months. Petitioner also mentioned she was undergoing hip surgery in the future. (PX 9)

Petitioner returned to see Dr. Kohlmann on March 2, 2011. She updated some forms for the doctor which included a statement indicating her visit was not the result of a work accident. She was there for her ongoing right knee pain. Petitioner was "hurting badly" and the doctor noted she had problems with both knees. Petitioner had decided she wanted a knee replacement and the doctor gave her various options but she wished to proceed with the replacement. Petitioner wished to proceed with the surgery when school was out. (PX 9)

On June 14, 2011, Petitioner saw Dr. Moran who is with the Department of Orthopedics at Carle Clinic. He ordered bilateral knee x-rays that were taken that day. It was noted that Petitioner had been complaining of right knee pain for the past year. She indicated that she was told by another doctor that she needed a knee replacement. Dr. Moran examined the right knee and his impression was severe osteoarthritis. He scheduled her for a right total knee replacement. (PX 6)

On June 24, 2011 Petitioner was cleared for surgery by her cardiologist. (PX 6)

The total right knee replacement took place at Carle Foundation Hospital on July 11, 2011. On the Admission History Petitioner denied any other musculoskeletal problems beyond her right knee. According to the Discharge Summary, Petitioner had reported right knee pain for the past several years and she had been unable to walk more than one block. Petitioner was in the hospital through July 14, 2011. (PX 6; PX 10)

Petitioner called Dr. Muscatella's office on July 27, 2011 stating that she had undergone a knee replacement but was now having some ankle pain and trouble with walking rehab on the right knee. (PX 6)

After her discharge, Petitioner had a short stay in a rehabilitation facility. On July 29, 2011 the nurse practitioner noted that Petitioner was being discharged to go home with a prescription for a quad cane and instructions to continue outpatient therapy and follow up with the doctors as noted in her discharge instructions. (PX 6)

Petitioner began undergoing physical therapy on August 5, 2011. (PX 10)

Petitioner was also seen by Dr. Uloza on August 5, 2011 for her chronic kidney disease. She reported doing alright at home after her knee surgery despite having steps there. (PX 6)

Petitioner returned to see Dr. Muscatella on August 9, 2011. Dr. Muscatella arrived at an assessment of lateral ankle pain status post knee replacement. An ankle brace was dispensed and she was placed at Medrol dose pack to decrease the inflammation. (PX 4)

Petitioner saw Dr. Moran post TKR on August 9, 2011 who noted gradual progress and that Petitioner was using a cane. (PX 6)

On August 18, 2011, Petitioner reported that she was doing well. Objectively, she was tender along the lateral aspect of the right ankle over the anterior talofib ligament and was tender with inversion. The assessment was arthritis in the right ankle and she was given an injection and sent to physical therapy. (PX 4)

Petitioner was seen in Physical Therapy on August 23, 2011. She gave a history of falling down stairs on September 23, 2008. Petitioner reported difficulty with walking, turning when walking, and going upon and down stairs. She was to undergo therapy two times a week for four weeks. Petitioner continued with therapy through August 31, 2011. (PX 10)

On September 1, 2011 Petitioner signed her Application for Adjustment of Claim in case # 11 WC 35602 alleging injuries to her legs, arms, feet and "MAW" when she fell on March 31, 2009. (PX 2)

When Petitioner returned to see Dr. Muscatella on October 4, 2011, she reported that she was doing well as she had good improvement with her symptoms with the therapy and the bracing. She was asked to go back to orthotics in order to prevent excessive pronation in the future. (PX 4)

Petitioner saw Dr. D'Souza on December 15, 2011 for a second opinion of her right ankle. Petitioner told the doctor that her ankle had been doing very well following her surgery on it but it had flared up temporarily after she underwent a knee replacement. Her current pain was "0/10." Petitioner told the doctor that when she notices pain it is along the medial side of her joint. She lacked any mechanical symptoms. The amount of swelling noted in her ankle has been constant for many years. She is diabetic. Petitioner indicated to the doctor that she still had pain inside the joint but not feeling any pain on this day. Because Petitioner was not having any symptoms at that time the doctor felt that she probably just needed periodic injections in the future and use of a brace. (PX 5)

The medical records indicated that Petitioner returned to see Dr. Muscatella on October 23, 2012 for a recheck. The assessment was "other rheumatoid arthritis." Apparently, she had increased pain that was being aggravated by the shoe gear. (PX 4)

On November 5, 2012, Petitioner returned to Dr. Muscatella for a recheck of the right foot. She indicated that she was getting worse and it would get worse with activity. The assessment was tenosynovitis of the right ankle and arthritis of the lower leg. (PX 4)

On November 12, 2012 Dr. Muscatella's diagnoses were tenosynovitis of the foot/ankle and osteoarthritis of the lower leg. (PX 4)

Petitioner went to the emergency room at Carle Clinic on March 4, 2013 where she was seen in Occupational Medicine indicating that she missed the last four steps and fell backwards and struck her head and injured her shoulder. Petitioner reported feeling tightness and pain in her right shoulder girdle region and right scapular area as well as right neck pain. She also reported right knee pain and discomfort. Stiffness and soreness was confirmed on physical examination. Range of motion of her cervical spine was limited but that was felt to possibly be due to body habitus, in part, and pain. She was assessed with contusions of the right shoulder region and, possibly, the occipital region of her head, mild right knee pain and discomfort and right-sided neck pain. She was given a trial of Tramadol and told to use ice. She was to return in one week. (PX 12)

Beverly Lacy completed a witness statement on March 4, 2013. She indicated that she heard Petitioner fall and saw her sliding down the stairs. She dropped her purse and coffee cup. Petitioner reported hitting her head. She also said she was somewhat dizzy. She did not complain of any pain. When asked to describe what Petitioner was doing at the time of the accident, Ms. Lacy wrote, "She was walking down the stairs." In response to the question, "Could this accident have been prevented?" Ms. Lacy wrote, "I didn't see it." (PX 12)

Joel Wright also completed a witness statement on March 4, 2013. He saw the accident occur and described a head injury. She fell and hurt herself on the stairs. He didn't see any cuts or bruises. Petitioner did complain of head pain. Mr. Wright also wrote that Petitioner was carrying work materials (books, papers, pencils) and so both hands were occupied so she couldn't grab the handrail. (PX 12)

Petitioner completed an accident report on March 4, 2013 indicating she fell going down the stairs and hit her head and right shoulder. (PX 12)

On March 5, 2013 Petitioner's Supervisor completed a "Supervisor's Injury Report." The supervisor noted he did not question the legitimacy of the injury as witnesses backed it up. (PX 12)

On March 7, 2013, Petitioner returned to Occupational Medicine at Carle as previously instructed. By history, she had slipped on the steps and had a right shoulder contusion and neck strain. There was no head injury. Petitioner indicated that she was still a little sore from the fall and could return to work without restrictions. She was allowed to do so. (PX 12)

Petitioner signed her Application for Adjustment of Claim in case # 13 WC 16262 on April 30, 2013 alleging injuries to her head, neck, back, both arms and "MAW" when she fell on March 4, 2013 and struck her head on stairs. (PX 3)

Petitioner followed up at Carle on May 6, 2013 and saw Dr. William Scott. At that time, Petitioner reported that she had significantly improved about a week following the initial accident on March 4, 2013, but that a couple of weeks ago, she began to notice ongoing chronic right shoulder pain. The doctor's records indicated that Petitioner did not know what caused this. She did report that she remembered tripping and falling. The doctor stated that he did not know whether or not these symptoms were related to the prior incident. She had been taking Tramadol that she had for other conditions and was requesting a refill. She didn't know why she hurt. Dr. Scott noted that Petitioner had many medical problems and needed to be careful as to the pain medications she used because they could be hard on her kidneys and lead to kidney disease. He felt she had multiple medical problems and had now developed right shoulder pains and stiffness which seemed to be myofascial in origin. He wrote, "No red flags are discovered during this evaluation." He was willing to try Tramadol but not on a long-term basis. He also recommended ThermaCare and heat wraps. He concluded, "Overall, I am not clear on the work relatedness of this condition, given the fact that she did recover and now this seems to be relatively new." (PX 12)

On May 30, 2013, Petitioner returned to Carle's Occupational Medicine Department and was released from the doctor's care from the March 4, 2013 accident to return as needed. She was still complaining of left-sided soft tissue pain over her left shoulder and could reproduce the pain by pressing and touching the left trapezius muscle. It was felt she was approaching maximum medical improvement for the soft tissue pain and he thought it would go away on its own. (PX 12)

Petitioner returned to see Dr. Muscatella on August 15, 2013 regarding her left ankle pain and swelling. X-rays were taken indicating a non-displaced fracture of the tibia and fibula. She was dispensed a 3D walker and was told to return in 3 weeks. She returned a couple of times for a stress fracture. It was noted that on September 11, 2013, Petitioner had a stress fracture of the left ankle. Some right foot swelling was noted in September of 2013; however, it was attributed to Petitioner's not using certain medications. (PX 4; PX 14)

Since that visit, Petitioner has continued to treat with Dr. Muscatella in 2013 and 2014 but the records clearly reflect that treatment was either for her left foot or for a refill of medication. (PX 14)[1]

Due to Petitioner's complaints of leg weakness Dr. Muscatella had Petitioner undergo an EMG on December 9, 2013, the results of which suggested severe diffuse polyneuropathy and superimposed carpal tunnel syndrome. (PX 4)

The Arbitration Hearing

Petitioner's case proceeded to arbitration on March 9, 2017. Petitioner was the sole witness testifying. The disputed issues were accident, causal connection, medical bills, and the nature and extent of any injury. (AX1)

[1] The doctor's bills found in PX 14 also suggest visits in 2015 but no records were included with the exhibit.

Petitioner testified that she was hired by Respondent in 1988 as a teacher's assistant. Petitioner testified that on September 9, 2008, she fell down some steps. She explained that the steps were "kind of misty" or "damp" and she just slipped and fell down the steps. She testified that "misty" wasn't really a good word to use as the steps "were just – and I slipped and I fell and I –." The steps were not wet. Petitioner was going down the steps from her classes upstairs to her classes on the second floor. She did not have anything in her hands. After she slipped several teachers and a student came to see if she was okay and they took her to the office and she wrote out a statement. Petitioner further testified that she noticed both her right foot and low back hurt.

Petitioner testified that after accident, she went to Provena Emergency Room on September 10, 2008 and she underwent right wrist, shoulder and ankle x-rays. She then followed up with her primary care doctor, Dr. Raman, who, in turn, referred her to Dr. Muscatella.

Petitioner testified that Dr. Muscatella treated her with pain medication, a cam walker boot, and physical therapy. She attended physical therapy through December 4, 2008 and described her progress in therapy as "okay."

Petitioner returned to work on December 8, 2008. She returned to work in the same position. She proceeded to follow up with Dr. Muscatella several more times over the next couple of months and underwent an injection to her ankle at one point. Petitioner testified that Dr. Muscatella eventually ordered an MRI of her ankle because she was still having problems. That took place on March 10, 2009.

Petitioner testified that she had another accident on March 31, 2009 at work when a chair she was sitting on gave way and she fell and her foot "kind of like went under her." She testified that, as a result, her right foot hurt a little bit more. She also noticed back pain. When asked about whether she hurt her knee, she replied, "I am thinking yes, it was."

Petitioner then followed up with Dr. Muscatella who put her back in the cam boot until April 30, 2009 when he advised her she could proceed into regular shoes. He then released her to return as needed.

Petitioner testified that when she resumed shoe gear she was in a lot of pain and when she increased her activities her ankle hurt more. Petitioner testified that during the summer she called Dr. Muscatella's office requesting pain medication. She then returned to work in August of 2009 at which point she noticed a certain amount of ankle pain leading her to return to see Dr. Muscatella. At that point he recommended ankle surgery and she underwent surgery on November 13, 2009.

Petitioner further testified that after her surgery the doctor had her undergo physical therapy which she did through January 8, 2010. While she was doing well, the doctor injected her ankle in late January of 2010 and she was released from his care as of February 10, 2010.

Petitioner also testified that after she had been released by Dr. Muscatella she underwent an MRI of her low back but she didn't recall who ordered it, maybe Dr. Kohlmannn. He then injected her back in July of 2010.

Petitioner indicated that following the initial treatment of her back that she did not receive any additional treatment until 2016 when she began undergoing water therapy. She just took medication.

Petitioner testified to seeing Dr. Kohlmann's assistant in January of 2011 for right knee pain. She did not recall when her right knee began to hurt. When asked if it was from one of the two accidents, she replied "Yeah, I think it was when I fell down the steps." She was then asked if it was the fall in 2008 and she replied, "Yeah, initially." She received a knee injection in January of 2011 and she underwent the knee replacement in July of 2011. Petitioner testified that after she had a knee replacement she followed up with Dr. Muscatella in July of 2011 and he treated her for a short period of time. In October of 2011 she was placed back in an orthotic for her ankle per Dr. Muscatella. She could not remember when she stopped using it but she no longer does.

Petitioner testified to falling down some steps on March 4, 2013. She was coming down steps from the third floor to the second floor and she slipped. She had books in her hands but she could see. She could not recall if the steps were "misty" or not. After falling, Petitioner felt pain in her shoulder, foot and back. She went to the emergency room that day and gave them a history of missing the last four steps. She then proceeded to treat at Carle for the next few months and primarily for her shoulder. She was released from Carle as of May 30, 2013.

Petitioner further testified that she had no further ankle problems after October of 2011 until about a year ago when it began hurting and swelling up again. She returned to Dr. Muscatella. According to Petitioner he ordered Neurontin for her to take and she does so.

Petitioner testified to pain and swelling in her right ankle and that it "sometimes works and sometimes it doesn't." She has trouble walking more than half a mile before she notices problems with pain.

Petitioner also notices back pain when walking half a mile and she takes prescription medication for it as prescribed by Dr. Hoffman, her primary care doctor. She indicated that she was diagnosed with degenerative disc disease and she underwent therapy at that time. Petitioner acknowledged having back surgery in 2003 or 2004. The therapy helps her back but in just the last few weeks Petitioner has been having problems with walking due to her back and leg pain.

Petitioner further testified at the hearing that she was not having any problems with her right knee. It was okay.

Petitioner is still working for Respondent and earning more than before. She has, however, pain.

Petitioner denied any other accidents than the three she testified to.

Petitioner testified to a painful right shoulder and no range of motion. She has recently gone to Sports Medicine and has been told it's where it was hurt when she fell at school because she has a degenerative condition that "opened up" and is now more painful. She has to get steroid injections now. Up until then she had undergone no shoulder treatment since being released in 2013.

On cross-examination Petitioner was asked about each of the accidents. With regard to the 2008 accident Petitioner agreed there were no chips, cracks or defects in the stairs. She denied the presence of any standing water. It was just "misty." She clarified that the steps she was going down were the ones from the second floor going out to the playground. Some students were with her when she fell.

Petitioner was asked about how she fell when the chair broke on March 31, 2009 and she explained that the chair cracked and she fell like sideways and maybe backwards but it had happened a long time ago and she couldn't remember.

Petitioner also testified that when she fell down the stairs on March 4, 2013 she had books in her hands but she could see the stairs in front of her.

Petitioner agreed that she saw Dr. Moran on June 4, 2011 regarding her knee. When asked about the doctor who had previously recommended a knee replacement she thought it was Dr. Kohlmann; however, she could not recall when he told her that.

Petitioner acknowledged having diabetes and being insulin dependent now; however, she wasn't on insulin before the first accident in 2008.

On redirect examination Petitioner explained that the steps she fell down in 2008 led to the outdoors. There wasn't a door at the bottom of the steps; rather, there was a small landing and then there was a door. That was the area that was "misty."

Proofs were closed.

The Arbitrator concludes:

(C) Did an accident occur on September 9, 2008 that arose out of and in the course of Petitioner's employment by Respondent?

Petitioner failed to prove she sustained an accident on September 9, 2008 that arose out of and in the course of her employment with Respondent.

The Illinois Supreme Court has long recognized that "the mere fact that the duties take the employee to the place of the injury and that, but for the employment, he would not have been there, is not, of itself, sufficient to give rise to the right to compensation." *Caterpillar Tractor Co. v. Industrial Comm'n,* 129 Ill. 2d 52, 63 (Ill. 1989).

"For an injury to 'arise out of' the employment its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Caterpillar Tractor Co.*, 129 Ill. 2d 52, 58, 541 N.E.2d 665, 667 (Ill. 1989). "The object of comparing between the exposure of the particular employee to a risk and the exposure of the general public to the risk is to isolate and identify the distinctive characteristics of the employment." *Caterpillar Tractor Co. v. Indus. Comm'n*, 129 Ill. 2d 52, 62, 541 N.E.2d 665, 669 (Ill. 1989), citing 1 A. Larson, The Law of Workmen's Compensation § 8.42 (1985).)

The Illinois appellate courts have recognized that "There are three types of risks which an employee might be exposed to, namely: 1) risks distinctly associated with the employment; 2) risks which are personal to the employee; and 3) 'neutral risks which have no particular employment or personal characteristics.'" *Potenzo v. Illinois Workers' Comp. Comm'n*, 378 Ill. App. 3d 113, 116, 881 N.E.2d 523, 526-27 (1st Dist. 2007), quoting *Illinois Institute of Technology Research Institute v. Industrial Comm'n*, 314 Ill.App.3d 149, 162, 247 Ill.Dec. 22, 731 N.E.2d 795 (1st Dist. 2000).

Going up and down stairs is a neutral risk. In the instant case Petitioner failed to prove that she was exposed to a neutral risk greater than that to which the general public is exposed. Petitioner testified that the stairway where she fell led to the door to the playground. No evidence was presented showing that this stairway was not accessible to the public. Petitioner testified that there were no defects in the stairs and there was no standing water. She was not carrying anything nor was she in a hurry. Petitioner provided no testimony as to why she was going down the steps in the first place other than to get from one floor to another.

Of interest is the fact that Petitioner did not even mention this fall occurred at work when presenting to the emergency room on September 9th or 10th. The first mention of it being at work was on September 29th when she went to her family doctor. Petitioner also testified that the accident was witnessed and that statements, including her own, were provided to Respondent. The Arbitrator cannot help but note that witness statements, as well as a statement by Petitioner, were furnished in regard to a fall she had on stairs in March of 2013 and included in the exhibits herein; however, Petitioner did not furnish any statements or witnesses in support of her accident which is the subject of this claim. When testifying about the 2013 accident Petitioner testified that it was witnessed by students, but that is contrary to the statements found in the PX 12. Mr. Wright was a student teacher. Ms. Lacy did not appear to be a student.

While Petitioner's testimony focused on the steps being "damp" or "misty", no evidence was presented that it was raining on the day of Petitioner's fall. No explanation as to why the steps were like that was given. The Arbitrator cannot help but also note that the word "wet" was marked out on Petitioner's Application for Adjustment of Claim from which she reasonably infers that water was not an issue.

The Arbitrator also notes inconsistencies as to how Petitioner fell. While she testified that she slipped, her history to Dr. Muscatella on October 1, 2008 refers to her having "tripped." The Arbitrator is unable to determine with certainty as to the mechanism of injury and she cannot speculate as to how it came to be that Petitioner fell down the stairs. Illinois has not adopted the positional risk doctrine. Petitioner did not prove that her fall stemmed from a risk associated with her employment. Petitioner failed to prove she sustained an accident arising out of and in the course of her employment with Respondent.

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

(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?

Consistent with her liability determination, these remaining issues are considered moot. Petitioner's claim for compensation is denied and no benefits are awarded.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Richard Powell,
Petitioner,

vs. NO: 13 WC 13496

17IWCC0817

Jack Cooper Transport,
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, temporary total disability, permanent partial disability, and 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 May 12, 2016, is hereby affirmed and adopted.

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,00.00.00. 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: DEC 19 2017

Joshua D. Luskin

o-12-05-17
jdl/wj
68

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Charles J. DeVriendt

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

POWELL, RICHARD
Employee/Petitioner

Case# **13WC013496**

JACK COOPER TRANSPORT
Employer/Respondent

17IWCC0817

On 5/12/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.38% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2028 RIDGE & DOWNES LLC
JOHN E MITCHELL
415 N E JEFFERSON AVE
PEORIA, IL 61603

0687 KNELL O'CONNOR DANIELEWICZ
THOMAS R BOYD
901 W JACKSON BLVD SUITE 301
CHICAGO, IL 60607

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

RICHARD POWELL
Employee/Petitioner

v.

JACK COOPER TRANSPORT
Employer/Respondent

Case # 13 WC 13496

Consolidated cases: _____

17IWCC0817

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the cities of **Mt. Vernon**, on **February 5, 2016**, and **Herrin**, on **March 7, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **November 22, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$Not stipulated**; the average weekly wage was **$1,663.00**.

On the date of accident, Petitioner was **54** years of age, ***married*** with **0** dependent children.

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

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

To date, Respondent has paid **$10,499.06** in TTD, TPD and/or for maintenance benefits, and is entitled to a credit for any and all amounts paid. Please see the decision, below, regarding applicability of said credit(s).

Respondent shall be given a credit of **$9,342.28** for TTD, **$1,156.78** for TPD, **$N/A** for maintenance, and **$N/A** for other benefits, for a total credit of **$10,499.06.** Please see the decision, below, regarding applicability of said credit(s).

Respondent is entitled to a credit of **$5,801.03** under Section 8(j) of the Act. Please see the decision, below, regarding applicability of said credit(s).

ORDER

The Petitioner's lumbar and cervical spine conditions, and need for surgery, are causally related to the November 22, 2012 accident.

Respondent shall pay Petitioner temporary total disability benefits of **$1,108.67** per week for **17-5/7 weeks**, commencing **February 7, 2013 through June 10, 2013**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary causally related medical services, as provided in Section 8(a) of the Act, with regard to the following providers: WorkHealth, Dr. George, Dr. Vashishta, Dr. Fabi, Dr. Finkelstein, Dr. Girton and the Laser Spine Institute and Surgical Center, as well as any related diagnostic testing requested by these providers. The Respondent's liability for these expenses is limited by the Fee Schedule contained in Section 8.2 of the Act.

Respondent shall be given a credit of for any awarded medical benefits that have been paid prior to hearing, as well as any of the awarded medical expenses paid pursuant to Section 8(j) of the Act, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$712.55** per week, the maximum allowable rate under the Act, for **125 weeks**, because the injuries sustained caused the **25% loss of the person as a whole**, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

May 11, 2016
Date

ICArbDec p. 2

MAY 12 2016

STATEMENT OF FACTS

The Petitioner worked for Respondent and its predecessor as a car hauler for 30 years, specifically for Respondent since 2008. This involved loading and unloading eight to ten cars on a carrier semi-truck and delivering them to and from plant and rail locations and dealerships. The loading process involved climbing ladders and moving around the truck racks with crouching and bending in order to strap the cars down, and then to unstrap and unload them at the delivery site. He testified that the trucks now lower the racks to ground level with hydraulics, so while he still has to strap cars down and unstrap them, other than to get to the one over the truck cab, he no longer has to climb ladders, and they now have quick release straps that are less physical to use.

Petitioner testified he had prior low back injuries with Respondent and had undergone epidural injections, but was not undergoing active treatment at the time of the accident at issue. He "hardly ever had" any prior neck problems. He was having no problems performing his job.

On 11/22/12 he was in Effingham, Illinois, doing his morning pre-trip truck inspection, which is required of all drivers. He noticed a strap was off on a vehicle, so he went around the tire and tightened it down. As he was stepping out, he stepped on a rail that was wet from the dew, and slipped and fell about 2.5 to 3 feet onto the blacktop, landing on his left side. He noticed immediate shoulder, elbow, neck and back pain.

He called in to the terminal to report the injury, but had to leave a voice mail because it was the Thanksgiving holiday. He delivered his load from Effingham, Illinois to Indiana, and then continued to his Lansing, Michigan terminal, and testified that his pain continued to worsen. He testified that 11/23 was the Friday after Thanksgiving, and a company holiday, so he completed injury forms for the Respondent the following Monday, 11/26/12, and was sent to the company clinic, WorkHealth. The Michigan injury report noted complaints to the low and mid back, ribs, neck, left arm and hand. The form indicated it was Thanksgiving and the Petitioner wanted to get home, so he drove back. (Px1).

The Petitioner noted that under Michigan workers' compensation law, he was not allowed to see his own physician for 30 days. He saw Dr. George at WorkHealth on 11/26/12, who diagnosed him with low back and left hand/wrist strains and limited the Petitioner to light duty work. The Petitioner testified that he told Dr. George he had prior chronic back pain and prior injuries. The Petitioner indicated 8/10 low back pain with a 4/10 to 5/10 pain baseline, with radiation into the right leg and calf numbness, and that he had landed on the left hand/arm. The report also notes chronic pain and several years of treatment at a pain clinic. X-rays were taken of the low back (scoliosis and degenerative changes, minimal L5/S1 right facet arthritis) and left wrist (negative). At a 12/3/12 follow up, Petitioner reported his pain radiated to both legs with right leg numbness, and light duty was continued. A 12/13/12 note indicates Petitioner also complained of neck stiffness and soreness, and x-rays showed moderate C6/7 spondylosis, mid cervical minor facet arthrosis and possible minor C3/4 foraminal encroachment. Cervical strain was added to the diagnosis, and cervical MRI was requested along with right leg EMG. Dr. George noted the EMG was to "rule out acute vs. chronic radiculopathy which will help in determining pre existing conditions and assessing severity of his current condition." This test was not authorized by Respondent. (Px1). After some delay with authorization, the Petitioner underwent MRIs of the neck and back. Due to ongoing neck, back and left shoulder pain, and Petitioner's belief that WorkHealth was not really doing anything that helped him, after the 30 day waiting period ended the Petitioner sought treatment with his family physician, Dr. Vashista.

The 12/10/12 lumbar MRI was compared by the radiologist to 12/29/03 films, noting mild increase in right paracentral L4/5 herniation with subtle progression into the right neuroforamen causing mild stenosis, and

otherwise was stable with redemonstration of multilevel hypertrophic spondylosis and degenerative disc changes. No prior cervical studies at that facility were noted, so there was no comparison to prior films. The 12/18/12 cervical MRI showed moderately advanced multilevel disc degeneration including endplate spondylosis and osteophyte formation and uncovertable spurs, greatest at C5/6 and C6/7. No disc extrusions were noted. (Px1).

Asked if he'd had prior similar symptoms, the Petitioner testified that he'd had back pain in the past, noting that the previous process of chaining cars had resulted in a lot of work injuries for drivers. The Petitioner testified that he had to undergo a physical when the Respondent took over the facility in 2008, and every two or three years thereafter for the DOT, and passed them all.

Several medical records which predated the 11/22/12 accident were presented into evidence. The 12/29/03 lumbar MRI notes those films were compared to 8/15/02 films. The report indicates a small eccentric L3/4 right bulge producing some mild foraminal stenosis but no definite impingement and mild to moderate bilateral facet arthropathy, a small central L4/5 protrusion without stenosis and mild facet arthropathy, and a stable L5/S1 left bulge with left foraminal stenosis and moderate facet arthropathy. (Px3). A 2/23/07 cervical MRI showed a moderate central C5/6 herniation without lateralization and a degenerated C6/7 disc with bulge but no significant stenosis. There also was a small L4/5 bulge. (Px1 & Px2; Rx6).

Prior to the accident, Petitioner sought to establish care with his apparently new primary care provider, Dr. Vasishta, on 10/22/12. He gave a history of chronic pain in his neck and back, but noted he had not seen a provider in some time. He also noted a bulging disc, and that he had previously been told to have it fused, but that he didn't have it done because he wouldn't be able to drive after that. He also noted a history of multiple unrelated surgeries that did not involve the spine, kidney stones and diverticular disease. Objectively, he was normal except for a painful limitation of lumbar range of motion. The assessment was that of back pain, degenerative disc disease, and chronic pain. Mobic was prescribed. (Px2).

Petitioner first saw Dr. Vashishta post-accident on 12/21/12 to follow up on fatigue, and noted he had fallen and sprained his back. Petitioner reported he had bulging discs and requested referral to a neurosurgeon. The diagnoses included back pain with radiculopathy. A 12/12/12 renal ultrasound had indicated multiple bilateral kidney stones. (Px2). On 1/8/13, Dr. Vashishta reported Petitioner was treating for back and neck pain, and that he had radicular symptoms in the left arm and right leg. Straight leg raise testing was positive on the right side. His neck had a painful range of motion. Dr. Vashishta noted Petitioner brought his MRI results in, and the diagnosis was degenerative cervical joint disease with bulging discs, as well as an L4/5 bulge with radicular symptoms. He was going to continue treatment with the company doctor, and if not, they would send him to a neurosurgeon for consult. (Px2).

Physical therapy from 1/14 to 1/25/13 provided no improvement. (Px1). The Petitioner testified that Dr. George discharged him back to work on 2/7/13, stating Petitioner's problem was arthritis, and his workers' compensation benefits were discontinued at that time. He was frustrated with Dr. George, and agreed he sent angry letters to him accusing him of incompetence and malpractice. These letters were part of the WorkHealth record exhibit. The Petitioner testified that no matter what happened to a Respondent worker, Dr. George would indicate that the problem was arthritis. A final report of Dr. George dated 2/7/13 noted his opinion that Petitioner sustained cervical and lumbar strains in the accident, and that they had resolved, returning him to his baseline preexisting condition. He referenced significant advanced degenerative arthritis in both the cervical and lumbar spine which was responsible for his chronic symptoms. Dr. George also noted that the physical therapist had indicated signs of symptom magnification. (Px1).

At a 2/8/13 follow up with Dr. Vashishta, the Petitioner noted he had been discharged by workers compensation because he had degenerative joint disease. Petitioner reported some left elbow pain and numbness. Dr. Vashishta noted Petitioner had chronic radicular symptoms, and the Petitioner was very concerned about his ongoing problems. Dr. Vashishta's recommended a lumbar MRI, left elbow x-ray, light duty and referral to an orthopedic surgeon. (Px2).

Petitioner testified that Dr. Vashista suggested he see a neurosurgeon, Dr. Fabi, whom Petitioner initially saw on 2/19/13. The report states: "This is a chronic problem", noting the work accident, ongoing stabbing and shooting low back pain radiating to the right leg to the foot greater than to the left leg to the knee. The majority of his pain was in the back as opposed to the legs. Cervical and thoracic pain were also noted in the review of systems. Dr. Fabi stated the Petitioner "has had a long history of intractable low back pain." The Petitioner also noted prior lumbar epidurals were performed in 2002/2003. Lumbar exam showed decreased range of motion in flexion and extension as well as tenderness, but cervical range of motion was normal. Films showed some progression of degenerative disc disease (DDD), most notably at L4/5 and L5/S1, with an L4/5 bulge encroaching on the right nerve root. Dr. Fabi's report states: "At this point, he has tried multiple modalities of therapy. He has undergone multiple injections and physical therapy and in fact is getting worse, not better." He noted Petitioner had been evaluated a number of years prior, and that there had been a possible consideration of disc replacement at that time. Dr. Fabi noted, in reviewing the films, he wasn't sure such a surgery would help, and that insurance would not pay for it in Michigan anyway. Opining that the Petitioner had a 2 level disease, all he could offer was a fusion of those levels with decompression of the right L4 nerve root. A discogram was recommended, to include L3 to S1. Dr. Fabi added that "it is not the best situation" given he had more back pain than leg pain, and that there was no perfect surgery or remedy for Petitioner. (Px3). The Arbitrator notes that an intake form asked the Petitioner if he ever had a problem with the complained of body parts before, and he responded: "Not in my middle back and not into my arm Neck hurts more." His pain diagram showed symptoms in the back of his neck, throughout the low back area, into both legs to the calves with stabbing pain. Also noted were symptoms in the left forearm and elbow, along with burning pain behind his knees. (Px3). A letter from the Petitioner to Dr. Fabi is also in Px3. The Petitioner testified he did not want the cage fusion, and that he had gone to Dr. Fabi specifically because he preferred to have a disc replacement, but Dr. Fabi indicated that an insurance company would not cover it.

It appears the Petitioner last saw Dr. Vashishta on 2/27/13, and after noting the neurosurgeon wouldn't take him off work despite pain limiting his abilities, the doctor gave an off work slip, but said that work status would thereafter be up to the neurosurgeon. (Px2). The Petitioner testified that Dr. Vashishta then referred him to the Laser Spine Institute, and the Petitioner remained off work.

The Petitioner initially sought treatment at the Laser Spine Institute on 3/11/13. He was noted to present with a 10 year history of low back pain, and the pain was radiating into both buttocks and down his back and right leg to the calf. He also complained of numbness and tingling in the groin area and outside the left heel. The report states: "Most recently, (Petitioner) states he fell off his truck 11/22/12 which aggravated his current symptoms." He had tried therapy, epidurals and chiropractic treatment with no lasting relief. He also complained of neck pain radiating into the back of his head, down both shoulder blades and into his left arm, again noting his symptoms were aggravated by his 11/22/12 fall. He had tried chiropractic treatment and NSAID's for this with no lasting relief. Petitioner reported his average pain was 3 to 8 out of 10 at rest, 5 to 8 out of 10 when active, and 6 out of 10 at the visit. The pain pattern was noted to be "progressive, intermittent", increased with any activity, any prolonged position or looking down. "Nothing" reduced the pain. The diagnoses were lumbar disc displacement and lumbosacral spondylosis without myelopathy and with neurogenic claudication, and lumbar DDD. Cervical and lumbar x-rays, lumbar MRI and fluid testing were prescribed. On 3/11/13, surgery was

recommended, with Dr. Finkelstein noting it may not resolve all symptoms and that an additional surgery might be needed in the future. (Px4).

Petitioner completed a form at Laser Spine Institute indicating neck pain for 5 to 10 years, arm pain for less than a year, with no worsening over the prior three months. He also indicated a 5 to 10 year history of low back pain, leg pain for less than a year, and again noted no worsening over the last three months. (Px4).

A 3/11/13 lumbar MRI showed multilevel degenerative changes, most pronounced at L4/5. Mild diffuse disc bulges were noted at all levels from L2/3 to L5/S1 along with varying levels of bilateral foraminal stenosis. (Px4).

On 3/12/13 Dr. Finkelstein administered a diagnostic select nerve root block on the right at L4, and Petitioner reported 70% improvement. (Px4).

On 3/13/13, Dr. Girton noted a history of chronic back and leg pain with an acute November, 2012 exacerbation that had persisted, becoming increasingly limiting. The back pain was primary, and the leg pain was 75% on the right, with Dr. Girton indicating the pattern was primarily S1. Pre op diagnoses includes lumbar degenerative disc disease, lumbar facet degeneration/hypertrophy, lumbar foraminal stenosis, lumbar osteoarthritis, lumbar spinal stenosis and lumbar ulnar tear. On this same date, Dr. Girton performed a lumbar laminotomy and foraminotomy including a partial facetectomy with decompression of the disc and nerve root at right L4/5. Post operatively diagnoses remained the same. (Px4).

On 3/15/13, Dr. Finkelstein reviewed an MRI done that day on the cervical spine with normal findings at C2/3 and from C7 to C10; a disc osteophyte complex centrally and towards the left side causing mild to moderate foraminal stenosis at C3/4, left greater than right; mild foraminal stenosis bilaterally at C4/5; a disc osteophyte complex centrally and towards the left side causing moderate left greater than right foraminal stenosis as well as moderate central stenosis at C5/6; a disc osteophyte complex centrally causing mild foraminal stenosis bilaterally at C6/7. The history noted pain radiating down the left arm for 4 months. The radiologist's report noted the impression was degenerative cervical changes. Surgery was recommended, with Dr. Finkelstein noting it may not resolve all symptoms and that an additional surgery might be needed in the future.

On 3/18/13, Dr. Girton performed a cervical surgery, indicating the pre and post-operative diagnoses of cervicalgia, cervical degenerative disc disease, cervical foraminal stenosis, cervical osteophyte and cervical bulging/herniated disc. He noted 75% of the pain was axial neck pain, and 25% radicular, with 90% of that being in the left arm in a predominantly C6 distribution by history. The procedure performed was a cervical laminectomy and foraminotomy, including partial facetectomy with decompression of the left C5/6 nerve root, as well as thermal ablation of the paravertebral facet joint nerves at left C4/5 and C6/7, and at right C4/5, C5/6 and C6/7. (Px4).

On 8/5/15, Dr. Girton authored a narrative report. (Px5). He noted that Petitioner reported 80% improvement two weeks post-operatively. On 4/10/13 he reported by phone that he had 50% improvement of his overall pain – he was feeling okay but having some low back pain. On 5/30/13 Petitioner requested a return to full duty work as of 6/10/13, which was provided to him. Dr. Girton reviewed the Petitioner's medical and received a detailed history regarding the accident, and compared the MRIs. He acknowledged that Petitioner had previously sustained injuries to his neck and lower back, but believed that the 11/22/12 work accident aggravated those preexisting cervical and lumbar conditions, noting the accident increased his previous symptoms and was "a precipitating event which required him to subsequently require surgery of the cervical spine and lumbar spine areas" based on a reasonable degree of medical certainty. The history and subsequent treatment indicated to him

that the Petitioner had a superimposed new injury upon the old. The Petitioner had a history of chronic pain, "but this did not reach the level requiring surgery." He did not believe the Petitioner needed work restrictions. Dr. Girton also indicated his reasoning in performing the surgeries, that they were performed in accordance with surgical standard principles, and explained why he performed the two surgeries close in time. (Px5).

Petitioner was examined by orthopedic surgeon Dr. Graf on 10/16/14 at the Respondent's request pursuant to Section 12 of the Act. (Rx3). Dr. Graf reviewed medical records and summarized the medical care rendered, as well as his general examination findings, noting that although Petitioner indicated some neck and back pain, he was neurologically normal. Following the exam and medical review, Dr. Graf initially opined that he was unable to comment on causation: "as it is evident that (Petitioner) was treated in the past in a chronic pain clinic. It is noted during his discharge summary that he reported a pain level of 5-6/10 which was noted to be his baseline pain level." He then goes on to comment on causation, stating that the cervical and lumbar surgeries would not be considered secondary to the work accident because they occurred after the Petitioner had been released by Dr. George. While he indicated that the accident was "possibly consistent" with Petitioner's complaints, he opined that, after reviewing Petitioner's lumbar MRIs (8/15/02, 12/29/03, 12/10/12 and 3/11/13), only the 3/11/13 films showed an increase in the size of L4/5 disc herniation versus the others, and that this film was taken subsequent to Dr. George's release. He was not able to provide much information on the preexisting condition because he had not been presented with prior progress notes to review, and stated that in order to determine if the Petitioner's current condition was caused or aggravated by the work accident versus a normal progression of degeneration, he would need to review the prior medical. He believed that the Petitioner had reached maximum medical improvement and objectively needed no further treatment or work restrictions.

Dr. Graf issued an addendum report on 2/9/15, after being forwarded the records of the Laser Spine Institute. He referred to those records indicating that the Petitioner had a 5 to 10 year history of prior neck and back pain, and had undergone prior chiropractic treatment, 15 lumbar epidurals and physical therapy. He stated: "It is evident from the records that (Petitioner) has chronic neck and back pain for 10 years and having undergone over 15 epidural injections in the past with continued pain. The surgeries that (he) underwent are noted to be for degenerative changes and foraminal stenosis." (Rx4). As such, his opinion was that the Petitioner's post accident care and treatment were not related to that claim. He also questioned the surgeries themselves, indicating it was not standard procedure to perform injections, nerve root ablations and decompression "simultaneously". (Rx4).

Dr. Graf also testified in this case, via deposition on 6/25/15. (Rx2). On direct, he testified consistent with his reports. He noted that the 12/10/12 lumbar MRI, which was performed after the accident but prior to Dr. George's release, did not show an increase in the size of the L4/5 herniation, while the 3/11/13 films after Dr. George's discharge did show such increase. He reiterated that the injections, ablations and surgeries performed at the Laser Spine Institute so close in time was not normally seen in the medical community. On cross examination, Dr. Graf agreed he had not seen any medical records regarding the Petitioner for the period between the 2003 MRI and the injury of 2012. He also agreed his conclusions that the Petitioner had returned to his baseline pain level after the work accident came from the records of Dr. George. He was aware of Petitioner having five episodes of lumbar injections in 2002 and 2005, but had no indication that the Petitioner had not been capable of working from 2005 to 2012, and he agreed that it appeared the Petitioner worked full duty during that time notwithstanding his prior spinal condition. Dr. Graf disputed the radiologist's conclusions in the 12/10/12 lumbar MRI that there was a subtle progression of the paracentral disc herniation at L4-5 since 2003, noting he viewed the films himself side by side and there was no appreciable change. He agreed that the Petitioner's cervical and lumbar surgeries were the type that could relieve the complaints of pain that Petitioner had prior to the accident, and that it was possible that those procedures did take pressure off the nerves in the cervical and lumbar spines. While he agreed that its possible to have an exacerbation of a pre-existing condition,

he did not think that occurred here, referencing that Petitioner had significant degeneration, had improved post-accident to baseline level, and that the only indication in the increase in the size of the lumbar disc was about 4 months post accident, after one performed a month post-accident did not indicate such increase. (Rx2).

Petitioner testified that his neck has been great since the surgery and that his arm was fine. He will have a twinge here and there because he still has other herniated cervical discs, but he's had no further problems with his shoulders and has been able to work, so he feels like the right disc was addressed. On redirect testimony, the Petitioner noted he still has neck pain all the time, but that it is tolerable and that he is able to work. He testified that his low back pain is an off and on thing. Sometimes he gets sciatic nerve pain mostly down the right buttock into his right leg, occasionally to the foot, but at times it catches in his left.

During cross exam, the Petitioner testified that, as to his neck, he had no prior work injury, and no cervical diagnostic studies, MRIs or x-rays prior to this accident that he could think of. He was then shown a 2/23/07 cervical MRI report which disclosed a moderate central C5/6 herniation without lateralization as well as degeneration at C6-7. Lumbar films from the same date reportedly showed a bulging disc at L4/5. (Rx6). The Petitioner then testified that he had been injured at work on 12/10/03, noting he injured the low back when he slipped while walking in front of his truck, grabbed the post on the front and slid underneath the truck. He initially sought treatment at WorkHealth. He testified that he had mainly low back pain, and some neck pain. They examined his neck and took a cervical MRI, but only treated the low back, including epidurals. He testified that he did have ongoing back pain after that, as the epidurals didn't work as well as they had in the past, but that he was able to work. He wasn't certain, but overall he believed that he'd had about 15 lumbar epidural steroid injections in series' of threes over the years, as well as 4 or 5 MRIs over the years. He testified this was because of multiple injuries at work, the days when they used chains to secure vehicles and the chains or bolts would break.

His injuries from 2002 to the present included a plate in his left elbow from an injury at home, a right shoulder surgery due to work injury sometime before 2008. He testified he'd had no work injuries since the Respondent took over the facility in 2008 until 11/22/12. The Petitioner testified he had a claim filed in Michigan for the 12/10/03 accident until it was dropped in 2011. The attorney who represented him withdrew and told Petitioner that he didn't see any money in it for him. The Petitioner agreed that a 2003 lumbar MRI indicated an L4/5 disc bulge and an L5/S1 disc bulge/protrusion, and a 2002 film showed an L2/3 herniation and degenerative changes in L3 through S5.

The Petitioner submitted medical expenses alleged to be causally related to the 11/22/12 accident in Petitioner's Exhibits 6, 10, 11 and 12. Respondent submitted evidence of what it had paid as Respondent's Exhibit 1.

CONCLUSIONS OF LAW

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

The Arbitrator finds that the Petitioner has sustained his burden of proof with regard to the causal relationship of his cervical and lumbar conditions, and resulting surgeries, to the 11/22/12 date of accident.

The Arbitrator acknowledges that the Petitioner clearly had preexisting conditions in both his neck and low back. The evidence also indicates that the Petitioner's main problems in both areas of the spine were

degenerative problems. However, the greater weight of the evidence indicates that the Petitioner's condition was aggravated by the accident at issue, and that the accident was at least a cause of the need for the surgeries.

The medical evidence reflects that the Petitioner has had longstanding back pain, as well as neck pain, prior to the 11/22/12 accident. This is reflected in both the fact that prior MRIs have been taken of both the cervical and lumbar spine, as well as evidence that the Petitioner had prior lumbar epidurals, and what appears to have been therapy and/or chiropractic treatment to both areas. The Respondent correctly argues in its proposed decision that the Petitioner initially denied any prior injuries or treatment to the neck. On cross exam, after being shown a prior 2007 cervical MRI, he agreed he had prior neck problems. Petitioner testified he had been injured at work on 12/10/03, injuring his low back when he slipped while walking in front of his truck, grabbed the post on the front and slid underneath the truck. He also acknowledged prior lumbar injections, possibly up to 15 epidurals.

That said, there is no evidence of any treatment in the record of evidence between 2008 and 2012. There also appears to be no dispute that the Petitioner continued to work his regular job during that time. As such, there appears to the Arbitrator to have been a clearly defined, and accepted, accident wherein he fell off his truck on 11/22/12 and had increased symptoms in the neck and low back, including radicular complaints. The Arbitrator would also acknowledge that there are medical records in evidence which appear to indicate both that a fusion had been recommended to him in the past, and that he wanted to delay it, as well as to instead try to obtain a disc replacement surgery. However, the Arbitrator also believes that there was no indication, given no evidence of treatment for at least 4 to 5 years, that the Petitioner would have sought the surgeries currently under consideration but for the 11/22/12 accident. Even the Respondent's Section 12 examiner, Dr. Graf, agreed that the accident likely at least initially caused an increase in the Petitioner's symptoms.

The question then becomes whether the aggravation was temporary, such that the Petitioner returned to his baseline condition, or if the aggravation resulted in the need for surgery. As noted, the Arbitrator believes that the accident was at least a cause of the need for surgery. The primary cause for the surgery was clearly the Petitioner's degenerative spinal conditions, both cervical and lumbar. However, there is no evidence indicating that the Petitioner had enough significant symptoms that he either had to take time off work or to seek treatment since a 2/23/07 cervical MRI. While Dr. George indicated that the Petitioner had returned to his baseline pain levels upon his 2/7/13 release, there are simply no records in evidence which conclusively support what the baseline condition was. It appears he relied upon the Petitioner's statements in making this determination. However, the Arbitrator notes that the records from physical therapy indicated no improvement between 1/14 and 1/25/13, so it is unclear how Dr. George determined a return to baseline. The Petitioner's letters to Dr. George made it very clear that he did not agree with this determination. The Arbitrator has no real prior medical in the record to review that would tend to show ongoing significant preexisting problems in the several years prior to this accident. He continued to pass his DOT physicals per his testimony, and there is no evidence that rebuts the testimony.

The Arbitrator does not find the opinion of Dr. Graf to be persuasive in this case. After initially indicating he couldn't comment on causation without first reviewing pre-accident medical records, he nevertheless then opined that there was no causal relationship of the surgeries to the accident. His opinion was significantly based on the findings of Dr. George at the time he released the Petitioner from care. As noted, there is no solid proof of what the Petitioner's baseline condition was prior to 11/22/12, and thus Dr. Graf's reliance on that information is not persuasive to the Arbitrator. Dr. Graf's other key basis in denying causation was his opinion that the initial post-accident lumbar MRI of 12/12/12 showed no change versus the 2002 and 2003 films, and that the disc was significantly larger in /13 films, which were taken after Dr. George's 2/7/13 release. First, the Arbitrator notes with interest that the radiologist noted an appreciable, albeit mild, change in the 12/12/12 films versus the 2003 films, and that the change indicated a greater level of impingement on the right nerve root. Dr.

Graf's opinion that the change in the disc occurred between the 12/29/12 and 3/11/13 MRIs does not make logical sense to the Arbitrator. Unless there was evidence that the Petitioner sustained some type of new accident in that time period, it is unclear how Dr. Graf comes to the conclusion that the change in the disc is no longer related to the accident because he had been released by Dr. George. What then caused the disc to worsen between 12/29/12 and 3/11/13?

In the Arbitrator's view, this was a very close case. What pushed the case, in the Arbitrator's mind, in the Petitioner's favor by the preponderance of the evidence is the gap in treatment between 2007 and 2012, as well as the limited evidence available as to what the specific prior complaints, treatment and recommendations were. Again, the Petitioner need only prove the accident was a cause of the condition or conditions, and the Arbitrator finds that this was fulfilled in this case.

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 Petitioner's alleged medical expenses were presented in his exhibits 6, 10, 11 and 12. The parties stipulated that Respondent is entitled to a Section 8(j) credit, as noted above and below, and Respondent also submitted documentation with regard to the payments made by Respondent towards medical in this case. (Rx1).

In reviewing the medical expense exhibits, it was difficult for the Arbitrator to determine the total amounts billed and/or due and owing. While Petitioner's proposed decision seeks a total of over $200,000 in expenses from the Laser Spine Institute and the Laser Spine Surgical Center, it appears to the Arbitrator that some of the expenses for these facilities may be overlapping. As such, the Arbitrator awards the medical expenses incurred by Petitioner at the following facilities and providers between 11/22/12 and 6/10/13: WorkHealth, Dr. George, Dr. Vashishta, Dr. Fabi, Dr. Finkelstein, Dr. Girton and the Laser Spine Institute and Surgical Center. The expenses from any diagnostic testing and other associated charges from these facilities are also awarded.

The Respondent is entitled to credit for all expenses to the noted facilities and providers that was paid prior to the 2/5/16 hearing, and to 8(j) credit for all of the expenses paid via group health prior to the hearing date, so long as the Respondent holds the Petitioner safe and harmless with regard to all credited expenses.

With regard to the travel expenses (hotel and mileage) submitted by Petitioner as part of Petitioner's Exhibit 10, these expenses are denied. There is no evidence that the Petitioner was required to travel to Pennsylvania for treatment. Instead, it appears that the Petitioner made a voluntary choice to treat with a facility that was a significant distance from his home. As a Michigan resident, he clearly could have treated at facilities much closer to his home.

The Petitioner is entitled to reimbursement from Respondent for any and all out of pocket medical expenses paid by him that are related to his cervical and/or lumbar treatment between 11/22/12 and 6/10/13.

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

The Request for Hearing form (Arbx1) indicates the Petitioner is seeking TTD benefits from 2/7/13 through 6/11/13 "in addition to paid TTD." The Petitioner's proposed decision, however, requests benefits from 11/23/12 through 6/11/13.

The Request for Hearing form indicates the Respondent claims that it paid TTD benefits totaling $9,342.28 and TPD (temporary partial disability) benefits totaling $1,156.78. The Petitioner did not stipulate to this one way of the other. The Respondent submitted evidence, with no objection to admissibility from Petitioner, supporting that these payments were made. However, this credit appears to be applicable to TTD and TPD that was incurred prior to 2/7/13, which is not specifically being claimed as part of this case at hearing, per the Request for Hearing form (Arbx1) because it had already been paid.

The Arbitrator finds that Respondent shall pay Petitioner temporary total disability benefits of $1,108.67 per week for 17-5/7 weeks, commencing February 7, 2013 through June 10, 2013, as provided in Section 8(b) of the Act.

It appears to the Arbitrator that the evidence supports the finding that all TTD and TPD incurred prior to the 2/7/13 release of Dr. George has been paid by Respondent, and that the credit being claimed is applicable to the payments paid for that period. As the Arbitrator is not awarding TTD or TPD incurred prior to 2/7/13, pursuant to the Request for Hearing form, the Respondent is not entitled to take the $10,499.06 credit against the TTD awarded after 2/6/13. The only exception to this would be if the parties agree that there was an overpayment of TTD and TPD in the period prior to 2/7/13.

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

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

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

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

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. As such, 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 Petitioner was employed as a truck driver. As a truck driver involving the pick up and delivery of automobiles, the Arbitrator notes that the job involves some fairly physical manual labor that could continue to impact the Petitioner's spine. At the same time, the Petitioner testified that the job has been made easier as the amount of climbing required has been significantly reduced with trucks that now lower the racks where the cars are stored to ground level. Petitioner also noted that the straps used to hold the cars down are quick release and also easier to use than the mechanism used previously. The Petitioner had returned to his regular work duties as of June, 2013, and testified that he continued to perform these duties through the 2/5/16 date of his testimony. The Arbitrator finds that weight should be given to a higher percentage of loss based on the fact that the Petitioner continues to have a physical job, but weight should also be given to a lower percentage of loss since he had returned to his regular work duties for almost two years by the time of hearing.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 54 years old at the time of the accident. No evidence was presented as to how his age impacts the percentage of loss that is to be awarded in this case. As such, the Arbitrator gives no weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that no evidence was presented indicating that the Petitioner sustained a loss of future earning capacity. No evidence was presented indicating that the Petitioner's condition could result in any change in employment that could impact his future earning capacity. As such, the Arbitrator gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the records of the Laser Spine Institute indicated that the Petitioner had a very good result with minimum symptoms. The Petitioner's testimony corroborated this, as he testified that he felt he was doing quite well post-surgery. The Arbitrator gives this factor significant weight.

The Petitioner testified that his neck felt quite good, although he had some ongoing low back pain. The Petitioner's testimony, in the Arbitrator's view, was quite positive with regard to how he felt his condition was as a result of the surgery, even commenting that they must have picked the right disc given the level of relief he sustained. He is working full duty with no evidence indicating a need for restrictions, and he has suffered no diminution of wage. The surgeries performed appeared to be minimally invasive for spinal surgeries. The Arbitrator also takes into account that a significant part of the Petitioner's spinal problems, and likely part of his ongoing pain, appears to be based on spinal degeneration which predated this accident. Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 25% loss of use of the person as a whole pursuant to §8(d)(2) of the Act.

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

As noted above, the TTD/TPD credit requested by the Respondent totaling $10,499.06 is to be first credited against the TTD/TPD period that the parties agreed was paid for the time between 11/22/12 and 2/6/13. Respondent is only entitled to credit against the currently awarded TTD period of 2/7/13 through 6/10/13 if the parties agree that there was an overpayment of TTD/TPD that was due from 11/22/12 to 2/6/13, and only in the amount of said overpayment.

The parties stipulated that the Respondent is entitled to 8(j) credit of $5,801.03 for medical expenses paid via a group health plan contributed to at least in part by the Respondent.

STATE OF ILLINOIS)
) SS.
COUNTY OF WHITESIDE)

☒ 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

Veronica Ramirez,
Petitioner,

vs. NO: 12 WC 40686

State of Illinois
Department of Employment Security,
Respondent.

17IWCC0818

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 29, 2015 is hereby affirmed and adopted.

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: DEC 19 2017

o-12/05/17
jdl/wj
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Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RAMIREZ, VERONICA
Employee/Petitioner

Case# **12WC040686**

SOI-DEPT OF EMPLOYMENT SECURITY
Employer/Respondent

17IWCC0818

On 9/29/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% 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:

4954 McDONALD WOODWARD & CARLSON
HEATHER L CARLSON
3432 JERSEY RIDGE RD
DAVENPORT, IA 52807

0499 CMS BUREAU OF RISK MANAGEMENT
WORKERS' COMP MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0988 ASSISTANT ATTORNEY GENERAL
BRETT KOLDITZ
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

SEP 29 2015

Ronald A. Piasia, Acting Secretary
Illinois Workers' Compensation Commission

17IWCC0818

☐ 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

Veronica Ramirez
Employee/Petitioner

v.

State of Illinois – Department of Employment Security
Employer/Respondent

Case # 12 WC 40686

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Rock Island**, on **08/05/2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0818

FINDINGS

On **07/19/2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**46,934.68**; the average weekly wage was $**902.59**.

On the date of accident, Petitioner was **38** years of age, ***married*** with **2** children under 18.

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

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

Respondent shall be given a credit of $**0**for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**0**.

ORDER

PETITIONER FAILED TO PROVE THAT SHE SUSTAINED AN ACCIDENT ARISING OUT OF HER EMPLOYMENT CAUSALLY RELATED TO HER EMPLOYMENT.

THE CLAIM IS DENIED.

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

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

D. Dylan MacCarthy
Signature of Arbitrator

September 22, 2015
Date

SEP 29 2015

In Support of Arbitrator's decision relating to:

(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 casually related to the injury?

(j) Were the medical services that were provided to Petitioner reasonable and necessary?

(k) What temporary benefits are in dispute? xTTD

(l) Nature and Extent

Petitioner, Veronica Ramirez, was a 38 year old customer service representative for the Illinois Department of Employment Security, having been hired in March 2011. Initially, she worked as a claims processor. She would click and type through approximately 200 online unemployment applications a day to verify data and eligibility. Petitioner began her position in March 2011 and worked five days a week from 8:30 AM to 5 PM with two 15 minute breaks and an hour lunch. In March 2012, her job changed in that she also saw claimants in person. Her job continued to involve the use of a keyboard and mouse most of the work day. She did not use a head set for her phone calls. Petitioner testified that she received 13 paid holidays a year and utilized 10 vacation days a year.

On 08/02/2012, Petitioner sought a surgical consult from Dr. George Kontos in relation to a possible hernia. On that date, she informed the doctor that she was also experiencing some right elbow pain and was referred to Dr. Jason Clark, an orthopedic surgeon. Petitioner first met with Dr. Clark on 08/15/2012 and indicated that she started developing lateral aspect right elbow pain while working out. Dr. Clark recommended physical therapy and injections to reduce the inflammation.

Petitioner began physical therapy on 08/16/2012 and stated to the physical therapist that the pain began while working out with kettle bells then continued to hurt due to work. (PX 4 at 3) Petitioner attended physical therapy regularly, but indicated she could not rest her arm properly due to cooking, pinteresting, straightening her hair, and fiddling on her phone all day. Due to only temporary relief from physical therapy and injections, Dr. Clark recommended and performed a right tennis elbow release on 10/05/2012. Petitioner recovered from the surgery without issue and returned to work full duty on 12/11/2012.

In support of her claim, Petitioner submitted the evidence deposition of Dr. Clark wherein Dr. Clark testified that mouse and keyboard work can aggravate lateral epicondylitis. Dr. Clark said that the act of keyboarding and using a mouse would put pressure on the tendon which is associated with lateral epicondylitis. He suggested that typing and mouse use required one put slightly elevate their wrist, and while doing this with the forearm pronated, it could aggravate the condition and increase one's level of discomfort. (PX 11 at 17) Dr. Clark also said that the use of a headset would imply more continuous keyboarding, and the Petitioner's use of a headset would help solidify his opinions on causation. (Id at 31,32) The Petitioner, however, testified that she

did not use a headset when answering the phone at work. Dr. Clark testified that activities such as working out could cause the condition, but he had no evidence showing that she worked out much. Further, Dr. Clark testified that he was not personally aware of studies regarding lateral epicondylitis and its relation to office work.

In contrast, Respondent submitted the evidence deposition of Dr. Vender, an orthopedic surgeon who examined the Petitioner pursuant to Section 12. Dr. Vender indicated that the literature shows that lateral epicondylitis most often idiopathic, but could also be caused by forceful repetition in the form of an acute injury or degenerative condition. He also acknowledged that the repetitive use of a hammer, for example, could cause the required amount of force to stress the tendon involved. (RX 2 at 12) He testified that office work in the form of mouse work and keyboarding cannot rise to that level of force. He felt that mouse and keyboard use would not involve any wrist extension, and that when using a mouse, one's wrists are kept pretty still. (Id at 27) He also was unaware of any studies linking lateral epicondylitis to secretarial work.

The evidence is not present to support a finding of accident and causation between Petitioner's work duties and her lateral epicondylitis. Petitioner presented no evidence that her job had any forceful repetitive movements involving her wrist, but did submit evidence in the form of medical documentation that she was very active at the gym. Multiple doctors and medical records give an independent history that Petitioner injured herself at the gym and began having pain at work once she developed lateral epicondylitis from that event. Neither of the orthopedic surgeons who testified had much detail on the Petitioner's job, but in this case they both knew the essential fact that her job was full time and primarily required her to use her keyboard and mouse. Both also testified that lateral epicondylitis involves a tear of the ECRB tendon at it's insertion in the elbow. The Arbitrator concludes that Dr. Vender is slightly more persuasive on the issue of causation. In addition to his testimony on the lack of supporting studies, he said "You don't tear a tendon (at the elbow) by typing. You don't tear a tendon by answering the phone. "(Id at 17)

The Arbitrator finds that Petitioner has not met her burden of proof that she had an accident arising out of her employment causally related to her condition, and her claim for benefits related to her lateral epicondylitis is denied.

All other issues become moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeff Winfield,
Petitioner,

vs. NO: 16 WC 32284

17IWCC0819

Winpak Portion Packaging,
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 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 19 2017 is hereby affirmed and adopted.

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

17IWCC0819

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $14,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: DEC 19 2017

Joshua D. Luskin

o-12/13/17
jdl/wj
68

L. Elizabeth Coppoletti

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WINFIELD, JEFF
Employee/Petitioner

Case# **16WC032284**

WINPAK
Employer/Respondent

17IWCC0819

On 5/19/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.02% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0874 FREDERICK & HAGLE
PHILIP W. PEAK
129 W MAIN ST
URBANA, IL 61801

0532 HOLECEK & ASSOCIATES
BARNALDI ROY-MOHANTY
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Jeff Winfield
Employee/Petitioner
v.

Case # 16 WC 32284

Winpak, Inc.
Employer/Respondent

17IWCC0819

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, IL**, on **March 24, 2017**. By stipulation, the parties agree:

On the date of accident, **10/2/2014**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$81,383.12**, and the average weekly wage was **$1,565.06**.

At the time of injury, Petitioner was **50** years of age, ***single*** with **0** dependent children.

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

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

THE ONLY DISPUTED ISSUE WAS THE NATURE AND EXTENT OF PETITIONER'S INJURY.

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

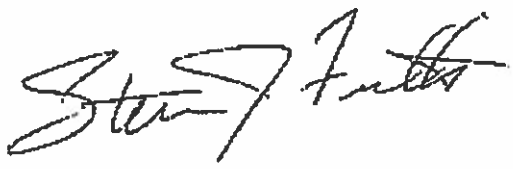
ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $735.37/week for **20** weeks, because the injuries sustained caused disfigurement of the face and neck, as provided in §8(c) of the Act.

Respondent shall pay Petitioner compensation that has accrued from **10/2/2014** through **3/24/2017**, and shall pay the remainder of the award, if any, in weekly payments.

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

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



Signature of Arbitrator

May 18, 2017
Date

MAY 19 2017

FINDINGS OF FACT

Petitioner Jeff Winfield is employed as a maintenance mechanic for Respondent Winpak, Inc. On October 2, 2014, Petitioner was burned by 450° liquid plastic while changing a die. The liquid caused burns to the left side of his face and neck, and also caused burns to his left chin, left eyebrow, and left earlobe. The Petitioner was taken to the emergency room at Franciscan Health Chicago Heights where the wound was cleaned and dressed (PX A).

Petitioner followed up the next day, October 3, at Advocate Occupational Health (PX B). A small burn to the left side of the forehead, a burn to the ear lobe, and a large 8 cm by 5 cm burn to the left side of the neck was noted (PX B). He was prescribed Silvadene cream. Petitioner was treated for second degree burns over the course of the following month at Advocated Occupational Health where his wounds were debrided and dressed. He was also prescribed medication for pain. He was released from care on October 27, 2014 with well-healed burns and no evidence of infection. Vitamin E was recommended for skin re-pigmentation.

Unhappy with the scarring he was left with, Petitioner sought a referral to a plastic surgeon, and was seen by Dr. David Dreyfuss on May 12, 2015 (PX C). Dr. Dreyfuss' examination revealed a hypopigmented and angulated scar extending from the left lateral mandible down on to the lateral neck. Dr. Dreyfuss also noted some reduction in size of the left earlobe, but no dramatic scarring. Petitioner was provided a scar gel with sunscreen to use on a daily basis, and was instructed to return in 6 to 8 weeks.

Petitioner returned to see Dr. Dreyfuss on June 23, 2015 to discuss scar revision surgery (PX C). The options provided to Petitioner were scar resection versus just leaving the scar alone. Essentially, scar resection would give the Petitioner a linear scar instead of the widened flat scar that he now has. Petitioner testified that he has not yet pursued the scar revision surgery because of current personal issues, but has not yet ruled it out.

At trial Petitioner displayed his scarring to the Arbitrator. The scarring located primarily on the left side of the neck and lower mandible. The scarring, roughly in the shape of a numeral seven, is approximately 3 ½ to 4 inches in length. The width of the scar varies from ½ inch at its narrowest to 3 inches at its widest. The borders on the scar are irregular and the skin color of the scar is lighter than surrounding skin. There

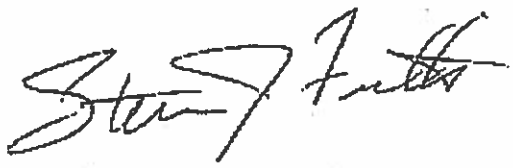
was no evidence of a keloid. Petitioner presented two color photographs taken the day before trial which accurately depict the scarring (PX D).

The Arbitrator initially reserved ruling on the admissibility of Petitioner's Exhibit D but determined the photos were admissible.

Petitioner testified that he is self-conscious about his scarring. He testified that he is does not let his photo be taken. He currently uses Jergens moisturizers on the scarring on recommendation of his doctor.

CONCLUSION OF LAW

The only issue in this case is the nature and extent of the injury. The Arbitrator finds that the Petitioner suffered serious and permanent disfigurement to the face and neck as a result of the October 2, 2014 work accident. Based upon the appearance of the scarring on the left side of Petitioner's face and neck, and the Arbitrator's viewing of that scarring, the Arbitrator finds that the injury caused disfigurement to the left side of the face and neck to the extent of 20 weeks pursuant to §8(c) of the Act.



May 18, 2017

Steven J. Fruth, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Thomas Kirchner, Jr.,

Petitioner,

vs. NO: 13 WC 33393

Taylor Development, Inc.,

17IWCC0820

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner herein and notice provided to all parties, the Commission, after considering the sole issue of prospective medical care and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of an amount 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 modifies the Arbitrator's Decision to award TTD benefits from October 4, 2012 through October 27, 2016, a period of 212-1/7 weeks, based on the Request for Hearing stipulation of the parties. The Arbitrator provided Respondent credit for $64,354.72 paid in TTD benefits but failed to award TTD benefits. The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's November 28, 2016 decision is modified for the reasons stated herein and otherwise affirmed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $303.54 per week for a period of 212-1/7 weeks, that being the period of temporary total incapacity for work pursuant to §8(b) of the Act and as provided in §19(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for prospective medical care consisting of a second radiofrequency ablation, a spinal cord stimulator and medications at their current level is hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay for an addiction specialist to assist Petitioner in weaning off his current medication regimen and pay for whatever medications are allowed by the addiction specialist during the program, pursuant to §8(a) of the Act, subject to the Medical Fee Schedule pursuant to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. The Commission notes Respondent paid $64,354.72 in TTD benefits.

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

Bond for 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: DEC 19 2017
LEC/maw
o11/01/17
43

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

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

KIRCHNER JR, THOMAS
Employee/Petitioner

Case# **13WC033393**

TAYLOR DEVELOPMENT INC
Employer/Respondent

17IWCC0820

On 11/28/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0154 KROL BONGIORNO & GIVEN LTD
RANDALL SLADEK
120 N LASALLE ST SUITE 1150
CHICAGO, IL 60602

1120 BRADY CONNOLLY & MASUDA PC
ANDREW R MAKAUSKAS
10 S LASALLE ST SUITE 900
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF DU PAGE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

THOMAS KIRCHNER, JR.,
Employee/Petitioner

v.

TAYLOR DEVELOPMENT, INC.,
Employer/Respondent

Case # 13 WC 33393

Consolidated cases: ___

17IWCC0820

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Gerald Granada, Arbitrator of the Commission, in the city of Wheaton, Illinois, on October 27, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0820

FINDINGS

On the date of accident, 10/03/2012, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$23,676.64**; the average weekly wage was **$455.32**.

On the date of accident, Petitioner was 34 years of age, ***single*** with 0 dependent children.

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

Respondent shall be given a credit of $64,354.72 for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

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

ORDER

The Petitioner's request for radiofrequency ablation, a spinal cord stimulator, and medications at the current level is denied. However, the Arbitrator finds the Petitioner is to wean off of his medications at the direction of an addiction specialist and orders the Respondent to pay for the addiction specialist and medications allowed by this specialist during the program.

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

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

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

Signature of Arbitrator

11/22/16
Date

FINDINGS OF FACT

This case involves a Petitioner alleging injuries he sustained while working for the Respondent on October 3, 2012. The only issue in dispute is the question of prospective medical care.

On October 3, 2012, Petitioner, Thomas Kirchner, was an employee of Taylor Development, Inc. He had worked for the company approximately ten months as a plumber. He started experiencing back pain digging up a sewer. To uncover a pipe, he had to dig approximately 6 feet down into the ground.

He first sought medical treatment with Dr. Paul Glaser. His first visit was October 10, 2012. Petitioner's father recommended Dr. Glaser to him. At the initial visit he took a urine test, which was positive. He admitted that between the time of the incident and the visit to Dr. Glaser on October 10, 2012 he had taken maybe ten Norco that he borrowed from a friend. He also admitted testing positive for marijuana. Petitioner testified that Dr. Glaser gave him a Medrol Dosepak along with Norco and Flexeril at the time of the initial visit. During the next visit to Dr. Glaser of October 26, 2012, Dr. Glaser prescribed six 10 mg tablets of Norco per day.

Petitioner underwent a lumbar MRI on October 31, 2012 which indicated some bulging disks in the lower back.

On December 20, 2012, he received a transforaminal epidural steroid injection at L4-L5 and L5-S1. Petitioner testified that as of the time of the follow-up visit on January 14, 2013, his bilateral leg pain had decreased but he still had back pain.

Petitioner was seen by Dr. Kern Singh for an Independent Medical Examination on December 31, 2012. He diagnosed Petitioner with degenerative disc disease at L4-L5, L5-S1 and herniated nucleous pulposis at those levels. He believed Petitioner sustained an aggravation of an underlying degenerative condition. He suggested four weeks of physical therapy, followed by two to four weeks of work conditioning. He did not believe epidural injections were indicated at that time as he believed the patient should exhaust non-operative measures including physical therapy (Rx. 3).

Another transforaminal injection was performed on February 7, 2013. As of a follow-up visit of February 25, 2013, the patient reported a 10% reduction in pain but that radicular pain had returned. He underwent a third transforaminal injection on March 13, 2013. Petitioner reported no change in his condition after the series of the three injections. On March 20, 2013, Petitioner underwent facet joint injections at L3-L4, L4-L5 and L5-S1. Petitioner reported that he had not experienced any change in pain after these injections.

Petitioner was referred to an orthopedic surgeon. He saw Dr. Mirkovic on May 21, 2013. A lumbar MRI scan was ordered. Mr. Kirchner returned to Dr. Mirkovic on June 5, 2013. Dr. Mirkovic noted that Petitioner had undergone three epidural steroid injections, the last being performed on March 13, 2013. Dr. Mirkovic was told by Petitioner that he gained no relief following the first injection; improvement in his leg pain for a few weeks following the second and one day of relief following the third/last injection. He was also told by Petitioner that he had undergone one facet block on March 20, 2013 with minimal relief of his lower back pain for a few days, without change in his leg symptoms . . . symptoms have

remained constant and are very limiting; he has been unable to golf or work since the injury. On June 11, 2013, he saw Dr. Mirkovic again and was told he had multi-level degenerative changes at L3-L4, L4-L5 and L5-S1. Dr. Mirkovic did not believe a spinal cord stimulator would be effective long-term (Rx. 2 p. 15). Dr. Mirkovic did not feel an epidural steroid injection would help (Rx. 2 p. 34).

Petitioner returned to Dr. Glaser on June 21, 2013 and discussed a discogram as well as the possible use of a spinal cord stimulator.

On August 27, 2013, Petitioner returned to Dr. Mirkovic. It was noted the discograms were found to be positive at L3-L4 and L5-S1. Dr. Mirkovic said he was reluctant to order a three-level fusion. In the alternative, Dr. Mirkovic discussed a Functional Capacity Evaluation and likely permanent restrictions. Dr. Mirkovic placed him at sedentary level with occasional lifting of 10 pounds. Dr. Mirkovic reiterated the likelihood was not very high that a spinal cord stimulator would provide him with long-term lower back pain relief (Rx. 2 p. 9).

Petitioner was re-examined by Dr. Singh on December 16, 2013. Dr. Singh found 5/5 Waddell findings. He stated his current complaints were out of proportion to his examination findings. He said the patient's pain complaints were non-anatomic in nature and cannot be objectified, based upon his diagnostic imaging studies as well as his MRI findings. He stated he believed only one of the prior multiple injections received by Petitioner were indicated. He recommended two to four weeks of work conditioning at an independent site with validity and effort testing. He said that if an invalid effort were given, Petitioner should be released for work without restriction and placed at maximum medical improvement (Rx. 4).

On January 16, 2014, Petitioner saw Dr. Richard Noren for an Independent Medical Evaluation. Petitioner reported that he typically would take eight 10 mg tablets of Hydrocodone per day. He would also take three tablets of Flexeril, a muscle relaxant, per day along with Ambien for sleep. Dr. Noren noted that he found it odd Petitioner was sitting at the edge of the exam table with no back support in light of his condition when he could have been sitting in a chair (Rx. 1, p. 14-15). He also noted a number of inconsistencies during his physical examination (Rx. 1, p. 15-19). He found that the medial branch block and facet injections were not indicated and that further injections were not indicated (Rx. 1, p. 38). He said that people with facet syndrome do not complain of leg pain (Rx. 1, p. 27). In terms of the medial branch blocks not being indicated, Petitioner reported essentially the same pain after the facet injections had been done (Rx. 1, p. 25-26). Additionally, injecting facet joints with the intention of burning the nerve that goes to these joints would not relieve his disc pain (Rx. 1, p. 39-40). He said there were risks with the patient taking 80 mg of Hydrocodone a day (Rx. 1, p. 40-41). It was not reasonable or necessary for him to be taking those amounts of Hydrocodone that he took from October 10 of 2012 to the time of the examination of January 16, 2014. Dr. Noren testified the pattern that Petitioner demonstrated was a pattern of addiction and opiate abuse. He found him to be at maximum medical improvement in pain management and from an interventional pain management standpoint, meaning it was unlikely that Petitioner would improve in his subjective pain complaints from injections or continued medications. He thought that appropriate medical care would typically include anti-inflammatories and low-dose narcotics as appropriate.

On June 7, 2014, Petitioner received medial branch blocks at L2 through L5. As of July 15, 2014, Dr. Glaser suggested the branch blocks showed that the Petitioner would need radiofrequency ablation of the medial branch nerves. The expectation was that the procedure would cause him to experience 50% relief of his pain for at least one year. Petitioner said he was told it would be up to one year. The ablation procedure was also to either eliminate the need or at least significantly reduce the amount of medications he would be taking. On August 21, 2015, Petitioner underwent bilateral L2, L3, L4 and L5 medial branch radiofrequency lesioning.

On August 28, 2015, Petitioner reported to Dr. Glaser that he had a 10% to 20% relief in his pain. On September 29, 2015, he reported that he had 50% relief but that the pain had returned. Petitioner testified he had to fly to Florida for a family emergency and he said being on the plane was very uncomfortable and that it brought back a lot of pain. Dr. Glaser testified that he was told by the Petitioner that he had tried to just increase his usual activities of daily living and he felt that he possibly exacerbated the condition (Px. 3 p. 25-26). On October 27, 2015, Dr. Glaser discussed a second radiofrequency ablation procedure. Dr. Glaser told him that doing a second procedure might take better than the first time.

Petitioner was examined again by Dr. Noren on November 12, 2015. At that examination, Petitioner reported that after undergoing the radiofrequency ablation, his leg pain had improved for three or four weeks, before returning. His back pain returned within four to five weeks of the procedure (Rx. 1 p. 46). Dr. Noren stated that improved leg pain from a radiofrequency ablation procedure is anatomically impossible (Rx. 1 p. 49). Dr. Noren was told by Petitioner that on a daily basis he was taking 80 mg of Percocet, 30 mg of a muscle relaxant, Ambien and Neurontin. Dr. Noren testified the Percocet was 30% to 40% stronger than the Norco Mr. Kirchner had previously been taking. The amount of medication he was taking exceeded the federal guidelines for morphine equivalents (Rx.1 p. 52). Dr. Noren's diagnosis was narcotic-induced hyperalgesic syndrome consistent with the pattern of narcotic use. He found Petitioner to be at maximum medical improvement as of the date of the examination and said he should be weaned off his medications.

Dr. Noren authored an addendum report on December 16, 2015 which discussed alternative ways to wean off of medications. The weaning process would be done by an addiction specialist. Dr. Noren described two alternative plans that could be followed (Rx. 1 p. 99).

As of December 31, 2015, Dr. Glaser was still discussing the radiofrequency ablation with other options including a spinal cord stimulator, another discogram, and maybe fusion.

As of the trial date, Petitioner was taking Percocet, Flexeril, Ambien and Neurontin (Tr. p. 25). Petitioner testified he wanted a second radiofrequency ablation but did not want to have surgery. The Petitioner testified he has been treating with Dr. Glaser for over four years. He acknowledged that as of October 18, 2013, he had developed a tolerance to Norco. Thus, Dr. Glaser began prescribing Percocet, which is stronger than Norco. Petitioner acknowledge that over the four years treating with Dr. Glaser, he has been taking stronger and stronger medications and has had no real improvement in his condition. He received no long-term improvement with the injections administered by Dr. Glaser.

CONCLUSIONS OF LAW

The only issue in dispute is whether the Petitioner is entitled to prospective medical care in the form of a second radiofrequency ablation, in addition to the spinal cord stimulator and the current medication regimen prescribed by Dr. Glaser. The Arbitrator finds that Petitioner's request for the prospective medical care recommended by Dr. Glaser is not reasonable or necessary and accordingly denies Petitioner's claim for that treatment. This finding is based on both the Petitioner's testimony and the medical evidence. Specifically, the Arbitrator finds persuasive the testimony and opinions of Dr. Noren on this issue. By Petitioner's own admission, he has been treating with Dr. Glaser for over four years without any long-term improvement in his condition. Most of Petitioner's treatment has been an alarming regimen of narcotic medication combined with medication for sleep, nerve treatment and injections with only limited relief. Of significant note is that Dr. Glaser prescribed Petitioner a Medrol Dosepak along with Norco and Flexeril at the time of the initial visit, despite the Petitioner testing positive for marijuana and admitting to having taken ten Norco tablets before that first visit. In reviewing the deposition testimony of both Dr. Glaser and Dr. Noren, it is clear that Dr. Glaser is not as concerned as Dr. Noren with the amount of medication Petitioner has been taking. Dr. Glaser acknowledges that the Petitioner has developed a tolerance for the narcotic medication he has been prescribing, yet continues to provide the medication, despite Petitioner's continued complaints of pain. The fact that Dr. Glaser is now recommending a second radiofrequency ablation, when the Petitioner testified and the medical evidence established that the first radiofrequency treatment did not relieve Petitioner's pain beyond three to four weeks, is clearly unreasonable and unwarranted. Accordingly, the Petitioner's request for the second radiofrequency treatment is denied.

In his evidence deposition, Dr. Glaser also advocated for use of a spinal cord stimulator (Px. 3 pp 31-32). However, his opinion was not shared by Dr. Mirkovic or Dr. Noren. On June 11, 2013, Dr. Mirkovic wrote in his report that he did not believe a spinal cord stimulator is effective long-term (Rx. 2 p. 15). On August 27, 2013, he reiterated the likelihood is not very high that a spinal cord stimulator would provide him with long-term lower back pain relief (Rx. 2 p. 9). Dr. Noren stated there was no underlying pathology that could indicate use of a spinal cord stimulator and that it was not warranted (Rx. 1 p. 66). The Arbitrator finds persuasive the opinions of both Dr. Mirkovic and Dr. Noren and relies on those opinions in denying the request for a spinal cord stimulator.

The Arbitrator further finds that Petitioner's current medication regimen is not reasonable and necessary. Furthermore, the current medication regimen is possibly more injurious than beneficial to Petitioner's condition. In reviewing both the Petitioner's testimony and the medical evidence as a whole, the Arbitrator agrees with Dr. Noren that Petitioner should be weaned from the medications by an addiction specialist. The Respondent is ordered to pay for the addiction specialist and any medications allowed by this specialist during the program.

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

BRANDON CISARIK,

Petitioner,

vs. NO: 08 WC 33526

NORTHWEST BUILDING MATERIAL,

17IWCC0821

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

I. Temporary Disability

The parties stipulated Petitioner is entitled to 294 5/7 weeks of temporary total disability benefits, representing June 4, 2008 through January 26, 2014, as well as 32 4/7 weeks of maintenance benefits, representing January 27, 2014 through September 11, 2014. The Commission observes, however, Petitioner reached maximum medical improvement on September 30, 2013, the date Dr. Smith reviewed the September 10, 2013 FCE, concluded Petitioner could not return to his previous occupation, and released Petitioner to follow up prn. PX4. As such, as a matter of law, Petitioner's entitlement to temporary total disability benefits ended on September 30, 2013 (*Matuszczak v. Illinois Workers' Compensation Commission*, 2014 IL App (2d) 130532WC, ¶14 - once an injured employee's condition stabilizes, *i.e.*, once the employee reaches MMI, he is no longer eligible for TTD benefits), and the remainder of the stipulated temporary benefits are properly classified as maintenance benefits, concomitant to vocational rehabilitation under Section 8(a). Therefore, the Commission finds Petitioner entitled to temporary total disability benefits of $636.75 per week from June 4, 2008 through September

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30, 2013, a period of 277 6/7 weeks, and maintenance benefits of $636.75 per week from October 1, 2013 through September 11, 2014, a period of 49 3/7 weeks.

Temporary partial disability benefits were awarded for September 12, 2014 through June 16, 2016. However, as set forth below, Petitioner's entitlement to wage differential benefits commenced on September 12, 2014. Petitioner cannot be simultaneously entitled to temporary partial disability benefits and Section 8(d)1 benefits for the same consequences of the same injury, and Petitioner concedes as much in his brief. The Commission vacates the award of temporary partial disability benefits.

II. Permanent disability

At arbitration, Petitioner sought wage differential benefits. Under Section 8(d)1, an impaired worker is entitled to a wage differential award when (1) he is "partially incapacitated from pursuing his usual and customary line of employment" and (2) there is a "difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning or is able to earn in some suitable employment or business after the accident." *820 ILCS 305/8(d)1* (West 2012). There is no dispute Petitioner's permanent restrictions prohibit him from resuming his career as a laborer; therefore, the first element was satisfied. Upon review of the evidence, the Arbitrator concluded Petitioner proved the second element and, finding the part-time position at Riviera Country Club constitutes suitable employment, awarded Section 8(d)1 benefits.

Respondent challenges the wage differential award, arguing Mr. Steffan's "unrebutted" opinions establish Petitioner's current position is not otherwise available in the labor market at large, and therefore, Petitioner is permanently and totally disabled. Respondent further claims "Petitioner has simply accepted a part time job with a low hourly rate in an attempt to artificially increase the amount of workers' compensation benefits he is entitled to." The Commission finds Respondent's arguments lack merit.

Firstly, labeling Mr. Steffan's opinions unrebutted is folderol. The notion there is no stable labor market for Petitioner is rebutted not only by the Vocamotive records but also by Mr. Steffan's own testimony confirming he himself had concluded in his May 20, 2016 vocational progress report that Petitioner was "placeable and employable." (June 16, 2016 Transcript, p. 32) The Commission finds it extraordinary that less than a month later Mr. Steffan would testify there is no stable labor market for Petitioner because his restrictions (unchanged since May 20, 2016) are now so burdensome that any offer of employment would constitute gratuitous employment. The Commission further notes Mr. Steffan's belief that Riviera Country Club affords substantial accommodations to Petitioner conflicts with Petitioner's credible description of the job:

> Basically, there's two positions that we would either do. One is what we call the receptionist desk, and I do the billing, answer phone calls, take messages. We also have like a small juice bar where we make protein shakes, bottles of water, stuff like that. And then the other side is what we call the check-in. That's where the members come up, when they come there and check in with us there. We would fold towels, and that's pretty much it. I am able to sit and stand whenever I choose, walk a little

bit whenever I choose. It works out. (May 20, 2016 Transcript, p. 33)

The Commission highlights Petitioner's testimony regarding his co-worker who has the "same position," "same job description," and "same everything" he does (May 20, 2016 Transcript, p. 59), and observes Petitioner's description of his duties is consistent with the receptionist/front desk person position at countless health clubs, fitness centers, and gyms. The Commission finds the suitability of the job demands can be further inferred from Vocamotive directing Petitioner to target physical therapy centers, rehabilitation centers, and gyms in his job search. PX11. The Commission finds Mr. Steffan's opinion that Petitioner's restrictions are so onerous no employer would retain Petitioner as an employee and thus no stable labor market exists for him, to be in direct conflict with the record and not credible.

The Commission similarly finds no support for Respondent's claim Petitioner manipulated the vocational rehabilitation process to obtain higher benefits. To be clear, Petitioner is working a job secured with the blessing of Respondent's chosen vocational provider and approved by Respondent: Respondent selected Vocamotive to provide job placement services; Vocamotive's records repeatedly document Petitioner was cooperative and investigated job leads as instructed; one of the leads Vocamotive provided to Petitioner was the position at Riviera Country Club; Petitioner applied for the position and after interviewing was offered the job; and not until both Vocamotive and the adjuster approved the placement did Petitioner accept. Given Respondent directed the entire job search process, the Commission finds Respondent's assertion Petitioner engineered the ultimate placement to be spurious.

The Commission affirms the Arbitrator's finding that Petitioner established entitlement to a wage differential. The analysis necessarily then turns to the proper rate for that benefit.

Calculating the wage differential rate requires the Commission to make two earnings determinations: (1) "the average amount which he would be able to earn in the full performance of his duties in the occupation in which…he was engaged at the time of the accident," and (2) "the average amount which he…is able to earn in some suitable employment or business after the accident." *820 ILCS 305/8(d)1*. With respect to what Petitioner's earnings would be if he was still employed as a laborer for Respondent, the Commission highlights the following: Petitioner credibly testified his normal workweek for Respondent was 40 hours (May 20, 2016 Transcript, p. 18), and the April 28, 2016 missive from the Construction and General Laborers' District Council of Chicago & Vicinity evidences the union's base wage rate as of the June 16, 2016 close of proofs was $40.20 per hour (PX12). Therefore, the Commission finds the average amount Petitioner would be able to earn in the full performance of his duties as a union laborer is $1,608.00 per week ($40.20 x 40 = $1,608.00).

As to the second earnings determination, the Commission emphasizes this analysis involves more than automatic reliance on post-accident wages. As the Illinois Supreme Court noted: "Although wages are indicative of earning capacity, they are not necessarily dispositive. The initial hearing on any employee's claim gives both employers and employees the opportunity to present evidence beyond wages to establish long-term earning capacity." *Cassens Transport Company v. The Industrial Commission*, 218 Ill. 2d 519, 531, 844 N.E.2d 414 (2006). "'[P]ost-injury earnings and earning capacity are not synonymous' because other evidence can show that

'the actual earnings do not fairly reflect claimant's capacity.'" *Jackson Park Hospital v. Illinois Workers' Compensation Commission*, 2016 IL App (1st) 142143WC, ¶44, 47 N.E.3d 1167, quoting 4 A. Larson & L. Larson, *Larson's Workers' Compensation Law § 81.03[1]* (2005). As the Appellate Court explained in *Crittenden v. Illinois Workers' Compensation Commission*, 2017 IL App (1st) 160002WC, 73 N.E.3d 654, Section 8(d)1 permits the Commission to consider other evidence pertaining to what constitutes suitable employment:

> We note that in the case where the claimant is working at the time of the calculation, but functional and/or vocational evidence is submitted which is sufficient to determine another suitable occupation for the claimant, there is nothing in *section 8(d)(1)* of the Act (*820 ILCS 305/8(d)(1)* (West 2012)) that would prevent the Commission from utilizing such evidence to determine the average wage the claimant could make in some suitable employment as set forth in this opinion, and *vice versa*. *Crittenden*, ¶23, n.4.

"Suitable employment is employment which the claimant is both able and qualified to perform." *Crittenden*, ¶24. With this principle in mind, the Commission examines the evidence herein.

Petitioner's September 10, 2013 FCE placed him at the Light-Medium work level, capable of lifting 35 pounds infrequently and up to 20 pounds frequently. PX4. The FCE does not identify any restriction or limitation on Petitioner's workday tolerance. Respondent thereafter initiated vocational services through Vocamotive. In her vocational assessment, Certified Rehabilitation Counselor Kari Stafseth concluded Petitioner is employable; she specified his potential job targets included driver, parts clerk, security guard, and dispatcher, and his anticipated wage range was $10.00 to $14.00 per hour. PX11. Ms. Stafseth did not indicate Petitioner's restrictions were a barrier to full-time placement opportunities.

While Petitioner was participating in job placement, Dr. Smith imposed additional restrictions: sitting for a maximum of 20-30 minutes, walking for a maximum of 10-20 minutes, standing for a maximum of five minutes at a time, and no kneel/squat/stair. PX4. When these revised restrictions were provided to Vocamotive in May, 2014, Ms. Stafseth concluded Petitioner was limited to sedentary work. The Commission highlights that while Ms. Stafseth noted the potential placements needed to be adjusted, she did not opine Petitioner was no longer capable of full-time employment. Ms. Stafseth identified Petitioner's new job targets as dispatcher, receptionist, front desk coordinator, office clerk, administrative assistant, and customer service representative (sedentary). These positions had a slightly lower wage range: $9.00 to $12.00 per hour. PX11.

In July of 2014, Vocamotive provided Petitioner with a job lead for a customer service representative with Riviera Country Club. PX11. Petitioner pursued the lead and was granted an interview. In early September, Petitioner was offered the job of early-morning customer service representative; the position paid $10.00 per hour and Petitioner was to start at 20 to 30 hours per week but could potentially increase to full-time. PX11. The placement was approved and Petitioner started on September 12, 2014. Petitioner testified he has asked for increased hours and his boss stated he would try to do so, but as of the arbitration date, the increase to full-time status had not materialized. T. 58.

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The Commission finds the physical demands of the Riviera Country Club job comport with Petitioner's sedentary restriction and the $10.00 hourly rate is within the wage range predicted by Ms. Stafseth, however the part-time hours do not represent Petitioner's true earning capacity. As detailed above, there is no physical limitation or medical restriction prohibiting Petitioner from working 40 hours per week. Moreover, nowhere in the Vocamotive records is there evidence to suggest Petitioner is limited to part-time hours. Therefore, the functional and vocational evidence establish Petitioner is able to perform full-time employment.

The Commission finds the suitable employment Petitioner is "able and qualified to perform" is 40 hours per week as a customer service representative earning $10.00 per hour. Therefore, the Commission concludes the appropriate measure of Petitioner's earning capacity is $400.00 per week.

The Commission finds Petitioner entitled to wage differential benefits of $805.33 per week ($1,608.00 - $400.00 = $1,208.00 x 66 2/3% = $805.33) commencing on September 12, 2014 and continuing through the duration of his disability.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $636.75 per week for a period of 277 6/7 weeks, representing June 4, 2008 through September 30, 2013, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner maintenance benefits in the sum of $636.75 per week for a period of 49 3/7 weeks, representing October 1, 2013 through September 11, 2014.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of temporary partial disability benefits from September 12, 2014 through June 16, 2016 is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $805.33 per week commencing September 12, 2014 and continuing for the duration of his disability, as provided in §8(d)1 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $2,699.39 for medical expenses, as provided in §§8(a) and 8.2 of the Act.

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

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

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Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1,900.00. 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: DEC 19 2017

L. Elizabeth Coppoletti

LEC/mck

D: 11/1/17

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L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CISARIK, BRANDON
Employee/Petitioner

Case# **08WC033526**

NORTHWEST BUILDING MATERIAL
Employer/Respondent

17IWCC0821

On 8/22/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.44% 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:

0347 MARSZALEK AND MARSZALEK
STEVEN A GLOBIS
120 W MADISON ST SUITE 801
CHICAGO, IL 60602

1596 MEACHUM STARCK BOYLE ET AL
JAMES JANNISCH
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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)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

BRANDON CISARIK
Employee/Petitioner

v.

NORTHWEST BUILDING MATERIAL
Employer/Respondent

Case # 08 WC 33526

Consolidated cases: ____

17IWCC0821

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **5/22/16 and 6/16/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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FINDINGS

On **06-03-08**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$49,666.76**; the average weekly wage was **$955.13**.

On the date of accident, Petitioner was **24** years of age, ***single*** with **1** dependent children.

Respondent shall be given a credit of **$283,396.01** for temporary total, temporary partial and maintenance benefits paid.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$636.73/week** for **294-5/7th weeks**, commencing **June 4, 2008** through **January 26, 2014**, as provided in Section **8(b)** of the Act.

Respondent shall pay Petitioner maintenance benefits of **$636.73/week** for **32-4/7th** weeks, commencing **January 27, 2014** through **September 11, 2014**, as provided in Section **8(a)** of the Act.

Respondent shall pay Petitioner temporary partial disability benefits for **92 weeks**, commencing September 12, 2014 through June 16, 2016, as provided in Section **8(a)** of the Act.

Respondent shall be given a credit of **$283,396.01** for all temporary total, temporary partial and maintenance benefits paid. Respondent is entitled to a credit for any other TTD, TPD, maintenance and/or medical benefits paid after May 20, 2016 through the date of the Arbitration decision.

Respondent shall pay Petitioner permanent partial disability benefits, commencing **September 12, 2014** of **$883.86/week** for the duration of the disability, because the injuries sustained caused a loss of earnings, as provided in Section **8(d)1** of the Act.

Respondent shall pay reasonable and necessary medical services of **$2,699.39**, as provided in Sections 8(a) and 8.2 of the Act.

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

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

Signature of Arbitrator

8-22-2016
Date

AUG 22 2016

17IWCC0821

FINDINGS OF FACT

Petitioner Brandon Cisarik ("Petitioner") filed an application for adjustment of claim against Northwest Building Material ("Respondent") for injuries sustained on June 3, 2008 arising out of in the course of his employment. Ax2. On May 20, 2016 and again on June 16, 2016, the parties proceeded to arbitration on the disputed issues of liability for unpaid medical bills, nature and extent of the injuries and wage differential beginning September 12, 2014. Ax1. The following is a recitation of the fax adduced at trial.

Petitioner testified he graduated from of Sandburg High School in 2002 with no special vocational training. While in high school he worked at ChiTown Sounds for three years selling and installing custom sound systems in vehicles. He also worked at Browns Chicken in a food prep position, breading chicken. He has taken five courses at Moraine Valley College, but did not receive a degree. After high school he began working at Jeff's Concrete as a laborer. From September of 2004 to February of 2007 he worked as a union laborer for ATMI/Dynacorp. In September of 2004 he became a member of the Construction and General Laborers District Council Local #288. In June 2007 he began working as a union laborer for Northwest Building Material. In this position he was covered by a collective bargaining agreement setting laborer's wages. As a laborer for Northwest Building Material he was on his feet all day long, and lifted twenty pounds or more all day long. His job duties included loading trucks with drywall and delivering it to construction locations.

On June 3, 2008 he was pushing a tilt cart loaded with 12-foot long drywall sheets. The drywall shifted on the cart and forced him into a deep squat. He then noticed pain in his left knee. June 3, 2008 was the last day worked at Northwest Building Material or as a laborer. That same date, Petitioner treated at Rush Copley Medical Center Emergency room. Petitioner reported injuring the left knee while pushing carts and working with a tilt cart. Pain was 10 out of 10. He had tenderness and limited movement in the left knee. Diagnosis was left knee sprain. The plan was for rest, ice pack and an Ace bandage. Px1.

From June 10, 2008 through June 27, 2008, Petitioner treated with Tyler Medical Services per Respondent's referral. Px2. He provided a history a left knee injury at work after being in a kneeling position. Exam demonstrated soft tissue swelling and an inability to fully extend the knee. Diagnosis was left knee sprain with probable internal derangement. Petitioner began a course of medications, therapies and light duty.

An MRI of the left knee was performed on June 13, 2008 showed joint effusion and findings suggestive of chondromalacia of the patellar apex. Px2. He next sought treatment with Dr. David Smith, an orthopedic surgeon with Bone and Joint Physicians. He was under the care of Dr. Smith from July 7, 2008 through April 7, 2014. Px4. The history of injury noted that Petitioner injured his left knee at work while trying to move drywall into an elevator when his knee gave out.

Findings included effusion, patellofemoral crepitus, medial joint line tenderness and an unsteady antalgic gait. He was initially prescribed physical therapy and was kept off work and given Relafen and crutches. A new MRI of the left knee on August 13, 2008 showed extensive displaced meniscal tear laterally with effusion and mild chondromalacia with possible bucket-handle tear/rupture. Dr. Smith prescribed arthroscopic surgery which was performed on October 23, 2008 at Ingalls Memorial Hospital. At that time Dr. Smith performed a left knee meniscectomy. The postoperative diagnosis was a displaced tear of the lateral meniscus. Over 50% of meniscal tissue was lost. Post surgically, the Petitioner underwent a course of physical therapy. Px4.

Petitioner returned to Dr. Smith on January 7, 2009 complaining of right knee pain which had been present for the past two or three months. Px4. Dr. Smith did an examination of the right knee, which

demonstrated a positive McMurray's Sign. MRI of the right knee demonstrated a horizontal tear of the lateral meniscus and a Baker's cyst. Dr. Smith prescribed arthroscopic surgery for the right knee.

In a July 22, 2009 report, Dr. Smith found the right knee related to Petitioner's work accident as Petitioner was forced into a semi-squatting position causing an injury which could have been asymptomatic initially as there is no nerve supply to the meniscus. The doctor further believed that the tear progressed due to compensating for the left knee. The doctor ruled out prior history and other history as a cause. In January 2010, Petitioner was discharged from physical therapy for the left knee. He was referred to Dr. Brian Cole for possible left meniscal transplant. Px4. Petitioner followed up with Dr. Smith in May and July, largely unchanged.

In June 2010, Dr. Smith's evidence deposition was taken. Px5. The doctor opined Petitioner's conditions were related to his work accident, that Petitioner was in need of further medical treatment, work restrictions and could be a candidate for a transplant in the future. Px5.

On August 9, 2010, the Petitioner saw Dr. Brian Cole at the request of Dr. Smith. Dr. Cole diagnosed left knee post lateral meniscectomy pain with a small lateral meniscus tear of the right knee. He recommended another MRI scan of the left knee and a Cortisone injection to the right knee. He opined the Petitioner may do well without surgery. Px3.

On November 17, 2010, the Petitioner underwent a postsurgical MRI scan of the left knee. It demonstrated a small lateral meniscal body and posterior horn probably posttraumatic with the inner half of the body truncated in appearance. The posterior horn was small in size with longitudinal signal alteration in a red zone either due to confluent longitudinal tear or meniscal defect. Px4.

2011

On March 15, 2011, the Petitioner underwent right knee lateral meniscectomy with chondroplasty shaving of the lateral femoral condyle by Dr. Smith. Postoperative diagnosis was an extensive tear of the lateral meniscus and chondropathy of the lateral femoral condyle. Post surgically the Petitioner underwent a course of physical therapy but continued to complain of bilateral postsurgical knee pain. Dr. Smith referred the Petitioner to Dr. Scott Glaser for pain treatment. Px4.

Petitioner was under the care of Dr. Scott Glaser from June 3, 2011 to February 13, 2012. Dr. Glaser diagnosed the Petitioner with neuropathic pain of the lower limb and prescribed Norco, Voltaren, Lidoderm and Flexeril. Px6. In July 2011, Petitioner again returned to Dr. Smith, complaining primarily of a left knee dislocating sensation.

On September 12, 2011, Petitioner returned to Dr. Smith complaining of lateral instability of the left knee. Dr. Smith referred the Petitioner to Dr. Carl Dillela, also of Bone and Joint Physicians. Dr. Dillela saw Petitioner on September 19, 2011, and prescribed a contrast enhanced gadolinium MRI arthrogram of the left knee. Arthrogram demonstrated a focal truncation of the free edge of the lateral meniscus suggesting a radial tear of the lateral meniscus. The Petitioner returned to Dr. Dillela on December 19, 2011. The doctor commented he cannot explain the Petitioner's episodes of instability. Px4.

On December 28, 2011, Petitioner returned to Dr. Smith, who recommended a course of physical therapy for the right knee. The doctor felt Petitioner had reached maximum medical improvement with regards to the left knee as no active treatment was being taken at that time. Px4.

2012

In October 2012, Dr. Robinson continued to diagnose degenerative arthritis of both lower legs. The doctor continued to prescribe Norco and Opana, along with Trazodone, Lidoderm and Voltaren. In November, impression and diagnosis was unchanged. Percocet was added. In 2012, Petitioner underwent five Supartz injections in the right knee. Petitioner continued to complain of bilateral knee pain.

2013

In 2013, Petitioner underwent five Supartz injections for the left knee with Dr. Smith. Px4. On May 6, 2013, Dr. Smith performed a Cortisone injection in the left knee. On June 17, 2013, Dr. Smith noted the Petitioner had a 15% improvement with the Supartz injection but felt the Petitioner had reached maximum medical improvement. On September 9, 2013, the doctor prescribed a functional capacity evaluation ("FCE"). Px4.

The FCE was performed at Ridge Rehabilitation on September 10, 2013. The evaluation report noted that the Petitioner's occupation of a laborer has critical job demands of lifting in excess of 100 pounds and that he has to be able to push hand trucks, climb ladders, stand, walk, sit, bend, stoop, squat, and reach above shoulder level and use his hands for gross manipulative type activities. The therapist who performed the test, Marc A. Cecchini, PT, DPT, indicated the functional capacity evaluation was valid, supported by consistent performance on a variety of objective functional tasks. The tests concluded the Petitioner could work at a light medium work level lifting 35 pounds infrequently and 20 pounds or less frequently and carrying 20 pounds or less. It was the opinion of Mr. Cecchini that the Petitioner "could not sustain the demands of his occupation. I would therefore restrict him to the 'light-medium' work level as outlined by this functional capacity evaluation." Px4.

Petitioner returned to Dr. Smith on September 30, 2013. He reported good days and bad days regarding his bilateral knees. Report of the left knee pain was greater due to dislocating and stiffness. His pain ranged from a 3 to 8 out of 10 on a pain scale of 0 to 10 with pain generators including prolonged walking, getting up in the morning, standing, sitting, squatting, kneeling, lifting and stair climbing. The doctor indicated he reviewed the functional capacity evaluation, which stated light to medium work level capability and that Petitioner cannot sustain the demands of his previous occupation as a laborer. Dr. Smith released Petitioner on a PRN basis. Px4. Through-out 2013, Petitioner continued to follow up with Dr. Robinson for medication management. Petitioner was largely continued on Percocet and Opana. Px4.

2014

Petitioner returned to Dr. Smith on April 7, 2014. Dr. Smith again noted the FCE findings. Petitioner reported the pain in his knees ranged from a 4 to an 8 on a 0 to 10 scale. The doctor recorded the Petitioner's walking tolerance was approximately 20 minutes, sitting tolerance with his knees bent was 30 minutes with increased pain in his left knee with sitting, standing tolerance of approximately 5 minutes. The physical exam of the knees demonstrated positive patellofemoral crepitus of the right knee with positive tenderness of the bilateral knees. Px4.

The Petitioner was examined at the Respondent's request by Dr. Kevin Tu on February 6, 2014. Dr. Tu noted that the September 10, 2013 FCE was valid and that reasonable restrictions would include no lifting over 35 pounds infrequently, 20 pounds less frequently and he could carry up to 20 pounds. He considered the restrictions permanent. He found the physical exam findings were consistent with his previous surgical intervention and that Petitioner likely developed a pain syndrome and still requires narcotic medications to help control his knee pain. Px8. After a second examination on February 5, 2015, Dr. Tu indicated he would not change the restrictions from his earlier report. *Id.*

Through-out 2014 and 2015 Petitioner continued to follow up with Dr. Robinson for refills of pain medication approximately every three months. The doctor has diagnosed degenerative arthritis of the lower leg and has prescribed Norco, Opana, Trazadone, Lidoderm and Voltaren. Px7.

Vocational Counselor Kari Stefsath

Petitioner was assigned vocational rehabilitation counselor Kari Stefsath ("Stefsath"), a counselor with Vocamotive beginning on January 27, 2014 by Respondent's carrier. Petitioner completed vocational testing, computer skills training, job seeking skills training and vocational counseling. He conducted a job search under Vocamotive guidance and was directed to an opening at the Riviera Country Club as a customer service representative. He interviewed for the position and was hired. He began working for Riviera Country Club on September 12, 2014 making $10.00 per hour working between 20 and 30 per week. Px11.

He continues to work at Riviera Country Club as of the date of his testimony on May 20, 2016. Petitioner's paycheck stubs from Riviera Country Club for the period September 12, 2014 to May 8, 2016 (86-2/7ths weeks) demonstrated gross earnings of $21,822.01, gross average weekly earnings of $252.90 per week. Px13.

Vocational Counselor Edward Steffan

After obtaining employment with Riviera, Petitioner was assigned a second vocational counselor, Mr. Edward Steffan of EPS, Rehabilitation, Inc. ("Steffan") by Respondent's carrier. Petitioner began meeting with Steffan on January 21, 2016. PX14. The plan was for compass testing and evaluation of training potential. In May 2016, Steffan wrote to Petitioner asking him to review or contact the potential employers identified for him. Enclosed were 19 potential contacts.

Steffan was called by the Respondent to testify at Arbitration. Steffan opined that while it would be possible for the Petitioner to be hired, he severely questioned his ability to maintain a job, "subsequent to needing accommodations to his subjective complaints." (T.24). He further testified that considering Petitioner's current rehabilitation variables, no stable labor market exists for him. (T.25).

On cross-examination, Steffan agreed that the Petitioner does have a loss of earning capacity as a result of the injury to his knees and that the position he is currently working at the Riviera Country Club is suitable for the Petitioner. (T.30).

Petitioner testified he continues to notice pain in both knees. The more active he is the, more the knees hurt. Standing or sitting more than five minutes increases the pain. He also notices painful dislocating of the left knee. He currently takes Opana ER and Norco, which were prescribed by Dr. Robinson.
On 4/28/16, Petitioner's collective bargaining agreement indicated an overall increase of $2.10 per hour effective 6/1/16. Px12. Petitioner submitted outstanding medical bills for injured workers pharmacy in the amount of $2349.39. Px10. The record shows there for dates of service December 24, 2014, March 1, 2016, March 29, 2016 and April 27, 2016 for prescriptions issued by Dr. Robinson. Petitioner also submitted an outstanding bill for lab pro in the amount of $350 for dates of service November 10, 2015 and February 9, 2016. Px16.

Respondent alleged payment in the amount of $20,671.11 issued to Petitioner and his attorney for temporary partial balance due for dates July 20, 2015 through April 29, 2016. The check date was issued on May 16, 2016. Rx2.

CONCLUSIONS OF LAW

ISSUE (L) What is the nature and extent of the injury?
ISSUE (O) Other – Wage Differential benefits after 9/12/14?

The Arbitrator incorporates the findings of fact as though fully set forth herein. The record demonstrates that Petitioner last actively treated for his bilateral knee conditions on or about April 7, 2014 with Dr. Smith, who at that time continued to endorse Petitioner's FCE limitations. Petitioner was subsequently evaluated by Dr. Tu at Respondent's request. Dr. Tu also endorsed Petitioner's work limitations. Petitioner testified and records show that since that time, Petitioner is not actively in treatment for either of his knees and is only undergoing period pain medication management with Dr. Robinson. Thus, the nature and extent of Petitioner's injuries are ripe for adjudication.

Petitioner claims entitlement to a wage differential under Section 8(d)1 of the Illinois Workers' Compensation Act. To qualify for a wage differential under Section 8(d)1, a claimant must prove (1) partial incapacity which prevents him from pursuing his "usual and customary line of employment" and (2) impairment of his earnings. *Gallianetti vs. Indus. Comm'n*, 315 Ill. App. 3d 721, 730, 734 N.E.2d 482 (2000).

Here, Petitioner was employed as a union laborer since September of 2004. He was a member of the Construction and General Laborers District Council, Local 288. He worked for the Respondent in this capacity since June, 2007. He testified that his job required him to be on his feet all day, that he lifted items more than 20 pounds all day that he had to lift up to 100 pounds. The Arbitrator finds that Petitioner has credibly established that his usual and customary employment is that of a union laborer based on his past work history as described by both Petitioner at trial and his medical and vocational records.

As a result of the accident on June 3, 2008, Petitioner underwent extensive medical treatment for both knees and an FCE later restricted Petitioner from returning to his former occupation, which was noted to be heavy, and placed him at the light to medium work level. Again, the FCE was subsequently endorsed by Drs. Smith and Tu. Based upon the above and the record as a whole, the Arbitrator concludes that the Petitioner is partially incapacitated from performing his usual and customary employment as a union laborer. In so concluding, the Arbitrator relies on Petitioner's valid FCE, his credible testimony regarding his former job duties and current limitations as well as the medical opinions of Drs. Smith and Tu.

The Arbitrator further finds that the Petitioner has amply demonstrated an impairment of earnings as a result of his inability to return to work as a laborer. Petitioner began working Vocamotive in January 2014 at Respondent's request. Stefsath's rehabilitation plan was comprehensive and targeted jobs that included a driver, parts clerk, security guard and dispatcher. Projected wages were $10.00 to $14.00 per hour. Px11. With help of Vocamotive, Petitioner commenced a job search and on September 12, 2014, he began employment at Riviera Country Club as a Customer Service Representative. The hourly rate of pay was $10.00 per hour averaging 20 to 30 hours per week. Vocamotive ceased involvement with the Petitioner after he obtained this position other than monitoring his earnings. Petitioner was later referred to vocational rehab counselor Steffan at Respondent's request in January 2016. At trial, Steffan agreed Petitioner had sustained a loss of earnings capacity. The Arbitrator concludes Petitioner has demonstrated suitable employment with Riviera based on accommodation of his restrictions, length of job search, the length of time of his employment, on his ability and willingness to perform his job duties there and based on his securing such employment via Vocamotive. Petitioner's current employment is within his restrictions endorsed by Drs. Smith and Tu and within the predicated pay range established by Vocamotive and Steffan. Nothing in the Act prohibits the use of part time

employment to calculate a wage differential award so long as the part time employment constitutes suitable employment.

Petitioner's paycheck stubs from Riviera Country Club for the period September 12, 2014 to May 8, 2016 (86-2/7ths weeks) demonstrated gross earnings of $21,822.01, gross average weekly earnings of $252.90 per week. Px13. As of April 28, 2016, the base hourly wage for laborers in the Petitioner's local was $40.20, or $1,608.00 per week, based on a 40 hour work week. Based upon the above, the Arbitrator concludes that the Petitioner sustained an impairment of his earning capacity. Px12. The Arbitrator further concludes that the average amount the Petitioner would be able to earn in the full performance of his duties as a union laborer is $1,608.00 and that his current earning capacity is $252.90 per week.

For injuries occurring before September 1, 2011, wage differential benefits shall be calculated by determining, "66 and 2/3rds percent of the difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning or able to earn in some suitable employment or business after the accident." 820 ILCS 305/8(d)1. Based on the foregoing, is liable for the sum of $903.40 per week, representing 2/3rds the difference between $1,608.00 and $252.90. However, pursuant to Section 8(b)4, the maximum wage differential for awards under Section 8(d)1 on June 3, 2008 was $883.86. Therefore, Respondent shall pay Petitioner permanent partial disability benefits, commencing **September 12, 2014** of **$883.86/week** for the duration of the disability, because the injuries sustained caused a loss of earnings, as provided in Section **8(d)1** of the Act.

Of note, although Steffan testified that there is no stable labor market for Petitioner, the Arbitrator declines to find Petitioner permanently and totally disabled as he is gainfully employed.
E.R. Moore Co. v. Indus. Comm'n, 71 Ill. 2d 353, 362, 376 N.E. 2d 206, 209 (1978).

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

The Arbitrator incorporates the findings of fact and conclusions of law as though fully set forth herein. The Arbitrator finds the Respondent liable for the medical expenses listed below pursuant to Sections 8(a) and 8.2 of the Workers' Compensation Act. These charges are for pain medications prescribed by Dr. Robinson and drug screens to insure compliance:

Petitioner's Exhibit # 10	Injured Workers Pharmacy	$2,349.39
Petitioner's Exhibit # 16	Lab Pro	$350.00
TOTAL MEDICAL		$2,699.39

The Arbitrator finds these outstanding charges reasonable and necessary to treat Petitioner's ongoing pain involving his knees and finds Respondent liable for such charges. Respondent shall pay reasonable and necessary medical services of **$2,699.39**, as provided in Sections 8(a) and 8.2 of the Act.

17IWCC0821

ISSUE (N) ***Is the Respondent due any credit?***

The Arbitrator incorporates the findings of fact and conclusions of law as though fully set forth herein. At trial, the parties stipulated that Respondent is entitled to a credit of **$283,396.01** for temporary total, temporary partial and maintenance benefits paid. Ax1. Furthermore, the Arbitrator finds Respondent is entitled to a credit for any other TTD, TPD, maintenance and/or medical benefits paid after May 20, 2016 through the date of the Arbitration decision.

Signature of Arbitrator

8-22-2016
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Saul Martinez,
Petitioner,

vs. NO: 07 WC 42501

Illinois Hydraulic Construction Co.,
Respondent.

17IWCC0822

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of should Petitioner's Motion for Reinstatement be granted 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 16, 2016 is hereby affirmed and adopted.

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

DATED: DEC 20 2017

Joshua D. Luskin

o-11/01/17
jdl/wj
68

Charles J. DeVriendt

L. Elizabeth Coppoletti

STATE OF ILLINOIS)
)
COUNTY OF Will)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
DECISION

Saul Martinez
Employee/Petitioner

v.

Illinois Hydraulic Corporation
Employer/Respondent

Case # **07 WC 42501**

17IWCC0822

The ***petitioner*** filed a petition or motion for **Hearing on Petition to Reinstate Case** on **October 29, 2015,** and properly served all parties. The matter came before me on **January 13, 2016** in the city of **New Lenox, IL** . After hearing the parties' arguments and due deliberations, I hereby ***deny*** the petition.
A record of the hearing ***was*** made.

See attached statement and findings

Unless a *Petition for Review* is filed within 30 days from the date of receipt of this order, and a review perfected in accordance with the Act and the Rules, this order will be entered as the decision of the Workers' Compensation Commission.

Signature of arbitrator

Date February 2, 2016

SAUL MARTINEZ VS. ILLINOIS HYDRAULIC CONSTRUCTION
Court No: 07 WC 42501

FINDINGS OF FACT AND CONCLUSIONS OF LAW:

The petitioner filed a petition or motion to vacate DWP. On Jan 13, 2016 the matte came before Arbitrator Robert Falcioni in the City of New Lenox, Illinois. After hearing the parties' arguments and due deliberations, the arbitrator hereby denies the petition. A record of the hearing was made.

UNDISPUTED FACTS:

The parties agree to the following facts:

On Sept 21, 2007 the law firm of Goldberg, Weisman and Cairo, Ltd. Filed an Application of adjustment on behalf of petitioner, Saul Martinez, and against Respondent, Illinois Hydraulic Corporation for alleged work related injuries sustained don Aug 30, 2007;

On Dec 9, 2009 Petitioner's attorney filed a motion to withdraw as counsel;

Counsel's motion was granted on Jan 7, 2010;

On March 18, 2011 Petitioner's application was dismissed for want of prosecution on petitioner's failure to appear;

On April 27, 2011 Respondent's counsel's office received an unfiled Notice of Motion cover sheet prepared by Saul Martinez seeking reinstatement of his claim and to be presented at the status call date of May 9, 2011. The Notice of Motion included a Certificate of Service signed by Saul Martinez no other papers/motion/brief were included with the notice. No actual Petition to Reinstate was attached to the notice. Petitioner did not produce a copy of a Petition to Reinstate at hearing of this matter.

No one on behalf of the Petitioner was present on May 9, 2011 and the motion was stricken.

The IWCC computer system shows a motion to reinstate was filed on June 21, 2011 to be presented on July 7, 2011. This motion was signed by petitioner's fiancée, Kristina Kaminsky. A copy of this notice of motion shows it was not sent to Respondent attorney's office. Per the front page of this notice is appears the motion was presented on July 7, 2011 and continued to July, 14, 2011 and then to Aug 4, 2011. Petitioner had previously signed a written power of attorney from himself to Kaminsky allowing her to act on his behalf in this matter.

On Aug 2, 2011 attorney Thomas Cowgill, filed his motion to reinstate for presentation on Aug 4, 2011. That motion was continued for hearing to Oct 6, 20011 and again to Nov 28, 2011;

On Nov 28, 2011 the parties appeared before Arb Falcioni for hearing. Arb Falcioni determined he did not have jurisdiction to hear the motion. No written order order was entered on that date;

On July 23, 2015 Saul Martinez filed another pro se motion to reinstate for presentation on Sept 4, 2015. That motion was not presented on Sept 4, 2015;

On Oct 26, 2015 Respondent's attorneys received a notice of motion from attorney Cowgill, to be presented to Arb Falcioni sitting in Rockford, IL on Nov 11, 2015. Due to scheduling issues within the IWCC that motion was not presented.

Attorney Cowgill prepared and filed another motion for presentation in New Lenox, and before Arb Falcioni on Jan 4, 2016. From that status call this matter was set for the hearing on Jan 13, 2016.

TESTIMONY AT HEARING TO REINSTATE:

Saul Martinez

Martinez testified he retained the Goldberg, Weisman firm to represent him in an alleged work comp originating on Aug 30, 2007. At some point in time, Martinez was arrested and incarcerated in the Metropolitan Correction Center in Chicago,, IL. Martinez was aware his attorneys withdrew from the case. Later, he learned from his prior attorney that on March 18, 2011 his workers compensation claim was dismissed. Martinez enlisted the help of his fiancée, Kristina Kaminsky, to help with getting his case reinstated. Martinez prepared and filed on April 28, 2011 a notice of motion for presentation on May 9, 2011. Martinez did not include a motion or other papers with the motion. Neither Martinez nor any representative on his behalf appeared at the IWCC on May 9, 2011 and the motion was stricken.

In 2011, Martinez retained attorney Cowgill for assistance with his motion to reinstate. In July, 2015 Martinez was released from jail. Martinez prepared a new motion to reinstate for presentation before Arb Flores in New Lenox on Sept 4, 2015. Later, attorney Cowgill filed another motion for reinstatement to be presented before Arbitrator Falcioni in Rockford.

Kristina Kaminsky

Kristina Kaminsky is Martinez's former fiancée and mother to his children. Kaminsky knew Martinez prepared a notice of Motion to be presented on May 9, 2011. Kaminsky intended to appear at the New Lenox WCC on that date but she had car trouble. With Martinez's permission Kaminsky prepared a notice of motion for July 7, 2011. Kaminsky was present for the motion on July 7, 2011. The motion was continued to July 14, 2011. Kaminsky was not present at the IWCC on July 14, 2011. Also, she was not present when the motion was set for Aug 4, 2001. Sept 9, 2011 or Sept 26, 2011.

The long held standard in Illinois is that is the petitioner has the burden to allege and prove facts to justify reinstatement of a case after dismissal. Banks v Industrial Commission, 134 Ill. App. 3rd 312(Fourth Dist., IL) 1985. In Banks, petitioner field an application on Nov 2, 1995 for alleged injuries sustained on Jun 29, 1995. On April 21. 1999 the case was DWP'd on petitioner's failure to appear. On June 28, 1999 Banks field a motion to reinstate. Banks

obtained new counsel who filed a motion to reinstate on Feb 28, 2001. Counsel's motion was denied by the arbitrator and said ruling confirmed by the Commission. The appellate court citing Bromberg v Industrial Commission 97 IL 2nd 73 (1983) restated the legal standard that it was petitioner's burden to allege and prove facts to justify the reinstatement. Petitioner argued the original motion was timely filed and the IWCC rules did not specifically state when a motion must be heard. The Appellate Court found the IWCC rules did require a movant to state on the notice a date and time the motion would be presented, and in Banks the petitioner did not meet the IWCC rule. The Appellate Court noted the significant time delay for dismissal to hearing on the motion and the prejudice to the parties in such circumstance supporting its denial of Petitioner's request. The court stated::

"By the time the arbitrator heard the petition almost 5 1/2 years had passed since the filing of the application for adjustment of claim… After a lengthy delay, such as one here, witnesses may be unavailable or their ability to recall the incident may be diminished."" Banks at 313.

In Zdunczyk v Cardinal Building Maintenance, 06 W.C. 21174, 10 IWCC 0342 (April 6, 2010), the Commission affirmed the decision of then Arb Joann M. Fratianni in denying petitioner's motion to reinstate. In Zdunczyk, Petitioner filed an application on the same date as the alleged accident, May 5, 2006 and later field a second application. Both claims were DWP'd by Arbitrator Fratianni on Dec 3, 2007. A motion to vacate the DWP and Reinstate the claim was filed on Dec 31, 2007 and to be presented on Jan 7, 2008. Petitioner did not present the motion on that date. Petitioner filed another motion for hearing on April 7, 2008. Petitioner did not appear for the motion on that date. Petitioner filed another motion for presentation on Nov 13, 2008 and was did appear. Petitioner failed to present a reason as to why nearly a year had elapsed since the original dismissal. Arb Fratianni cited to IWCC Rule 7020.90 for the MANDATORY RULES (emphasis added) on a motion for reinstatement. 7020.90 requires a written motion stating the grounds relied upon for the reinstatement and to set forth a date on which petitioner will appear before the Arbitrator and present the Petition.

In Zdunczyk, Arb Fratianni and the IWCC concluded the petitioner did not meet the mandatory requirement of Rule 7020.90 and denied petitioner's motion for reinstatement.

While there have been many motions prepared and file in this matter the only one which arguably was timely field is Martinez's pro se notice of motion of April 28, 2011.

Martinez was incarcerated in March, 2011 and was not present on March 18, 2011 when the case was dismissed for want of prosecution. He had been aware his prior attorney had withdrawn from the case. His incarceration alone is not a valid basis for reinstate the case. Martinez could have retained other counsel. Martinez prepared and filed the initial notice of motion to reinstate on April 28, 2011. The extent copy of this notice contains no Petition to Reinstate attached thereto. The notice of motion was received by respondent counsel less than 14 days prior to the call date on which it was to be presented. Therefore the initial motion did not meet the IWCC requirements of Rule 7020.90 as it did not allege facts to support reinstatement. Finally, while petitioner's finance was aware of the hearing date she did not appear. Kaminsky testified she had car trouble on May 9, 2011. However, none of the many motions to reinstate which have been prepared and filed either by Martinez, Kaminsky or attorney Cowgill contain this allegation other supporting facts to support petitioner's failure to have a representative appear at the New

Lenox IWCC on May 9, 2011. The Arbitrator further notes that the Power of Attorney Petitioner executed directing Kaminsky to act in his behalf in this case does not allow her to act as his attorney, as such activity would constitute unlawful practice of law, as no evidence was presented that Kaminsky was a licensed attorney.

Kaminsky's motion filed on June 21, 2011 (as shown on IWCC computer) is defective on its face as it was filed more than 60 days after the DWP, and does not meet the notice provisions. Additionally, the motions do not meet the substantive provisions of Rule 7020.90. While Kaminsky testified to appearing at the IWCC on July 7, 2011 she admitted to not appearing for her motion on any other dates in which her motion had been scheduled.

None of Attorney Cowgill's motions are timely filed either. By the time attorney Cowgill was retained and filed his initial motion, the time had passed for a proper motion to reinstate before an Arbitrator. Attorney Cowgill did follow through on the motion he filed in 2011; however, a clear reading of the IWCC rules and case law cited by Respondent led to the conclusion at that time that petitioner's motion to reinstatement must fail.

In sum, upon review of all the evidence including the multiple motions to reinstate, the IWCC computer printout and considering the testimony the arbitrator finds first, Petitioner's application was properly dismissed for want of prosecution on March 18, 2011. The arbitrator finds Petitioner's notice of motion filed on April 27, 2011 does not meet the clear standards set forth by the IWCC for a proper motion to reinstate. The arbitrator further finds it is undisputed that neither petitioner nor any representative appeared at the IWCC on May 9, 2011 and thus the motion was properly stricken. The arbitrator finds the subsequent notice of motion filed by Kaminsky was insufficient on its face and not timely filed. Also, all subsequent motions field by Martinez or attorney Cowgill were beyond the 60 day requirement and thus were outside of the jurisdictional powers of the Arbitrator to grant.

For all the foregoing reasons, Petitioner's motion to reinstate his application is denied.

Arbitrator Robert Falcioni

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jairo Martinez,

Petitioner,

17IWCC0823

vs.

NO: 12 WC 21613
14 WC 35154

Jewel-Osco Food Stores,

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

Findings of Fact and Conclusions of Law

The Commission adopts the Arbitrator's Findings of Fact. With respect to the Arbitrator's finding regarding whether the medical services provided to Petitioner are reasonable and necessary, the Commission agrees with that part of the Arbitrator's Decision finding the cost of medical care rendered Petitioner for his right and left shoulders was reasonable and necessary and is awarded except the cost of medical care rendered Petitioner for his condition of ill-being with his rotator cuffs is not causally related to the work injury on April 18, 2012 and is denied.

17IWCC0823

The Commission disagrees with that part of the Arbitrator's Decision regarding Petitioner's lumbar back medical treatment with Drs. Chappidi, Prodromos and Fahrenbach.

The Petitioner alleged a lumbar back injury occurred on September 30, 2014. He first treated at the Occupational Health Clinic at Concentra for his lumbar spine. The October 27, 2014 lumbar spine MRI showed minimal degenerative changes of the lumbar spine, specifically at L2-L3 and a congenitally narrowed spinal canal. Concentra's October 29, 2014 records noted the lumbar spine MRI was negative, Petitioner had multiple positive Waddell's signs, no objective findings and Dr. Trusewych found Petitioner was at maximum medical improvement (MMI).

On December 30, 2014, Petitioner's primary care physician (PCP), Dr. Jaramillo, referred Petitioner to a neurologist due to complaints of persistent back pain. Petitioner went to Dr. Chappidi, a neurologist on referral from Dr. Jaramillo, for the first time on October 7, 2015 reporting episodic back pain since September 30, 2014. Two months later Dr. Chappidi referred Petitioner to a rheumatologist. After seeing a rheumatologist, Petitioner consulted Dr. Gregory Fahrenbach at Northwest Orthopaedics & Sports Medicine. Dr. Fahrenbach's office note documents Petitioner was referred by Dr. Jaramillo, Petitioner's PCP. Dr. Fahrenbach ordered a second lumbar spine MRI on January 12, 2016.

On February 2, 2016, Dr. Fahrenbach reviewed the lumbar spine MRI performed on January 21, 2016 and noted short pedicles with left and right neuroforamen at different levels. Petitioner's pain scale was 2/10 at that time. The physical exam showed good flexibility of both lower legs with negative straight leg raise. Petitioner attended physical therapy at Athletico from February 3, 2016 through February 25, 2016. On February 3, 2016, at the Petitioner's initial evaluation, the Athletico record notes Petitioner's goal was to be able to dance and get back to his fitness activities. The April 14, 2016 Athletico office note documents Petitioner was discharged because Petitioner reported his doctor wanted him to continue with an independent home exercise program.

The Commission finds that Respondent is liable for the medical care rendered Petitioner for his lumbar spine by Dr. Chappidi, Prodromos and Fahrenbach and Athletico through his last visit to Athletico on February 5, 2016. Therefore, on page 9, under the section "FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY" the Commission strikes the third sentence which states "The cost of the medical care rendered the petitioner for his lumbar spine by Drs. Chappidi, Prodromos and Fahrenbach exceeded his choice of two medical providers and is denied."

In the Order, the Commission also strikes the last sentence on page 2, continued at the top of page 3, which states "The cost of the medical care rendered the petitioner for his lumbar spine by Drs. Chappidi, Prodromos and Fahrenbach is denied."

The Commission finds a scrivener's error in the Order of the Arbitrator's Decision as it relates to the Petitioner's temporary total disability (TTD) rate and award. The Commission notes on page 10 under "FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY" the Arbitrator's Decision listed the correct TTD rate in the second line, $519.49. The Commission, therefore, modifies the Arbitrator's Decision so both

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the Finding and Order state the Respondent shall pay the Petitioner TTD benefits of $519.49/week for 70-6/7 weeks, from May 19, 2012 through June 11, 2012, September 5, 2012 through February 8, 2013, March 24, 2013 through April 6, 2013, and July 21, 2013 through May 17, 2014 for the Petitioner's injury on April 18, 2012.

The Commission also finds Petitioner is entitled to TTD in the amount of $520.09 for 4/7 weeks from 10/22/14 through 10/25/14 as a result of the Petitioner's injury on September 30, 2014.

The Commission also notes the Arbitrator denied the Petitioner's request for §§19(k) and (l) penalties and §16 fees. Although the Commission agrees that penalties and fees are not warranted, the Commission finds no penalties or fees petition was contained in the record. The Commission notes, however, a fee petition was filed by the Petitioner's former attorney.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on June 9, 2016 is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $519.49 per week for a period of 70-6/7 weeks for periods of lost time from May 19, 2012 through June 11, 2012, September 5, 2012 through February 8, 2013, March 24, 2013 through April 6, 2013, and July 21, 2013 through May 17, 2014 as a result of the Petitioner's injury on April 18, 2012 and Respondent shall pay to the Petitioner the sum of $520.09 per week for a period of 4/7 week for lost time beginning October 22, 2014 through October 25, 2014 as a result of the Petitioner's injury on September 30, 2014, those being the periods of temporary total incapacity for work under §8(b), and as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is given an offset for the $13,272.21 in temporary total disability benefits and $3,871.28 in other benefits previously paid by them to Petitioner.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay for the medical care rendered Petitioner for his lumbar spine by Drs. Chappidi, Prodromos and Fahrenbach and Athletico through February 5, 2016.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay for the reasonable and necessary medical cost related to Petitioner's left shoulder superior labrum from anterior to posterior (SLAP) repair and for an evaluation, and further treatment if any recommended, by Dr. Cole for Petitioner's right shoulder biceps tendinitis condition post SLAP repair surgery.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the medical bills in accordance with §8(a) and §8.2 of the Act pursuant to the medical fee schedule or any prior adjustments or negotiated rate. The Respondent shall be given credit for any amount

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paid toward the medical bills including any amount paid within the provisions of Section 8(j) of the Act and shall hold Petitioner harmless for all the medical bills paid by its group health insurance carrier.

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 $45,100.00. 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: DEC 21 2017
KWL/bsd
O-10/24/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

17IWCC0823

MARTINEZ, JAIRO
Employee/Petitioner

Case# **12WC021613**

14WC035154

JEWEL OSCO
Employer/Respondent

On 6/9/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0307 ELFENBAUM EVERS & AMARILIO
RACHAEL SINNEN
940 W ADAMS ST SUITE 300
CHICAGO, IL 60607

2623 McANDREWS & NORGLE LLC
JAMES MURRAY
53 W JACKSON BLVD SUITE 315
CHICAGO, IL 60604-3962

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

19(b) ARBITRATION DECISION

17IWCC0823

Case #12 WC 21613
#14 WC 35154

JAIRO MARTINEZ
Employee/Petitioner

V.

JEWEL OSCO
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on May 5, 2016. After reviewing all of the issues, the stipulations of the parties and the evidence, it is hereby found and ordered as follows:

ISSUES:

A. ☐ Was the respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☐ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to the respondent?

F. ☒ Is the petitioner's present condition of ill-being causally related to the injury?

G. ☐ What were the petitioner's earnings?

H. ☐ What was the petitioner's age at the time of the accident?

I. ☐ What was the petitioner's marital status at the time of the accident?

J. ☒ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☒ What temporary benefits are due: ☐ TPD ☐ Maintenance ☒ TTD?

L. ☐ Should penalties or fees be imposed upon the respondent?

M. ☐ Is the respondent due any credit?

N. ☒ Prospective medical care?

FINDINGS

- On April 18, 2012, and September 30, 2014, the respondent was operating under and subject to the provisions of the Act.
- On those dates, an employee-employer relationship existed between the petitioner and respondent.
- On those dates, the petitioner sustained injuries that arose out of and in the course of employment.
- Timely notice of the accidents was given to the respondent.
- In the year preceding the injury on April 18, 2012, the petitioner earned $40,519.96; the average weekly wage was $779.23. In the year preceding the injury on September 30, 2014, the petitioner earned $15,379.71; the average weekly wage was $780.13.
- At the time of injury on April 18, 2012, the petitioner was 42 years of age, single with two children under 18. At the time of injury on September 30, 2014, the petitioner was 45 years of age, single with one child under 18.
- The parties agreed that the respondent paid $13,272.21 in temporary total disability benefits, $3,871.28 in other benefits and $6,903.41 in medical benefits through its group medical plan pursuant to Section 8(j) of the Act for the date of injury on April 18, 2012.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $467.54/week for 70-6/7 weeks, which is the period of temporary total disability for the date of injury on April 18, 2012. The respondent is given an offset for the $13,272.21 in temporary total disability benefits, and $3,871.28 in other benefits previously paid by them to the petitioner.
- The cost of the medical care rendered the petitioner for his right and left shoulders was reasonable and necessary and is awarded. The cost of the medical care rendered the petitioner for his lumbar spine through his last visit with Dr. Jaramillo was reasonable and necessary and is awarded. The cost of the medical care rendered the petitioner for his condition of ill-being with his rotator cuffs is not causally related to the work injury on April 18, 2012, and is denied. The cost of the medical care rendered the petitioner

for his lumbar spine by Drs. Chappidi, Prodromos and Fahrenbach is denied. The respondent shall pay the medical bills in accordance with the Act, the medical fee schedule or any prior adjustments or negotiated rate. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

- The petitioner is entitled to have from the respondent the reasonable and necessary cost for an evaluation of his right shoulder by Dr. Cole and for a left shoulder SLAP repair.

- The petitioner's request for penalties and fees is denied.

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

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

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

Robert E. Williams

Signature of Arbitrator

June 7, 2016
Date

JUN 9 – 2016

FINDINGS OF FACTS:

The petitioner, a food stocker, injured his shoulder on April 18, 2012, while stocking boxes of water on upper shelves. The incident is the subject matter of claim #12 WC 21613. He started medical care on April 27th with Dr. Jose Castellanos at Peterson Occupational Health and reported bilateral shoulder pain. The petitioner had 360 degrees of rotation for both shoulders and the ability to raise his hands fully above his head and to place his arms fully behind his back, equally. Localized tenderness to palpation of his bilateral biceps tendons and minimal tenderness to his biceps muscles were noted. The assessment was tendinitis of his bilateral biceps. He was treated with medication and lifting restrictions. Dr. Frederick Wunker at Peterson Occupational Health saw the petitioner on May 11th and noted a full ROM of his shoulder and elbows and tenderness in the origin of the deltoid muscles, bilaterally and in the right biceps tendon insertion at the antecubital region. His diagnosis was tendinitis of the right biceps and bilateral deltoid, which he reiterated at three subsequent follow-ups through June 1st. The petitioner started physical therapy on May 25th. On June 8th, Dr. Castellanos noted mild to moderate tenderness with palpation of his biceps tendons and full use and rotation of his shoulders. On June 15th, Dr. Wunker noted minimal to no tenderness in the lateral deltoid of petitioner's shoulders, minimal tenderness in his right biceps tendon insertion, a good ROM of all upper extremity joints, normal strength in both deltoids, normal strength in both biceps muscles and some mild pain with abduction of his shoulders and flexion of his right elbow. He discharged the petitioner without restrictions. X-rays of his right elbow and shoulders on June 21st showed no evidence of fractures or dislocations. On June 21st, the physical therapist reported the petitioner's complaints of bilateral

shoulder pain and noted a normal ROM of the joints of both upper extremities. Manual muscle testing of his left arm was normal. MMT of his right shoulder abduction increased to 4+/5 from 4/5, the external rotation increased to normal from 4/5 and the flexion remained at 4+/5.

On September 5th, the petitioner saw Dr. Prodromos and reported continued right shoulder pain. The doctor noted a full ROM of his shoulder but pain past 90^0 of elevation, moderate coracoids tenderness and no AC joint tenderness. MRIs on October 5th revealed mild AC joint degenerations but were negative for rotator cuff tears and internal derangement of the glenohumeral joint. On October 29, 2012, Dr. Prodromos noted pain with elevation of the petitioner's arms at 90^0 with resisted contraction and gave the petitioner a right subacromial bursa injection. The petitioner reported no relief and Dr. Prodromos noted that it raised the possibility of an intraarticular problem such as a SLAP lesion.

On January 25, 2013, at the request of the respondent, Dr. William Heller evaluated the petitioner. Dr. Heller opined that the petitioner's upper extremities were neurologically intact, there was no evidence of rotator cuff weakness or instability or significant labral pathology. Dr. Heller assessed bilateral shoulder strain and stated that there was no evidence that he suffered any significant trauma event. He opined that the petitioner could return to regular work without restriction.

On February 4, 2013, Dr. Prodromos noted that the petitioner had marked pain with rotation of his right upper extremity. He was given a right subacromial injection and reported a 30% pain relief. The petitioner reported left shoulder pain to Dr. Prodromos due to overuse on February 18, 2013. An MRI with contrast of the petitioner's right

shoulder on July 12, 2013, revealed a SLAP tear, supraspinatus and infraspinatus tendinopathy, mild AC joint arthritis and mild subacromial/subdeltoid bursal inflammation. On August 22, 2013, Dr. Prodromos performed a right shoulder SLAP repair. On October 2, 2013, Dr. Prodromos noted that the petitioner's shoulders had no AC joint tenderness, that his left shoulder had normal PROM, stability and strength and that review of MRIs with arthrogram and CT scans of his shoulders were normal. On October 30, 2013, Dr. Prodromos started physical therapy and noted that a labral tear occurred on October 2, 2013. Evaluations of the petitioner by Dr. Prodromos on November 20, 2013, January 29, 2014, and March 5, 2014, were essentially the same as it was on October 2nd.

On April 9, 2014, the petitioner reported pain in the front of both shoulders. Dr. Prodromos noted AC joint tenderness in the petitioner's left shoulder and bicipital groove tenderness in both shoulders. On May 10, 2014, Dr. Prodromos noted tenderness on both of the petitioner's long head biceps tendons. The petitioner's right bicipital groove was injected with lidocaine, which provided complete relief. Dr. Prodromos gave the petitioner a second bicipital groove injection on June 2, 2014, and opined that a left shoulder SLAP lesion repair would eventually be necessary. The petitioner reported only right shoulder pain to Dr. Prodromos on June 9 and July 9, 2014, and the examination of his left shoulder was normal. On July 30, 2014, Dr. Prodromos noted tenderness over the critical zone of both rotator cuffs. Dr. Prodromos noted on September 24, 2014, that an MRI showed rotator cuff inflammation. The petitioner had a positive Hawkin's sign on his right and was given a lidocaine injection into his subacromial bursa.

The petitioner felt pain in his waist area while turning and putting a box down on September 30, 2014. The incident is the subject matter of claim #14 WC 35154. He saw Dr. Prodromos on October 1, 2014, and reported a 50% improvement in his right shoulder pain with a subacromial bursa injection. The petitioner denied any back pain. Dr. Prodromos noted bilateral bicipital groove and right rotator cuff tenderness. He believed the petitioner was at maximum medical improvement for his right shoulder.

The petitioner sought treatment for back pain at Occupational Health Centers (OHC) on October 3, 2014, and was provided medication, ice and hot packs and activity modification for lumbosacral and sacroiliac strains. He started therapy at OHC on the 6th and followed up on the 7th. On October 8, 2014, the petitioner reported right shoulder and back pain to Dr. Prodromos. Lumbar x-rays on October 15, 2014, revealed minimal degenerative facet arthritis from L3 through S1. The petitioner received therapy several times per week through October 21, 2014. A lumbar MRI on October 27, 2014, revealed minimal degenerative changes, specifically at L2-3, and a congenitally narrowed spinal canal. At his last follow-up at OHC on October 29, 2014, the doctor noted that the petitioner's bilateral lumbar region symptoms were no better, that his pain did not radiate but was aggravated by sitting, standing or bending and that the MRI was negative.

On October 31, 2014, Dr. Heller re-evaluated the petitioner and noted a normal testing for both shoulders but anterior pain on the right along the longhead biceps during the Speed and Yergason maneuvers without evidence of rupture or subluxation. Dr. Heller opined that the petitioner's shoulder strains on April 18, 2012, are not related to his right SLAP lesion, that he was at maximum medical improvement for both shoulders and that medical care after January 25, 2013, was not related to the April 2012 injury.

The petitioner started treatment with Dr. Janneth Jaramillo for his back on December 16, 2014. Dr. Jaramillo's diagnosis was a backache. The petitioner followed up on December 30, 2014, and January 13, 2015, at which time he was referred to Dr. Yapor. The petitioner reported continued right shoulder pain to Dr. Prodromos on December 17, 2014, and January 14, 2015. He reported pain in both shoulders to Dr. Prodromos on February 11, March 20, April 15 and May 13, 2015. Dr. Prodromos noted on June 3, 2015, that physical therapy did not help with the petitioner's back pain. The doctor gave the petitioner an injection into his right parasacral area for his assessment of a lumbar strain.

Dr. William Heller noted after his IME on June 22, 2015, that the petitioner had normal motion and no evidence of instability and no evidence of rotator cuff weakness or of biceps rupture or subluxation. Dr. Heller reiterated his prior opinions. Dr. Prodromos testified by deposition on October 26, 2016, that an MR arthrogram of the petitioner's left shoulder was performed and revealed a SLAP lesion.

The petitioner started care for episodic back pain with Dr. Prasad Chappidi on October 7, 2015. At a follow-up on December 30, 2015, the petitioner reported no change in his back pain and indicated that his pain was sharp with radiation to his right buttocks and leg occasionally. Dr. Chappidi's assessment remained low back pain. The petitioner saw Dr. Gregory Fahrenbach at Northwest Orthopaedics & Sport Medicine on January 15, 2016, whose assessment was low back syndrome. A lumbar MRI on January 21, 2016, revealed diffuse narrowing of the spinal canal, a broard-based left posterolateral disc protrusion at L2-3 encroaching mildly on the left anterolateral edge of the thecal sac and moderately on the left neural foramen, prominent facet joint hypertrophy on the right

at L5-S1 with mild encroachment on the right neural foramen and diffuse disc bulge with mild encroachment of the edge of the thecal sac at L4-5 with very mild facet hypertrophy on the left.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The cost of the medical care rendered the petitioner for his right and left shoulders was reasonable and necessary and is awarded. The cost of the medical care rendered the petitioner for his lumbar spine through his last visit with Dr. Jaramillo was reasonable and necessary and is awarded. The cost of the medical care rendered the petitioner for his lumbar spine by Drs. Chappidi, Prodromos and Fahrenbach exceeded his choice of two medical providers and is denied. The cost of the medical care rendered the petitioner for his condition of ill-being with his rotator cuffs is not causally related to the work injury on April 18, 2012, and is denied.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that his current condition of ill-being with his right and left shoulders is causally related to the work injury on April 18, 2012, and that his current condition of ill-being with his lumbar spine is causally related to the work injury on September 30, 2014. At the petitioner's initial medical care, he reported pain in his biceps and deltoid muscles in both shoulders. At the time of his release by Dr. Wunker on June 15, 2012, though improved, the petitioner still had pain with abduction of his shoulders. Dr. Prodromos noted in September and October 2012 that the petitioner reported continued pain in both shoulders and had positive pain with elevation of his arms and resisted contraction at 90 degrees.

Dr. Prodromos believed there was an intraarticular problem based on the lack of pain relief with a right subacromial bursa injection. After MR arthrograms, his assessment was bilateral SLAP lesions. Dr. Prodromos' opinions are based on a more reliable medical analysis.

The petitioner failed to prove that his current condition of ill-being with his rotator cuffs is causally related to the work injury on April 18, 2012. On September 5, 2012, Dr. Prodromos noted that the petitioner had a full ROM of his shoulder and moderate coracoids tenderness but no AC joint tenderness. MRIs on October 5, 2012, were negative for rotator cuff tears. On October 2, 2013, Dr. Prodromos noted that the petitioner's shoulders had no AC joint tenderness and that MRIs with arthrogram and CT scans of his shoulders were normal.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

The respondent shall pay the petitioner temporary total disability benefits of $519.49/week for 70-6/7 weeks, from May 19, 2012, through June 11, 2012, September 5, 2012, through February 8, 2013, March 24, 2013, through April 6, 2013, and July 21, 2013, through May 17, 2014, for the petitioner's injury on April 18, 2012, and $520.09/week for 4/7 weeks, from October 22 through 25, 2014, for his injury on September 30, 2014, as provided in Section 8(b) of the Act.

FINDING REGARDING PROSPECTIVE MEDICAL:

The petitioner proved that an evaluation of his right shoulder by Dr. Cole and a left shoulder SLAP repair as recommended by Dr. Prodromos is reasonable medical care necessary to relieve the effects of the work injuries. The petitioner is entitled to have

from the respondent the reasonable and necessary cost for an evaluation of his right shoulder by Dr. Cole and a left shoulder SLAP repair.

Based on the findings of casual relationship of his condition of ill-being, the petitioner failed to prove that a rotator cuff repair of his right shoulder is reasonable medical care necessary to relieve the effects of the April 18, 2012, work injury. On September 5, 2012, Dr. Prodromos noted a full ROM of petitioner's shoulder and no AC joint tenderness. MRIs on October 5, 2012, revealed that there was no rotator cuff pathology. A right subacromial bursa injection did not provide the petitioner any relief.

FINDING REGARDING PENALTIES AND FEES:

The petitioner failed to prove that he is entitled to §19(l) and §19(k) penalties and fees. The evidence was insufficient to establish that the respondent's delay in the payment of temporary total disability benefits was without a good and just cause or their conduct was vexatious and unreasonable. There was a genuine dispute regarding the issues of causation and prospective medical care. The petitioner's request for penalties and fees is denied.

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RAYMOND L. ROCKWELL,

Petitioner,

vs.

NORTHWEST MECHANICAL,

Respondent.

17IWCC0824

NO: 13 WC 006471

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issue of nature and extent of Petitioner's permanent disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Decision of the Arbitrator filed with the Commission on December 20, 2016, addressed the issues of causal connection and permanent disability and found for Petitioner on each issue. Arbitrator Gallagher concluded that Petitioner's current condition of ill-being is causally related to Petitioner's December 28, 2012, accident and also that said accident resulted in an 11% loss of the use of the person as a whole. Petitioner took timely appeal of the Decision of the Arbitrator and contested the permanent disability award. Petitioner sought both an increase to the amount awarded and also an additional award for injuries sustained to his right upper arm. The Commission concludes the injury to sustained to Petitioner's right shoulder resulted in a loss greater than 11% loss of the use of the person as a whole but also concludes that Petitioner suffered no permanent injury to his right upper arm.

The Commission finds, as did Arbitrator Gallagher, Petitioner, after being released from treatment, resumed working for employers in physical demand levels that were equal to and sometimes greater to the physical demand level he worked at with Respondent. Where the Commission differs from Arbitrator Gallagher's assessment of Petitioner's condition is that the Commission notes Petitioner's diminished residual right shoulder strength requires him to be

17IWCC0824

assisted by his coworkers with overhead activities and also the range of motion of Petitioner's right shoulder is only equal to that of his left arm with active assistance. These lingering effects from Petitioner's accident, the Commission finds, represents a 15% loss of the use of the person as a whole.

The Commission, however, fails to find any evidence of Petitioner sustaining a specific injury to his right upper arm as he claims. Specifically noted is Petitioner's testimony in which he stated his soreness was present where his right shoulder and right biceps meet. No testimony was made by Petitioner of biceps alone being painful. Even if such testimony was offered, it would conflict with the January 2, 2014, discharge note of Dr. Coe in which he found Petitioner had no pain.

The Commission, other than modifying the award under Section 8(d)2 of the Act, affirms and adopts all other aspects of the December 20, 2016, Decision of the Arbitrator, including how permanent partial disability was determined as required under Section 8.1b of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,001.81 per week for a period of 6-2/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.55 per week for a period of 75 weeks, as provided in §8(b)2 of the Act, for the reason that the injuries sustained caused the 15% loss of the 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 in the amount of $9,940.21 for payments under §8(a) and §8(b) of the Act made 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 $49,900.00. 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: DEC 21 2017
KWL/mav
O: 12/05/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0824

ROCKWELL, RAYMOND L
Employee/Petitioner

Case# 13WC006471

NORTHWEST MECHANICAL
Employer/Respondent

On 12/20/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.64% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0009 ANESI OZMON RODIN NOVAK KOHEN
JOHN M POPELKA
161 N CLARK ST 21ST FL
CHICAGO, IL 60601

0507 RUSIN & MACIOROWSKI LTD
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STATE OF ILLINOIS)
)SS.
COUNTY OF ROCK ISLAND)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

17 IWCC0824

Raymond L. Rockwell
Employee/Petitioner

v.

Northwest Mechanical
Employer/Respondent

Case # 13 WC 06471

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Rock Island, on November 2, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On December 28, 2012, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $52,094.12; the average weekly wage was $1,502.72.

On the date of accident, Petitioner was 54 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $6,440.21 for TTD, $3,500.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $9,940.21.

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

ORDER

Respondent shall pay temporary total disability benefits of $1,001.81 per week for six and two-sevenths (6 2/7) weeks commencing June 21, 2013, through August 4, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay permanent partial disability benefits of $712.55 per week for 55 weeks because the injury sustained caused the 11% 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

December 15, 2016
Date

ICArbDec p. 2

DEC 20 2016

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on December 28, 2012. According to the Application, "Petitioner sustained injuries while working" and the part of the body affected was described as "Multiple injuries" (Arbitrator's Exhibit 2). There was no dispute that Petitioner sustained a work-related injury; however, Respondent disputed liability on the basis of causal relationship. Petitioner alleged that he was entitled to payment of temporary total disability benefits of six and two-sevenths weeks commencing June 21, 2013, through August 4, 2013. Respondent agreed that Petitioner was entitled to payment of temporary total disability benefits for that period of time (Arbitrator's Exhibit 2). In regard to temporary partial disability benefits, at trial, counsel for Petitioner and Respondent agreed that Petitioner was entitled to a total payment of $3,500.00. Respondent's counsel agreed that Respondent would make immediate payment of this amount to Petitioner.

Petitioner worked for Respondent for approximately 16 years and was a foreman. Petitioner was a member of the plumbers/pipefitters' union. Petitioner's job duties included supervising a crew which was usually eight to 10 people. Petitioner was a non-working foreman when the crew was 10, but when he worked with a crew of eight or less, Petitioner would participate in some of the duties.

Petitioner testified that on December 28, 2012, he was assisting another employee pick up a piece of pipe. The pipe was a 25 foot section of two inch pipe that weighed approximately 70 pounds. The pipe was secured by a piece of rope and the other employee was at a level higher than Petitioner. The other employee dropped the rope attached to the pipe, but Petitioner was able to catch the pipe with both of his hands. At that time, Petitioner sustained a sharp pain in his right shoulder.

On the same day of the accident, Petitioner was seen at Heartland Chiropractic where he already had an appointment because of some back symptoms. The record noted that Petitioner had right shoulder pain after lifting some pipe (Petitioner's Exhibit 1).

Petitioner was subsequently seen at Quad City Occupational Health on December 31, 2012, by Aaron Schultz, a Physician's Assistant. PA Schultz diagnosed Petitioner with right shoulder pain, but suspected the possibility of a rotator cuff tear. He prescribed some medications and recommended Petitioner do some range of motion exercises (Petitioner's Exhibit 2).

Petitioner's condition did not improve and, when seen by PA Schultz on January 16, 2013, PA Schultz ordered an MRI arthrogram. The MRI arthrogram was performed on January 28, 2013, and, according to the radiologist, it revealed a SLAP tear but no rotator cuff tear (Petitioner's Exhibit 2).

Petitioner was evaluated by Dr. Tuvi Mendel, an orthopedic surgeon, on April 22, 2013. Dr. Mendel examined Petitioner and reviewed the MRI arthrogram. Dr. Mendel opined that the MRI arthrogram revealed a SLAP tear, but also noted some changes in the supraspinatus. Dr. Mendel administered an injection to the right subacromial space (Petitioner's Exhibit 4).

Dr. Mendel saw Petitioner on May 13, 2013, and again reviewed the MRI arthrogram. He opined that the MRI arthrogram revealed a SLAP tear with biceps tendon involvement and, at least, a partial tear of the supraspinatus. Dr. Mendel discussed treatment options with Petitioner and Petitioner decided that he wanted to proceed with surgery (Petitioner's Exhibit 4).

At the direction of Respondent, Petitioner was examined by Dr. Abdul Foad, an orthopedic surgeon, on June 13, 2013. Dr. Foad reviewed the MRI arthrogram and agreed it revealed a SLAP tear as well as a possible rotator cuff tear versus a partial tear of the supraspinatus. He also recommended Petitioner undergo surgery (Petitioner's Exhibit 6).

Dr. Foad subsequently became Petitioner's treating physician and he performed arthroscopic surgery on Petitioner's right shoulder on June 21, 2013. The surgical procedure consisted of right shoulder rotator cuff repair, biceps tenodesis with conversions to tenolysis and a subacromial decompression. The post operative diagnoses were large degenerative unstable SLAP tear, type 2, degenerative fraying with bicipital tenosynovitis along the biceps tendon, small tear in the supraspinatus tendon, subacromial impingement and degenerative changes of the glenohumeral articular surface (Petitioner's Exhibit 6).

Following surgery, Dr. Foad continued to treat Petitioner and ordered physical therapy. Petitioner received physical therapy from July 1, 2013, through September 27, 2013, and again from September 30, 2013, through November 20, 2013. When Dr. Foad saw Petitioner on January 2, 2014, he opined Petitioner was at MMI and released him to return to work without restrictions (Petitioner's Exhibit 5, 6, and 7).

At trial, Petitioner testified that he was fired by Respondent on December 11, 2013, because he refused to take a drug test. When cross-examined about his refusal to take the drug test, Petitioner stated that he used marijuana at a Thanksgiving party and again about one week thereafter. Because of that, Petitioner knew he would not pass the drug test so he refused to take it. Petitioner also testified that he started smoking marijuana in the eighth grade and that he was an occasional user. Petitioner specifically denied having been under the influence of marijuana at the time of the accident.

At the direction of his attorney, Petitioner was examined by Dr. Jeffrey Coe, an occupational medicine specialist, on March 4, 2014. In connection with his examination of Petitioner, Dr. Coe reviewed medical records provided to him by Petitioner's counsel. When seen by Dr. Coe, Petitioner complained of pain in the front of his shoulder when reaching upward or behind his back, shoulder stiffness and weakness. On examination, Dr. Coe noted a decreased range of motion, some subacromial impingement and shoulder girdle weakness. Dr. Coe opined that Petitioner's right shoulder condition was rated to the accident of December 28, 2012, and that it caused permanent partial disability to the right arm (Petitioner's Exhibit 8; Deposition Exhibit 3).

At the direction of Respondent, Petitioner was examined by Dr. Joseph Monaco, an orthopedic surgeon, on April 17, 2014. In connection with his examination of Petitioner, Dr. Monaco reviewed medical records provided to him by Respondent. When seen by Dr. Monaco, Petitioner stated that he had difficulties reaching behind his back as well as some pain in the area of the biceps tendon. On examination, there was a slightly decreased range of motion of the right

shoulder when compared to the left. Dr. Monaco opined that Petitioner's right shoulder condition was related to the accident of December 28, 2012. Dr. Monaco also opined that there was an AMA impairment rating of five percent (5%) of the upper extremity which converted to a three percent (3%) whole person impairment (Respondent's Exhibit 1; Deposition Exhibit 2).

Dr. Coe was deposed on March 8, 2015, and his deposition testimony was received into evidence at trial. Dr. Coe's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Dr. Coe specifically noted that Petitioner's complaints were consistent with his findings on examination. He also opined that given Petitioner's age, it could be anticipated Petitioner would continue to have residual symptoms in his right shoulder (Petitioner's Exhibit 8; pp 37-38).

Dr. Monaco was deposed on April 28, 2015, and his deposition testimony was received into evidence at trial. Dr. Monaco's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Dr. Monaco explained in detail the procedure for determining an impairment rating using the AMA guides and reaffirmed his impairment rating of five percent (5%) of the upper extremity and its comparison to three (3%) whole person impairment (Respondent's Exhibit 1; p 41).

At trial, Petitioner testified that following the termination of his employment by Respondent that he worked at Nelson Power Plant between December, 2013, and March, 2014. Petitioner did essentially the same type of work he did for Respondent, a foreman of a crew. Petitioner was subsequently laid off from that job, but began working for Ryan and Associates in June, 2014.

When Petitioner worked for Ryan and Associates, he did not work as a foreman, but as a member of the crew. Accordingly, the work Petitioner performed for Ryan and Associates was more physically demanding than the work he performed for Respondent. Petitioner worked for Ryan and Associates through March, 2015, and retired effective April 1, 2015. Following his retirement, Petitioner obtained a part-time job where he supervises three high school students.

At trial, Petitioner testified that his right shoulder is still sore especially the front portion of it. Petitioner still has difficulties doing overhead lifting, but stated his shoulder is in much better condition than it was prior to having surgery.

Scott Jackson testified on behalf of Respondent when this case was tried. Jackson was Respondent's Safety Director. He confirmed that Petitioner was fired on December 11, 2013, when Petitioner refused to take the drug test. Jackson explained that this was a drug test required of all of Respondent's employees that were scheduled to work on a specific job site. He also stated that Petitioner knew that he would be fired if he refused to submit to the drug test.

Conclusions of Law

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

The Arbitrator concludes Petitioner's current condition of ill-being is causally related to the accident of December 28, 2012.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner sustained a work-related accident on December 28, 2012, to his right shoulder.

The physicians who examined Petitioner at the request of counsel for Petitioner and Respondent, Dr. Coe and Dr. Monaco, respectively, both opined that Petitioner's right shoulder condition was related to the accident of December 28, 2012.

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

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 11% loss of use of the person as a whole.

In support of this conclusion the Arbitrator notes the following:

Dr. Monaco opined that Petitioner had an AMA impairment rating of five percent (5%) of the right upper extremity or three percent (3%) of the whole person. The Arbitrator gives this factor moderate weight.

Petitioner was a plumber/pipefitter and, at the time of the accident, was a foreman. As a foreman, when Petitioner supervised a crew of 10, he was a non-working foreman. However, when the crew was eight or less, Petitioner participated in some of the work activities. Following Petitioner's termination of employment by Respondent, Petitioner returned to work for two other employers. Petitioner worked as a foreman for one of the employers; however, for another employer Petitioner worked as a crew member and performed work that was more physically demanding than the work he performed while employed by Respondent. The Arbitrator gives this factor significant weight.

Petitioner was 54 years of age at the time of the accident. According to Dr. Coe, given Petitioner's age, it would be anticipated that Petitioner would continue to have residual right shoulder symptoms. The Arbitrator gives this factor moderate weight.

There was no evidence that the injury sustained had any effect on Petitioner's future earning capacity. The Arbitrator gives this factor no weight.

The medical records indicated that, as result of this injury, Petitioner sustained a SLAP tear, bicipital tenosynovitis, supraspinatus tear, subacromial impingement and degenerative changes of the glenohumeral articular surface, which required arthroscopic surgery. Petitioner has

residual complaints/symptoms consistent with the injury he sustained. The Arbitrator gives this factor significant weight.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF McLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

FREDERICK STEVENS,

Petitioner,

vs. NO: 14 WC 009981

McLEAN COUNTY SHERIFF'S DEPARTMENT,

Respondent.

17IWCC0825

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent and the Petitioner herein, and notice given to all parties, the Commission, after considering the issues of medical and prospective medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof, but makes a clarification as outlined below.

The Commission further clarifies the Arbitrator's Award as to temporary total disability ("TTD").

As to TTD, the parties stipulated at the Arbitration hearing that all TTD had been paid to date and that the Respondent was therefore entitled to a credit of $6,035.97. The Commission clarifies that the dates of TTD for which Respondent has issued payment are February 10, 2014, through May 6, 2014, for a period of 12 1/7 weeks.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed 5/24/16 is hereby affirmed and adopted.

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

17IWCC0825

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: DEC 22 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O: 12/5/17
49

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

STEVENS. FREDERICK
Employee/Petitioner

Case# 14WC009981

13WC037667

McLEAN COUNTY SHERIFF'S DEPARTMENT
Employer/Respondent

17IWCC0825

On 5/24/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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STEVEN WILLIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

0264 HEYL ROYSTER VOELKER & ALLEN
CRAIG S YOUNG
PO BOX 6199
PEORIA, IL 61601-6199

17IWCC0825

STATE OF ILLINOIS)
)SS.
COUNTY OF MC LEAN)

☐ 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)

Frederick Stevens
Employee/Petitioner

Case # 14 WC 09981

v.

Consolidated cases: 13 WC 37667

McLean County Sheriff's Department
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 Bloomington , on March 31, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, February 9, 2014, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $38,558.52; the average weekly wage was $741.51.

On the date of accident, Petitioner was 54 years of age, single with 0 dependent child(ren).

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

Respondent shall be given a credit of $6,035.97 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $6,035.97. At trial, the parties stipulated TTD benefits were paid in full.

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

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, prospective medical treatment for Petitioner's back condition is denied.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

May 19, 2016
Date

MAY 24 2016

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim which alleged he sustained accidental injuries arising out of and in the course of his employment for Respondent. In case number 13 WC 37667, the Application alleged that on June 24, 2013, Petitioner sustained an injury to the "whole body" as a result of an "altercation with inmate" (Arbitrator's Exhibit 3). In case number 14 WC 09981, the Application alleged that on February 9, 2014, Petitioner sustained injuries to the "back, knee, legs and other parts of the body" as a result of "subduing inmate" (Arbitrator's Exhibit 4).

The two cases were consolidated and tried in a 19(b) proceeding in which Petitioner sought for prospective medical treatment, specifically, a right total knee replacement and epidural steroid injections in the thoracic and lumbar spine. Respondent stipulated that Petitioner sustained work-related injuries on the dates alleged in the Applications; however, Respondent disputed liability for prospective medical treatment on the basis of causal relationship (Arbitrator's Exhibits 1 and 2).

The stipulation sheets noted that there were disputed medical bills and Petitioner introduced into evidence an exhibit that contained a large number of medical bills, some of which had outstanding balances (Petitioner's Exhibit 21). However, the parties also stipulated on the record that temporary total disability benefits and medical bills incurred to date had been paid.

Petitioner worked for Respondent as a medical officer and his job duties included monitoring the medical conditions of inmates. Typically, Petitioner would check inmates' vital signs, blood pressure, etc.

Petitioner testified that on June 24, 2013, he sustained injuries when he was attacked by a combative inmate. Petitioner was seen in the ER of St. Joseph Medical Center that same day. At that time, it was noted that Petitioner had swelling/tenderness in the right knee (Petitioner's Exhibit 4).

Petitioner was subsequently seen by Dr. Ira Halperin, his family physician, who ordered an MRI of the right knee. The MRI was performed on July 1, 2013, and it revealed a tear of the posterior horn of the medial meniscus. Dr. Halperin referred Petitioner to Dr. Brett Keller, an orthopedic surgeon (Petitioner's Exhibits 5 and 13).

Dr. Keller initially evaluated Petitioner on July 11, 2013. He reviewed the MRI and opined that arthroscopic surgery for a torn medial meniscus was indicated (Petitioner's Exhibit 14).

Dr. Keller performed arthroscopic surgery on Petitioner's right knee on August 7, 2013. The surgery consisted of meniscectomies of both medial and lateral meniscus as well as a chondroplasty of the trochlea (Petitioner's Exhibit 7).

Dr. Keller saw Petitioner following the surgery and ordered physical therapy. Petitioner continued to have complaints of pain and swelling in the right knee and Dr. Keller administered injections in the right knee on August 27, and September 5, 2013 (Petitioner's Exhibit 14).

When Dr. Keller saw Petitioner on September 24, 2013, Petitioner still had complaints of pain and swelling in the right knee. When Dr. Keller examined Petitioner, the straight leg raising test was positive on the right side and Dr. Keller opined that there was lumbar radiculitis/radiculopathy. He ordered an MRI of the lumbar spine (Petitioner's Exhibit 14).

The MRI was performed on October 15, 2013, and it revealed multiple bulging discs in the lumbar spine and a spondylolisthesis at L5-S1. Dr. Keller saw Petitioner on October 24, 2013, and reviewed the MRI. He opined that Petitioner had lumbosacral neuritis. He referred Petitioner to Dr. Ji Li for epidural steroid injections (Petitioner's Exhibit 14).

Dr. Li saw Petitioner on November 13, 2013, and opined that Petitioner had lumbar radiculopathy. Because Petitioner was taking Coumadin, he decided to manage Petitioner's low back pain symptoms with medications (Petitioner's Exhibit 8).

At the direction of Respondent, Petitioner was examined by Dr. Joseph Monaco, an orthopedic surgeon, on November 15, 2013. In connection with his examination of Petitioner, Dr. Monaco reviewed medical reports provided to him by Respondent. In regard to Petitioner's right knee, Dr. Monaco opined that Petitioner sustained tears of the medial and lateral meniscus which had been appropriately treated and that Petitioner was at MMI in regard to that condition. In regard to the low back, Dr. Monaco opined that Petitioner's low back condition/symptoms were not related to the accident of June 24, 2013. This was based upon the lack of any low back complaints following the accident and the fact that Petitioner had no low back complaints at the time of his examination (Respondent's Exhibit 1; Deposition Exhibit 2).

Petitioner was seen by Dr. Keller on December 5, 2013, primarily for his right knee symptoms. Dr. Keller aspirated some fluid from the bursa and gave Petitioner an injection. He also opined that Petitioner could benefit from some physical therapy for his low back issues (Petitioner's Exhibit 14).

Petitioner was seen by Dr. Keller on January 2, 2014. At that time, Petitioner's right knee condition had improved; however, Dr. Keller recommended Petitioner continue with Dr. Li for his lumbar spine issues. He authorized Petitioner to return to work without restrictions on January 6, 2014 (Petitioner's Exhibit 14).

At trial, Petitioner testified that on February 9, 2014, he was tackled by a mental patient which caused him to reinjure his right knee and back. Following this accident Petitioner was seen in the ER at St. Joseph Medical Center. X-rays were taken of the right knee and lumbar spine. The x-rays of the right knee revealed degenerative changes and the x-ray the lumbar spine revealed various degenerative changes and a compression fracture of L2 (Petitioner's Exhibit 10).

Petitioner was seen by Dr. Keller on February 10, 2014. At that time, Petitioner informed Dr. Keller that he had reinjured his right knee and low back while restraining an inmate. Dr. Keller noted on examination that Petitioner had recurrent effusion and he suspected possible medial and/or lateral meniscus tears. He ordered an MRI of the right knee. The MRI was performed on

February 18, 2014, and it revealed that the medial meniscus was smaller when compared to the prior study of July 1, 2013 (Petitioner's Exhibit 14).

Petitioner saw Dr. Li on March 3, 2014, for his back symptoms which now also included the neck and upper back. Dr. Li ordered an MRI scan of the thoracic spine. The radiologist's report of the MRI was not tendered into evidence; however, when Dr. Li saw Petitioner on March 20, 2014, he noted that the MRI revealed degenerative disc disease at T4-T5 and T5-T6. He recommended Petitioner have some epidural steroid injections to the thoracic spine (Petitioner's Exhibit 15).

Dr. Keller saw Petitioner on March 4, 2014, and noted that Petitioner had recently had an MRI performed and that Petitioner had been using a "Game Ready" system at home to control his knee swelling. Petitioner was again seen by Dr. Keller on April 18, 2014, for both right knee and low back pain (Petitioner's Exhibit 14).

Again at the direction of Respondent, Dr. Monaco examined Petitioner on April 22, 2014. In connection with his examination of Petitioner, Dr. Monaco reviewed medical records, regarding Petitioner's more recent treatment, that had been provided to him by Respondent. In regard to Petitioner's right knee, Dr. Monaco opined that Petitioner had sustained a contusion of the right knee with the subsequent development of a prepatellar bursitis. He did not find any further injury to the meniscus. Dr. Monaco stated that Petitioner was not at MMI for the prepatellar bursitis; however, he opined that any need for a total knee replacement was not related to this condition. He also recommended Petitioner avoid pressure on the right knee and perform sit-down work with standing and walking limited to 10 minutes every hour. In regard to Petitioner's back symptoms, Dr. Monaco again opined that there was not any relationship between them and the more recent work-related accident. He also noted that Petitioner was not complaining of low back pain, but rather, was complaining of pain consistent with a thoracolumbar strain. Dr. Monaco also opined that epidural steroid injections were not medically necessary because they would not produce any relief at that level (Respondent's Exhibit 1; Deposition Exhibit 4).

On May 28, 2014, Dr. Monaco prepared a supplemental report wherein he opined that Petitioner was at MMI and could return to work to his regular job so long as he could avoid kneeling on the right knee. He stated that Petitioner's prepatellar bursitis would resolve in three to six weeks from the time of his evaluation (Respondent's Exhibit 1; Deposition Exhibit 5).

Dr. Li saw Petitioner on June 5, and August 28, 2014, for Petitioner's mid and low back symptoms. He renewed his recommendation that Petitioner undergo some epidural steroid injections (Petitioner's Exhibit 15).

On September 12, 2014, Dr. Keller prepared a narrative medical report directed to Petitioner's counsel. In this report, Dr. Keller noted that Petitioner sustained an injury to his right knee on June 24, 2014, and that Petitioner subsequently had arthroscopic surgery for medial and lateral meniscus tears. He also noted that Petitioner had osteoarthritis in the knee and further opined that Petitioner will likely require a right total knee replacement. He further stated that the accident aggravated the pre-existing disease of degenerative osteoarthritis (Petitioner's Exhibit 3).

Dr. Keller saw Petitioner on November 7, 2014. On examination, the range of motion of the right knee was limited and Dr. Keller noted that most of the arthritis was at the patellofemoral joint which he opined was due to the fall Petitioner had sustained. He again made the recommendation that Petitioner have a total knee replacement (Petitioner's Exhibit 14).

Dr. Li was deposed on October 6, 2014, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Li's testimony was consistent with his medical records and that when he examined Petitioner on November 13, 2013, he diagnosed lumbar radiculopathy and lumbar disc disease. He recommended Petitioner have injections; however, because Petitioner was taking Coumadin, he attempted to manage Petitioner's pain symptoms by medication. Dr. Li noted that Petitioner's back symptoms worsened following the accident of February 9, 2014, and now also included the thoracic spine. He has continued to recommend Petitioner undergo epidural steroid injections (Petitioner's Exhibit 2; pp 8, 13-21).

On January 15, 2015, Dr. Monaco was supposed and his deposition testimony was received into evidence at trial. On direct examination, Dr. Monaco's testimony was consistent with his medical reports and he reaffirmed the opinions contained therein. On cross-examination, Dr. Monaco agreed that his findings on examination and the fact that Petitioner had an antalgic gait were supportive of Petitioner's ongoing complaints of knee pain. He also agreed that the knee surgery that Petitioner had could accelerate the arthritic process in the knee, but he did not believe it would have accelerated it that quickly (Respondent's Exhibit 1; pp 66-73).

Dr. Keller was deposed on February 20, 2015, and his deposition testimony was received into evidence at trial. Dr. Keller's testimony was consistent with his medical records and he reaffirmed his recommendation that Petitioner have total knee replacement surgery performed on his right knee. He testified that Petitioner had medial and lateral meniscus tears and osteoarthritis of the right knee and that the injury of June, 2013, caused the aforestated condition of ill-being. He further testified that the injury caused or contributed to the necessity of Petitioner requiring a total knee replacement (Petitioner's Exhibit 1; pp 27-29).

On October 13, 2014, Petitioner was involved in a motor vehicle accident for which he was seen in the ER of St. Joseph Medical Center shortly thereafter. According to the ER records, Petitioner had a recurrence of his thoracic spine pain. Petitioner did not seek any medical care for any injury sustained as result of that motor vehicle accident any time thereafter (Respondent's Exhibit 4).

At trial, Petitioner testified that he was able to return to work in May, 2014, to his regular job. He still walks with a limp and has back pain. Petitioner uses a cane on a regular basis and had it with him at the time of trial; however, for security reasons, Petitioner is not permitted to have his cane with him while he is at work. Petitioner does want to proceed with the total knee replacement surgery recommended by Dr. Keller. Petitioner did not testify whether or not he wants to proceed with the epidural steroid injections that have been recommended by Dr. Li. He did agree that the motor vehicle accident of October, 2014, did cause some worsening of his back and leg symptoms.

Conclusions of Law

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

The Arbitrator concludes that Petitioner's current condition of ill-being in regard to his back is not causally related to the accident of February 9, 2014.

In support of this conclusion the Arbitrator notes the following:

While Petitioner complained of back pain immediately following the accident of February 9, 2014, Dr. Li had treated Petitioner for back pain both before and after the accident of February 9, 2014. Prior to that time, Dr. Li had also recommended that Petitioner undergo epidural steroid injections; however, he did administer Petitioner these injections because of Petitioner's use of Coumadin.

Respondent's Section 12 examiner, Dr. Monaco, noted that when he saw Petitioner on April 22, 2014, that Petitioner did not have complaints in the low back but had complaints in the lower thoracic area.

The Arbitrator finds the opinion of Dr. Monaco to be more persuasive than that of Dr. Li.

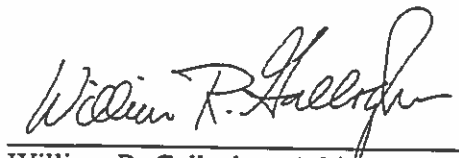
In regard to disputed issue (K) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner is not entitled to prospective medical treatment in regard to his back condition.

In support of this conclusion the Arbitrator notes the following:

As noted herein, in disputed issue (F) the Arbitrator concluded that Petitioner's low back condition was not causally related to the accident of February 9, 2014.

Further, Dr. Monaco opined that epidural steroid injections were not medically necessary for Petitioner's thoracic spine condition.



William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF McLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

FREDERICK STEVENS,

Petitioner,

vs. NO: 13 WC 37667

McLEAN COUNTY SHERIFF'S DEPARTMENT,

Respondent.

17IWCC0826

DECISION AND OPINION ON REVIEW

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

The Commission further clarifies the Arbitrator's Award as to temporary total disability ("TTD") and medical bills.

17IWCC0826

As to TTD, the parties stipulated at the Arbitration hearing that all TTD had been paid to date and that the Respondent was therefore entitled to a credit of $16,110.16. The Commission clarifies that the dates of TTD for which Respondent has issued payment are June 24, 2013, through January 5, 2014, for a period of 27 weeks.

As to the outstanding medical bills, the Commission takes judicial notice that the parties stipulated on the record that some payment of medical bills has been made through the group medical plan of an undetermined amount and that Petitioner agreed that Respondent is entitled to an 8(j) credit for whatever amounts have in fact been paid. However, the Arbitrator did not specifically address the outstanding medical bills in dispute by the parties. Petitioner's Exhibit 21 delineated bills from the following providers: Central IL Orthopedic Surgery, Applied Pain Institute, St. Joseph Medical Center, OSFMG, Bloomington Normal Healthcare, Eastland Open MRI, Ft. Jesse Imaging, BL/Normal ENT – Dr. Robert Russell, Midwest Medical/Game Ready, Bloomington Radiology, McLean County Anesthesia, and Heartland Emergency Services. Petitioner further asserted that there were $33,993.34 in outstanding medical bills. The Commission hereby awards the following outstanding medical bills regarding treatment to Petitioner's right knee, subject to the fee schedule: Central IL Orthopedic Surgery, OSFMG, Eastland Open MRI, Midwest Medical/Game Ready, Bloomington Radiology. The bills of Applied Pain Institute/Dr. Ji Li, are denied as pertaining to Petitioner's back and not causally related to Petitioner's work accidents.

The Commission takes judicial notice that per Petitioner's Exhibit 21, the bills of St. Joseph Medical Center, Bloomington Normal Healthcare, Ft. Jesse Imaging, BL Normal ENT – Dr. Robert Russell, McLean County Anesthesia, Ltd., and Heartland Emergency Specialists all show a $0.00 balance due. Respondent is entitled to an 8(j) credit for whatever amounts have been paid.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed 5/24/16, is hereby affirmed and adopted.

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

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

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

17IWCC0826

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: DEC 22 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O:
49

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

STEVENS, FREDERICK
Employee/Petitioner

Case# 13WC037667
14WC009981

McLEAN COUNTY SHERIFF'S DEPARTMENT
Employer/Respondent

17IWCC0826

On 5/24/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.48% 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:

0564 WILLIAMS & SWEE LTD
STEVEN WILLIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

0264 HEYL ROYSTER VOELKER & ALLEN
CRAIG S YOUNG
PO BOX 6199
PEORIA, IL 61601-6199

17IWCC0826

STATE OF ILLINOIS)
)SS.
COUNTY OF MC LEAN)

☐ 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)

Frederick Stevens
Employee/Petitioner

Case # 13 WC 37667

v.

Consolidated cases: 14 WC 09981

McLean County Sheriff's Department
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 Bloomington , on March 31, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0826

FINDINGS

On the date of accident, June 24, 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, in part, causally related to the accident.

In the year preceding the injury, Petitioner earned $38,558.52; the average weekly wage was $741.51.

On the date of accident, Petitioner was 53 years of age, single with 0 dependent child(ren).

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

Respondent shall be given a credit of $16,110.64 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $16,110.64. At trial, the parties stipulated TTD benefits were paid in full.

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

ORDER

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the right total knee replacement surgery as recommended by Dr. Brett Keller.

Based upon the Arbitrator's Conclusions of Law attached hereto, prospective medical treatment for Petitioner's back condition is denied.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

May 19, 2016
Date

MAY 24 2016

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim which alleged he sustained accidental injuries arising out of and in the course of his employment for Respondent. In case number 13 WC 37667, the Application alleged that on June 24, 2013, Petitioner sustained an injury to the "whole body" as a result of an "altercation with inmate" (Arbitrator's Exhibit 3). In case number 14 WC 09981, the Application alleged that on February 9, 2014, Petitioner sustained injuries to the "back, knee, legs and other parts of the body" as a result of "subduing inmate" (Arbitrator's Exhibit 4).

The two cases were consolidated and tried in a 19(b) proceeding in which Petitioner sought for prospective medical treatment, specifically, a right total knee replacement and epidural steroid injections in the thoracic and lumbar spine. Respondent stipulated that Petitioner sustained work-related injuries on the dates alleged in the Applications; however, Respondent disputed liability for prospective medical treatment on the basis of causal relationship (Arbitrator's Exhibits 1 and 2).

The stipulation sheets noted that there were disputed medical bills and Petitioner introduced into evidence an exhibit that contained a large number of medical bills, some of which had outstanding balances (Petitioner's Exhibit 21). However, the parties also stipulated on the record that temporary total disability benefits and medical bills incurred to date had been paid.

Petitioner worked for Respondent as a medical officer and his job duties included monitoring the medical conditions of inmates. Typically, Petitioner would check inmates' vital signs, blood pressure, etc.

Petitioner testified that on June 24, 2013, he sustained injuries when he was attacked by a combative inmate. Petitioner was seen in the ER of St. Joseph Medical Center that same day. At that time, it was noted that Petitioner had swelling/tenderness in the right knee (Petitioner's Exhibit 4).

Petitioner was subsequently seen by Dr. Ira Halperin, his family physician, who ordered an MRI of the right knee. The MRI was performed on July 1, 2013, and it revealed a tear of the posterior horn of the medial meniscus. Dr. Halperin referred Petitioner to Dr. Brett Keller, an orthopedic surgeon (Petitioner's Exhibits 5 and 13).

Dr. Keller initially evaluated Petitioner on July 11, 2013. He reviewed the MRI and opined that arthroscopic surgery for a torn medial meniscus was indicated (Petitioner's Exhibit 14).

Dr. Keller performed arthroscopic surgery on Petitioner's right knee on August 7, 2013. The surgery consisted of meniscectomies of both medial and lateral meniscus as well as a chondroplasty of the trochlea (Petitioner's Exhibit 7).

Dr. Keller saw Petitioner following the surgery and ordered physical therapy. Petitioner continued to have complaints of pain and swelling in the right knee and Dr. Keller administered injections in the right knee on August 27, and September 5, 2013 (Petitioner's Exhibit 14).

When Dr. Keller saw Petitioner on September 24, 2013, Petitioner still had complaints of pain and swelling in the right knee. When Dr. Keller examined Petitioner, the straight leg raising test was positive on the right side and Dr. Keller opined that there was lumbar radiculitis/radiculopathy. He ordered an MRI of the lumbar spine (Petitioner's Exhibit 14).

The MRI was performed on October 15, 2013, and it revealed multiple bulging discs in the lumbar spine and a spondylolisthesis at L5-S1. Dr. Keller saw Petitioner on October 24, 2013, and reviewed the MRI. He opined that Petitioner had lumbosacral neuritis. He referred Petitioner to Dr. Ji Li for epidural steroid injections (Petitioner's Exhibit 14).

Dr. Li saw Petitioner on November 13, 2013, and opined that Petitioner had lumbar radiculopathy. Because Petitioner was taking Coumadin, he decided to manage Petitioner's low back pain symptoms with medications (Petitioner's Exhibit 8).

At the direction of Respondent, Petitioner was examined by Dr. Joseph Monaco, an orthopedic surgeon, on November 15, 2013. In connection with his examination of Petitioner, Dr. Monaco reviewed medical reports provided to him by Respondent. In regard to Petitioner's right knee, Dr. Monaco opined that Petitioner sustained tears of the medial and lateral meniscus which had been appropriately treated and that Petitioner was at MMI in regard to that condition. In regard to the low back, Dr. Monaco opined that Petitioner's low back condition/symptoms were not related to the accident of June 24, 2013. This was based upon the lack of any low back complaints following the accident and the fact that Petitioner had no low back complaints at the time of his examination (Respondent's Exhibit 1; Deposition Exhibit 2).

Petitioner was seen by Dr. Keller on December 5, 2013, primarily for his right knee symptoms. Dr. Keller aspirated some fluid from the bursa and gave Petitioner an injection. He also opined that Petitioner could benefit from some physical therapy for his low back issues (Petitioner's Exhibit 14).

Petitioner was seen by Dr. Keller on January 2, 2014. At that time, Petitioner's right knee condition had improved; however, Dr. Keller recommended Petitioner continue with Dr. Li for his lumbar spine issues. He authorized Petitioner to return to work without restrictions on January 6, 2014 (Petitioner's Exhibit 14).

At trial, Petitioner testified that on February 9, 2014, he was tackled by a mental patient which caused him to reinjure his right knee and back. Following this accident Petitioner was seen in the ER at St. Joseph Medical Center. X-rays were taken of the right knee and lumbar spine. The x-rays of the right knee revealed degenerative changes and the x-ray the lumbar spine revealed various degenerative changes and a compression fracture of L2 (Petitioner's Exhibit 10).

Petitioner was seen by Dr. Keller on February 10, 2014. At that time, Petitioner informed Dr. Keller that he had reinjured his right knee and low back while restraining an inmate. Dr. Keller noted on examination that Petitioner had recurrent effusion and he suspected possible medial and/or lateral meniscus tears. He ordered an MRI of the right knee. The MRI was performed on

February 18, 2014, and it revealed that the medial meniscus was smaller when compared to the prior study of July 1, 2013 (Petitioner's Exhibit 14).

Petitioner saw Dr. Li on March 3, 2014, for his back symptoms which now also included the neck and upper back. Dr. Li ordered an MRI scan of the thoracic spine. The radiologist's report of the MRI was not tendered into evidence; however, when Dr. Li saw Petitioner on March 20, 2014, he noted that the MRI revealed degenerative disc disease at T4-T5 and T5-T6. He recommended Petitioner have some epidural steroid injections to the thoracic spine (Petitioner's Exhibit 15).

Dr. Keller saw Petitioner on March 4, 2014, and noted that Petitioner had recently had an MRI performed and that Petitioner had been using a "Game Ready" system at home to control his knee swelling. Petitioner was again seen by Dr. Keller on April 18, 2014, for both right knee and low back pain (Petitioner's Exhibit 14).

Again at the direction of Respondent, Dr. Monaco examined Petitioner on April 22, 2014. In connection with his examination of Petitioner, Dr. Monaco reviewed medical records, regarding Petitioner's more recent treatment, that had been provided to him by Respondent. In regard to Petitioner's right knee, Dr. Monaco opined that Petitioner had sustained a contusion of the right knee with the subsequent development of a prepatellar bursitis. He did not find any further injury to the meniscus. Dr. Monaco stated that Petitioner was not at MMI for the prepatellar bursitis; however, he opined that any need for a total knee replacement was not related to this condition. He also recommended Petitioner avoid pressure on the right knee and perform sit-down work with standing and walking limited to 10 minutes every hour. In regard to Petitioner's back symptoms, Dr. Monaco again opined that there was not any relationship between them and the more recent work-related accident. He also noted that Petitioner was not complaining of low back pain, but rather, was complaining of pain consistent with a thoracolumbar strain. Dr. Monaco also opined that epidural steroid injections were not medically necessary because they would not produce any relief at that level (Respondent's Exhibit 1; Deposition Exhibit 4).

On May 28, 2014, Dr. Monaco prepared a supplemental report wherein he opined that Petitioner was at MMI and could return to work to his regular job so long as he could avoid kneeling on the right knee. He stated that Petitioner's prepatellar bursitis would resolve in three to six weeks from the time of his evaluation (Respondent's Exhibit 1; Deposition Exhibit 5).

Dr. Li saw Petitioner on June 5, and August 28, 2014, for Petitioner's mid and low back symptoms. He renewed his recommendation that Petitioner undergo some epidural steroid injections (Petitioner's Exhibit 15).

On September 12, 2014, Dr. Keller prepared a narrative medical report directed to Petitioner's counsel. In this report, Dr. Keller noted that Petitioner sustained an injury to his right knee on June 24, 2014, and that Petitioner subsequently had arthroscopic surgery for medial and lateral meniscus tears. He also noted that Petitioner had osteoarthritis in the knee and further opined that Petitioner will likely require a right total knee replacement. He further stated that the accident aggravated the pre-existing disease of degenerative osteoarthritis (Petitioner's Exhibit 3).

Dr. Keller saw Petitioner on November 7, 2014. On examination, the range of motion of the right knee was limited and Dr. Keller noted that most of the arthritis was at the patellofemoral joint which he opined was due to the fall Petitioner had sustained. He again made the recommendation that Petitioner have a total knee replacement (Petitioner's Exhibit 14).

Dr. Li was deposed on October 6, 2014, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Li's testimony was consistent with his medical records and that when he examined Petitioner on November 13, 2013, he diagnosed lumbar radiculopathy and lumbar disc disease. He recommended Petitioner have injections; however, because Petitioner was taking Coumadin, he attempted to manage Petitioner's pain symptoms by medication. Dr. Li noted that Petitioner's back symptoms worsened following the accident of February 9, 2014, and now also included the thoracic spine. He has continued to recommend Petitioner undergo epidural steroid injections (Petitioner's Exhibit 2; pp 8, 13-21).

On January 15, 2015, Dr. Monaco was supposed and his deposition testimony was received into evidence at trial. On direct examination, Dr. Monaco's testimony was consistent with his medical reports and he reaffirmed the opinions contained therein. On cross-examination, Dr. Monaco agreed that his findings on examination and the fact that Petitioner had an antalgic gait were supportive of Petitioner's ongoing complaints of knee pain. He also agreed that the knee surgery that Petitioner had could accelerate the arthritic process in the knee, but he did not believe it would have accelerated it that quickly (Respondent's Exhibit 1; pp 66-73).

Dr. Keller was deposed on February 20, 2015, and his deposition testimony was received into evidence at trial. Dr. Keller's testimony was consistent with his medical records and he reaffirmed his recommendation that Petitioner have total knee replacement surgery performed on his right knee. He testified that Petitioner had medial and lateral meniscus tears and osteoarthritis of the right knee and that the injury of June, 2013, caused the aforestated condition of ill-being. He further testified that the injury caused or contributed to the necessity of Petitioner requiring a total knee replacement (Petitioner's Exhibit 1; pp 27-29).

On October 13, 2014, Petitioner was involved in a motor vehicle accident for which he was seen in the ER of St. Joseph Medical Center shortly thereafter. According to the ER records, Petitioner had a recurrence of his thoracic spine pain. Petitioner did not seek any medical care for any injury sustained as result of that motor vehicle accident any time thereafter (Respondent's Exhibit 4).

At trial, Petitioner testified that he was able to return to work in May, 2014, to his regular job. He still walks with a limp and has back pain. Petitioner uses a cane on a regular basis and had it with him at the time of trial; however, for security reasons, Petitioner is not permitted to have his cane with him while he is at work. Petitioner does want to proceed with the total knee replacement surgery recommended by Dr. Keller. Petitioner did not testify whether or not he wants to proceed with the epidural steroid injections that have been recommended by Dr. Li. He did agree that the motor vehicle accident of October, 2014, did cause some worsening of his back and leg symptoms.

Conclusions of Law

In regard to disputed issue (F) the Arbitrator makes the following conclusions of law:

The Arbitrator concludes that Petitioner's current condition of ill-being in regard to his right knee is causally related to the accident of June 24, 2013.

The Arbitrator concludes that Petitioner's current condition of ill-being in regard to his back is not causally related to the accident of June 24, 2013.

In support of these conclusions the Arbitrator notes the following:

The fact that Petitioner sustained an injury to his right knee on June 24, 2013, that required medial and lateral meniscus surgery was not disputed.

Petitioner's treating physician, Dr. Keller, opined that the accident of June 24, 2013, caused the tears of the medial and lateral meniscus as well as osteoarthritis in the knee joint which caused or contributed to the need for a total knee replacement.

Petitioner may have sustained some further injury to the right knee as result of the subsequent accident of February 9, 2014, as noted in the MRI of February 18, 2014.

Respondent's Section 12 examiner, Dr. Monaco, agreed in April, 2014, that Petitioner had prepatellar bursitis and that work restrictions were indicated even though he also opined that any need for a total knee replacement was not related to same. However, approximately one month later, on May 28, 2014, Dr. Monaco prepared a supplemental report wherein he opined that Petitioner could return to work without restrictions.

Petitioner credibly testified that he has significant complaints of knee pain and that he uses a cane on a regular basis.

The Arbitrator finds the testimony of Dr. Keller to be more persuasive than that of Dr. Monaco in regard to Petitioner's right knee condition.

In regard to the back, Petitioner did not have any complaints of back pain until he was seen by Dr. Keller on September 24, 2013, approximately three months post-accident.

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

The Arbitrator concludes that Petitioner is entitled to prospective medical treatment, including, but not limited to the total knee replacement surgery recommended by Dr. Brett Keller.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

THERESA SCHULTZ,

Petitioner,

vs.

NO: 15 WC 18108

WASHINGTON GROUP ALBERICI JV,

Respondent.

17IWCC0827

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 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.

In further support of the Arbitrator's decision, the Commission finds that Petitioner failed to prove that the aggressor's alleged actions were such that a reasonable person would objectively find rose to the level of a sudden, severe, emotional incident. In *Diaz v. Ill. Workers' Comp. Comm'n*, 2013 IL App (2d) 120294WC, ¶28, the Court held that they did not read *Pathfinder v. Industrial Comm'n*, 62 Ill.2d 556 (1976) to permit recovery for every non-traumatic physic injury from which an employee suffers merely because the employee can identify some stressful work-related episode which contributes in part to the employee's depression or anxiety, but rather is limited to the narrow group of cases in which an employee suffers a sudden, severe emotional shock which results in immediately apparent psychic injury and is precipitated by an uncommon event of significantly greater proportion or dimension that that to which the employee would otherwise be subjected in the normal course of employment. Anxiety, emotional stress or depression which develops over time in the normal course of an employment relationship does not constitute a compensable injury. *Id.*

17IWCC0827

In the instant case, Petitioner claims that her co-worker yelled at her and made a quacking-like motion with his hand, in close proximity to her face, while she traveled for a short distance in a vehicle at the work-site. Although Petitioner's co-worker's actions were inappropriate, and he was subsequently terminated for same, Petitioner's reaction that she felt kidnapped or was "unlawfully restrained" in a 3-5 minute drive when she possessed a radio and cell phone, were an extreme over-reaction to a disagreement with a co-worker. Petitioner has a long-standing history of depression and anxiety, and in fact, while undergoing a neurological exam in 2012, relayed an incident where her reaction did not correspond with the situation. (Rx8) Other witnesses testified that Petitioner's response to the incident was an overreaction "P was bawling like some serious drama like you just found out like your parents had died or something. P was that bawling. It seemed like an overreaction." (Px5) Further, there was evidence of a rift between Petitioner and the Teamsters and Petitioner was described as being overly needy and easily stirred up in the work place. Finally, Petitioner did not seek any treatment for the alleged traumatic event suffered until 4/10/15 – approximately 6 months after the alleged event. The alleged events of 10/16/14 did not constitute a severe emotional shock resulting disability, and the Arbitrator's decision is therefore affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed 6/2/2016 is hereby affirmed and adopted, that Petitioner's claim for benefits is denied as she has failed to prove that she sustained an accidental injury arising out of and in the course of her employment with Respondent.

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: DEC 22 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O: 12/05/17
49

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

SCHULTZ, THERESA
Employee/Petitioner

Case# 15WC018108

WASHINGTON GROUP ALBERICI JV
Employer/Respondent

17IWCC0827

On 6/2/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4493 GOLDENBERG HELLER & ANTOGNOLI
THOMAS J LECH
2227 S STATE ROUTE 157
EDWARDSVILLE, IL 62025

2904 HENNESSY & ROACH PC
MICHAEL J HOLT
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

17IWCC0827

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(a)

THERESA SCHULTZ
Employee/Petitioner

v.

WASHINGTON GROUP ALBERICI JV
Employer/Respondent

Case # 15 WC 18108

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Herrin**, on **March 8, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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FINDINGS

On the date of accident, **October 16, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$62,725.74**; the average weekly wage was **$1,320.54**.

On the date of accident, Petitioner was **48** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

The Petitioner failed to prove that she sustained accidental injuries arising out of and in the course of her employment with the Respondent on any date between October 16, 2014 and April 10, 2015. She failed to prove that she suffered a sudden, severe, emotional trauma pursuant to Illinois law.

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

May 26, 2016
Date

ICArbDec19(b)

JUN 2 - 2016

STATEMENT OF FACTS

The Petitioner testified that she worked for the Respondent at the Olmsted Lock and Dam as a union laborer. She essentially was a gofer who transported items from the land to 200 workers on barges and tugs in the river. To do so, she often would have to radio to get a ride from a Teamster's driver, up to 10 or more times per day. She testified that she had no problems with the Teamster drivers prior to 10/16/14. She also denied having any problems or conflict with Brian Dixon, one of the Teamsters who had given Petitioner rides.

On 10/16/14, Petitioner was on the river and received a call to return to land in order to meet with a fire extinguisher representative. She was in the area of "Mud Point," the river area where workers can gain access to the barges, tug boats and other equipment on the river. Mr. Dixon was there with his truck, and was putting on his life vest to deliver a package out on the river. Petitioner asked Dixon for a ride, and she testified that he did not respond. After making his delivery, Dixon returned to his truck and Petitioner asked again for a ride, and she said Dixon again did not respond. Petitioner testified that Dixon then just sat in the truck, so she thought maybe he was going to give her a ride. She opened the door and asked again. Mr. Dixon replied that he had heard Petitioner both times and answered her both times. Petitioner asked if that meant if he could give her a ride, and Dixon nodded his head so Petitioner entered the truck. She put on her seat belt, and as they drove away, Petitioner explained to Dixon that she couldn't hear well out of her right ear, and while doing so testified that: "that's when he reached over, and he said, right in front of my face, I heard you. If you shut your mouth sometime, maybe you can hear something." She testified that as he screamed this at her, he reached his hand right in front of her face and performed a quacking-type motion with his hand, and that his hand was so close to her face she could feel the wind of the hand gesture.

Petitioner testified that she was bewildered by what had occurred, and asked Dixon to let her out of the vehicle, so she could walk to her destination. Dixon remained silent, looking forward, hands on the steering wheel. Petitioner testified that she was "terrified", and thought about jumping out of the truck, but did not want to hurt herself. She again asked Dixon to stop the truck so she could walk. She testified that he again remained silent and continued to drive without any acknowledgement of Petitioner at all. Petitioner's thoughts continued to race as to what had just happened, but she saw they were approaching her warehouse destination, so she remained quiet. When they got to the warehouse, she exited the truck.

The Petitioner was not sure of the distance between Mud Point and the warehouse, but estimated she was in Dixon's truck for 3 to 5 minutes, and they were going about 10 m.p.h. Petitioner testified that she was allowed to walk this distance, but it would take 10 to 15 minutes. She disagreed with Mr. Dixon's testimony that he took her to the ice or water house, another location at the job site closer to Mud Point. The Petitioner described the site and route from Mud Point to the warehouse and ice house on an aerial photograph marked as Px12.

At the warehouse, the fire extinguisher rep and "J.D." (James Daniel), another laborer, were present. Mr. Daniel could tell something was wrong with Petitioner. The Petitioner testified she said she didn't want to talk about it, so Daniel told Petitioner she needed to either shake it off or tell someone about it. She did not tell Daniel what happened. Petitioner was with the fire extinguisher rep for about 20 minutes, and then she and Daniel caught a ride to the ice house. At the ice house or adjacent Conex, she met Wanda Charles, another laborer, and told Charles what had happened with Mr. Dixon. Ms. Charles reported the situation on to the laborer's steward, Randy, and Petitioner's direct boss, Bobby Garduno, and then additional management came in. This included Garduno's boss Chris, and the Teamster's boss Glen Braggs. She testified that she was crying and shaking, and she wanted to be left alone in the Conex, where she stayed until the end of her shift.

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The Petitioner agreed that she had a working radio and phone with her in Dixon's truck on 10/16/14, but testified she didn't even think to use them because she just wanted to get out of the truck. She agreed that Mr. Dixon never made physical contact with her in the truck that day and never threatened her. She testified that she had no prior problems or issues with Dixon, and that she had no knowledge of any rift between her and the Teamster's drivers or of any problems they may have had with her prior to 10/16/14. She acknowledged that "you never knew what kind of mood" the Teamster drivers would be in on a given day, in terms of their responsiveness to calls for a ride, but had no understanding that it was directed towards her specifically. She agreed that Wanda Charles was a long time friend of hers.

The Petitioner continued to work her regular job through 4/10/15, when she was taken off work, but testified she did so "cautiously" and became "highly vigilant", and she was in counseling during this time. She would walk instead of getting rides if she could, and when she would get a ride from a Teamster, she would sit in the back where she wouldn't have to wear a seatbelt. She feared that the event would repeat itself with another driver. At times, she would be upset and would cry at work.

Petitioner testified that the incident also changed how she acted outside of work. She was active before the incident. Afterwards, she would not go anywhere or do anything. She would back her car into her driveway and leave her doors unlocked in case she needed to exit quickly. She kept knives around the house to protect herself. She is always fearful and agreed she has some paranoia. She does not enjoy life. She has crying spells which she did not have previously. The Petitioner described occasions where she had emotional issues because she had to relive the incident by having to describe what occurred. This includes a 3/18/15 grievance hearing where the Petitioner had to testify while Mr. Dixon was present and trying to get his job back.

The Petitioner agreed that she has had prior psychiatric treatment, including medication, due to her daughter's development of a drug problem. She agreed that she had psychiatric treatment with Dr. Rollins from November, 2012 to January, 2014 for anxiety and depression. She denied telling him at that time that she'd had prior panic or anxiety attacks, or feelings of impending doom, but did agree that she reported a history of methamphetamine usage long ago. Between January 2014 and October 2014, she was not in psychological treatment or taking any medications for any psychological conditions. She testified that her emotional symptoms following the incident with Mr. Dixon are totally different than what she experienced previously when her daughter had her problems. As of the 3/8/16 hearing date, the Petitioner continues to treat with a psychiatrist and a counselor. She remained off work and does not believe she can return to work at this time, though she hopes she can do so in the future.

On cross examination, the Petitioner agreed that, as indicated in her time sheets (Rx2), she was off work after the 3/18/15 grievance until returning on 3/23/15, and she continued to work until 4/10/15. Petitioner agreed she had a small 9/13/15 wedding at her home, but did not do much planning herself.

Mr. Dixon testified he was working as a Teamsters field driver at Respondent's facility on 10/16/14, involving transporting people and material from one point to another across the job site. He would get radio calls from his foreman or other personnel on the site in this regard, and the 4 or 5 Teamsters on site would essentially address the calls on a first come, first serve basis. He testified that on 10/16/14, he initially saw the Petitioner at Mud Point. He was driving his usual two-door pick up truck and had to make a delivery of some boxes to the personnel barge. He testified that the Petitioner asked him for a ride as he was putting on his life jacket. He told Petitioner "yes." She asked a second time near the back of the truck, and again he told Petitioner "yes." He told her he had to make a delivery and would be right back to take her where she needed to go. After making the deliveries, he was taking off his life jacket at the truck, and he asked Petitioner if she still needed a ride. She told

Mr. Dixon she had asked him for a ride twice and accused him of not answering her. He told her that he answered both times. (Rx4).

Mr. Dixon indicated that the Petitioner was going to the ice house, not the warehouse. After they got in the truck, Dixon testified that the Petitioner started in on him with an attitude about how she did not understand why it was always so much trouble to have a Teamster provide a ride. Dixon felt the Petitioner was berating him and his trade, and he questioned Petitioner as to why every time one of the Teamsters picked her up, they had to put up with her berating and poor attitude. Petitioner at that point said she did not have to put up with Mr. Dixon and asked if he would stop the truck. Dixon told Petitioner he did not think that was an appropriate thing to do as it would seem like he was not doing his job as a field driver. He said she continued to negatively talk about the Teamsters, and he just kept quiet at that point until they reached the ice house. (Rx4).

Mr. Dixon testified he traveled the speed limit in his truck, which was 15 mph, and the entire drive took a couple of minutes. He described his tone of voice to Petitioner as a normal talking voice; he never shouted or raised his voice. He denied making a hand gesture to her or leaning across the bench seat of the truck towards Petitioner. He did not physically threaten her. He admitted the two had a disagreement and maybe argued, but it did not include yelling or a loud tone. He agreed she asked to be let out of the truck, but he thought it was his job to take her to the destination she requested. When he dropped Petitioner off, Petitioner was not crying. He believed she might have been frustrated, but was not angry. (Rx4).

When he dropped the Petitioner off at the ice house, Wanda Charles was present and indicated she wanted a ride. The Petitioner said she wanted another ride also. Mr. Dixon testified he indicated he had another delivery to make and would return to pick them up. He noted John Daniel was also at the ice house, but was not standing right where they were. He made his delivery and returned back to the ice house. Ms. Charles entered his truck and scooted over to let Petitioner in, but Petitioner indicated she would catch another ride. He did say he saw the Petitioner later that day behind the warehouse, but that they did not interact. (Rx4).

Mr. Dixon testified that, prior to 10/16/14, he had encountered Petitioner on multiple occasions where she had conveyed a similar, poor attitude towards the Teamsters. At the end of the work day, he was terminated but later reinstated after filing a grievance and being off work for 8 months. When he returned, Petitioner was already gone from the job site. He agreed there was no rule against a laborer walking the route instead of getting a ride. (Rx4).

The Petitioner testified that she did not read Mr. Dixon's deposition prior to her testimony, and indicated she was not aware that Dixon denied putting his hand in her face on 10/16/14, or that he said he was talking to her in a normal conversational tone, not yelling. She denied that Dixon told her he was a field driver and that taking her where she wanted to go was part of his job. She also denied his testimony that he drove her to the ice house that day, not the warehouse. She denied any conversation took place in the truck that day wherein Dixon indicated she had a poor attitude and was disrespectful to the Teamster drivers.

Mr. Garduno, Respondent's general laborer's foreman, including over the Petitioner, had worked with her for a number of years before 10/16/14. On that date, Randy Whitis reported to him that the Petitioner was upset over an incident with a Teamster. He went to go talk to her at the Conex by the water shack. She was very upset, "almost like hysterical." Petitioner initially indicated she didn't want anyone to know what happened, but then told him that she had asked Mr. Dixon a couple times to be picked up but that he ignored her, "and so then he turned to her and he just kind of I think she said pointed in her face and started screaming and hollering at her." She asked him to stop the truck and let her out, but he would not do so. She was worried he might "try to do something" to her. Mr. Garduno related the situation to his boss, Chris Coburn, and they notified the Teamster's

boss Glen Bragg, and those two investigated the matter further. He agreed that Dixon's behavior in the truck was not appropriate. Before this event, Mr. Garduno never had any problem with Petitioner working for him. He had seen the Petitioner upset before, but not to that magnitude. On cross exam, Mr. Garduno was asked if Petitioner had reported any problems with Dixon or other Teamster's prior to 10/16/14, and he testified: "Yeah, that they kind of it seemed like they've ignored her calls, you know, and just kind of deliberately, you know, treated her differently for sure." He testified that he has had to discuss issues with management regarding Teamsters not picking up all laborers, not just Petitioner. He had heard before that people discussed that Teamsters wouldn't pick the Petitioner up, that they didn't care for her and "she was viewed probably a little bit of a pain in the neck sometimes." There was some sort of a rift that existed between Petitioner and other Teamsters, not just Dixon. He himself never discussed the incident with Dixon, and never heard his side of the story. After the incident, Petitioner returned to work, but she was no longer under Garduno's direct supervision. (Px2).

John Daniel (J.D.) testified he was a laborer for Respondent, and that he spent a lot of time working with Petitioner for about 2 years. On a few occasions, Petitioner cried on the job, with Daniel noting an episode that involved a former spouse bringing alcohol to their daughter as a housewarming gift, and another occasion when a diver committed suicide. As to the day when Daniel was working with a fire extinguisher representative, the Petitioner on that occasion was very upset, crying and shaking, but the she wouldn't tell Mr. Daniel the specifics beyond it involving a Teamster. He suggested that Petitioner should take an hour to try and get over it and, if not, she should tell someone about it. Mr. Daniel thought Petitioner's response and emotional state was genuine. Mr. Daniel testified that, prior to the Teamster incident, there were 4 or 5 times where the Petitioner would get "stirred up" at work, mainly because of her ex-husband, and he would try and calm her down. He did not see the Petitioner very much after 10/16/14. He testified that the Petitioner's job duties resulted in dependence on the Teamsters for rides. His understanding is that the Teamsters were very busy, and they thought the Petitioner was a needy person, but Daniel indicated she was just trying to do her job, and her job needed the Teamsters: "They would just say that she was a very needy person constantly needing them all the time, and she would say she was just trying to do her job." Daniel testified the Petitioner "was just what some people call a high-strung person", and always was trying to do as much as she could and to help others. (Px3).

The Petitioner denied telling Mr. Daniel at some point prior to 10/16/14 that her ex-husband had given alcohol to her daughter and cried when she did so, but did indicated that at times when she was emotional for some reason she may have told him a story to avoid telling him what was really going on with her "so he would just shut up", as he was likely to tell her to shake it off like he did on 10/16/14.

Randy Whitis testified that he is the laborer's union steward. On 10/16/14, he testified that Wanda came and got him, indicating a situation with the Petitioner, and that the Petitioner was very upset. The Petitioner told him that Brian Dixon would not let her out of the truck. The two of them had been bumping heads on and off for two weeks. Petitioner told him she asked for a ride and Mr. Dixon did not answer. She asked a second time and that is when the situation escalated, and she said that Dixon was screaming at her. She said she asked him three or four times to get out of the truck and he did not let her out, and brought her up to Conex Row where he let her out. Whitis had not seen her like that before, noting the Petitioner was always able to do her job. He also believed her emotional state that day was genuine. On cross examination, Mr. Whitis agreed that Petitioner worked the rest of the day but she stayed in the Conex. Thereafter, she continued to work her regular job duties as a laborer, on the marine side, until she stopped working. Prior to October 2014, Mr. Whitis believed a problem existed in terms of the Teamsters not being responsive to the calls of laborers for rides. Essentially, his testimony indicated that there was a certain amount of tension between the Teamsters, who had a lot of people to try to satisfy with their help, and the laborers, who had to call them for that help. It was tough for any laborer to get a ride, and the Teamsters apparently argued that there were not enough of them to go around. Mr. Whitis

testified that, the day before the incident with Mr. Dixon, it took Petitioner about 45 minutes to get a ride. He had heard at times Petitioner calling and calling for a ride and not being picked up. Another person would call for a ride and be picked up right away. It would have been hard to prove that the Teamsters were ignoring her or anyone else in particular. Mr. Whitis told Petitioner to deal with the situation the best she could. Laborers were allowed to walk from Mud Point to the ice house, so Dixon could have let Petitioner out when she asked. He noted that if he himself had to wait for a Teamster, he would sometimes start walking instead. (Px4).

Wanda Charles testified that she was also a laborer at Respondent's facility. She testified that she has known the Petitioner for over 40 years, that they went to grade school together, had worked on other jobs together, and that they were friends. On 10/16/14, Robert Garduno (aka "Pops") came to ask for her help because the Petitioner was upset and he didn't know what to do. She went to their location, the water department Conex, and found the Petitioner hysterically bawling and shaking. The Petitioner indicated she had called for a Teamster for a ride and didn't get a response, and when Dixon showed up she asked him for a ride, and he didn't answer her at first. After he dropped off his stuff, she again asked him for a ride, and he said "fine." She said she got in the truck and said she guessed she was a little hard of hearing because she didn't hear him answer the first time, and that he told her if she shut her mouth long enough, maybe she would hear somebody. She told him to stop the truck and he didn't, and took her up to the water department where she originally stated that she was going. She testified that she was not present when the Petitioner was dropped off at the ice house: "I was at safety. Pops (Garduno) came and got me." (Px5). Charles testified that she asked Petitioner: "So why are you crying?" Petitioner said she felt like she was being kidnapped and that Dixon was being crazy around her. Charles told her she would get Mr. Garduno and Mr. Whitis to talk to her. She thought Petitioner's emotional state was genuine. Petitioner and Ms. Charles had worked together with Respondent and on other jobs, and Petitioner was able to do her job. Ms. Charles had never seen Petitioner like this before. (Px5).

On cross examination, Charles testified that it was a prior date, not 10/16/14, when Dixon had dropped off Petitioner at the ice house and Ms. Charles was present and asked for a ride. She herself never had any prior problems with Mr. Dixon – he had always been courteous and professional. (Px5). Before 10/16/14, the Petitioner had told Ms. Charles, and she heard from other sources, that a "misunderstanding" existed between the warehouse Teamsters and Petitioner. If Petitioner asked for a ride and did not get a quick response, she would be back on the radio asking for another ride. She testified: "Theresa was different. When Theresa would call for a ride, if she didn't get a ride within five minutes she's hollering on the radio again, and she's hollering on the radio again, and she's hollering on the radio again." Charles added that a rift had developed between the warehouse Teamsters and Petitioner, and that it may have come to a head on 10/16/14. To her knowledge, the Petitioner was able to do her job after 10/16/14 as a laborer until she stopped coming into work. Ms. Charles thought Petitioner's crying and balling was of the type as if she had just found out her parents had died, and it seemed like an overreaction. (Px5).

On redirect, Charles testified that outside of work, not on the job, she had known the Petitioner to have a "thin skin" and problems that resulted in her bawling like she was on 10/16/14. She had always been able to deal with adversity at work, however. She was asked about whether she felt there was an overreaction to her feeling that she was being held in a vehicle by someone who wouldn't let her out. Charles testified that: "I've known Theresa for 45 years. I know how she acts just to certain things and knowing things that's happened in her life why she would think that. That's also why I stopped right there with her and said I was going to go get the steward and her boss, because, you know, this wasn't an issue I needed to deal with." (Px5).

The testimony of Michael Zink (Rx5) and Michael Clark (Rx6) was also admitted into evidence. Mr. Zink was a Teamster steward, but he was not one on 10/16/14 – he worked in the warehouse at that time. His only encounter with Petitioner on 10/16/14 was when he saw her behind the warehouse later in the afternoon. His

recall is she was working on fire extinguishers, but "she didn't seem like anything was off at that time." He noted that some of the Teamsters had "gripes" about things the Petitioner was doing. He did not have any issues with Petitioner himself. Mr. Clark testified that he was a Teamster steward at the Respondent's site on 10/16/14, and he worked out of the warehouse. Mr. Dixon reported an incident with Petitioner on that date around lunchtime. He noted other Teamsters had previously complained about the Petitioner's attitude and how she would treat people rudely, giving a ballpark estimate of 12 such complaints. He didn't do anything about them, essentially testifying that it was his opinion that, on a construction site, reporting someone being rude would be a "waste of breath." (Rx5 & 6).

Dr. Qureshi, a board certified psychiatrist, testified that on 4/10/15, Petitioner returned for treatment with Dr. Qureshi's physician's assistant following a treatment gap of about a year. (Px1). She reported having a bad experience at work with a male employee. She reported symptoms of anxiety, trouble sleeping, hyper-vigilance, and paranoia since the incident. She was fearful that this employee and others were out to get her because she is a woman. She did not feel safe. She was having crying spells. Dr. Qureshi diagnosed Petitioner with major depressive disorder; anxiety disorder; attention deficit hyperactivity disorder; and post-traumatic stress disorder (PTSD).

Petitioner had previously treated with Dr. Qureshi beginning in November 2012, and her diagnoses were anxiety and depressive disorder but not PTSD. She had several follow up visits through January 2014 for ongoing complaints. There was no documented treatment for mental health issues from the January 2014 visit until the April 10, 2015 office visit.

Petitioner followed up with Dr. Qureshi further in 2015 and continued to treat with him as of his 10/23/15 deposition. Dr. Qureshi has kept the Petitioner off work since 4/10/15. He opined that the event that Petitioner described, being threatened by a co-worker, could cause her to develop PTSD. The symptoms she has described are consistent with a PTSD diagnosis. Even though Petitioner had a prior diagnosis of anxiety and depression, she was able to work. So, in Dr. Qureshi's opinion, it is the PTSD diagnosis that is causing her the inability to work. He has treated this condition with medications and Petitioner is also in counseling.

Dr. Qureshi opined that Petitioner's PTSD condition was related to the work incident where the co-worker "threatened her life" or she felt threatened. Dr. Qureshi did not think his opinions would change if Petitioner did not seek treatment immediately after the incident, but then first sought treatment for PTSD after reliving the incident due to participating in a hearing in March 2015.

On cross examination, Dr. Qureshi confirmed that the November 2, 2012 historical note in Petitioner's chart related a long history of anxiety and depression. She had a difficult prior marriage and some difficulties with her mother and father growing up. She had a past history of drug use. She was diagnosed with anxiety and depression and started on a medication regimen for those conditions. At the office visit on January 30, 2014, she was still actively treating for anxiety and depression, and the plan was for ongoing treatment. However, she was lost to follow up. Dr. Qureshi agreed he is relying on Petitioner's subjective history to him in forming a diagnosis of PTSD.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner failed to prove that she sustained an accidental injury which arose out of her employment on 10/16/14.

The Petitioner here is attempting to prove up a "mental-mental" claim based on the 10/16/14 incident with Brian Dixon, as there was no physical injury or contact involved. Single incident mental-mental injuries are governed by *Pathfinder Co. v. Industrial Comm.* 62 Ill.2d 556, 343 N.E. 2d 913 (Ill. 1976) and its progeny. In *Pathfinder*, the employee witnessed the severing of a fellow employees' hand while operating a punch press. The employee fainted and was hospitalized. After returning to work, she began suffering headaches and anxiety. The employee's doctor opined that she was suffering residual anxiety from the great mental shock she received from witnessing the hand severing. The court found the case compensable because the employee suffered a sudden, severe emotional shock traceable to a definite time and place which caused psychological harm.

The Petitioner specifically cites *Chicago Transit Authority v. Illinois Workers' Compensation Comm'n*, 989 N.E.2d 608, 371 Ill. Dec. 18 (2013), arguing that it provides that, under *Pathfinder*, the emotional shock needs to be 'sudden,' not the ensuing psychological injury, and thus that a claim may be compensable even if the resulting psychological injury did not manifest itself until sometime after the shock. In *Chicago Transit Authority*, the employee was a bus driver whose bus ran over a pedestrian. The employee did not see the person being hit but did see the person laying on the ground in the fetal position and moving before being taken away by ambulance. The employee was later notified that the pedestrian had died. The employee sought psychological treatment approximately two months after the incident. The court found that there must objective evidence supporting inferences of psychological injury, causation and disability. However, an employee is not required to prove that psychological injury from the emotional shock is immediately apparent. The court found that hitting a person who ultimately dies from their injuries is objectively reasonable and traceable to a definite, sudden event and a delay of two months for treatment was not dispositive.

In *General Motors Parts Division v. Industrial Comm'n*, 168 Ill.App.3d 678, 522 N.E.2d 1260 (1st Dist. 1988), the Appellate court found the petitioner's claim for depression was not compensable after he was subjected to verbal abuse by his supervisor. The petitioner confronted his supervisor about a shift change request being denied and initiated an argument with the supervisor. Following the confrontation, the petitioner felt "real bad" and "less than a man" and began drinking. In the following weeks and months, the petitioner was ridiculed by coworkers and this increased the amount of his drinking. Petitioner was subsequently diagnosed with depression and was unable to perform his prior job duties. The Court stated: "We conclude that the supreme court's decision in *Pathfinder* is limited to the narrow group of cases in which in which an employee suffers a sudden, severe emotional shock which results in immediately apparent psychic injury and is precipitated by an uncommon event of significantly greater proportion or dimension than that to which the employee would otherwise be subjected in the normal course of employment." The court held that anxiety, emotional stress or depression which develops over time in the normal course of an employment relationship does not constitute a compensable injury within the holding of *Pathfinder*. Compensation for non-traumatic psychic injury cannot be dependent solely upon the peculiar vicissitudes of the individual employee as he relates to his general work environment. The court held that the petitioner failed to establish the verbal abuse he suffered, albeit unpleasant, was anything other than an ordinary incident of employment which is not uncommon to and might well be encountered in a great many occupations. The court found that the claimant's evidence supported a finding his breakdown was caused by a gradual deterioration of his mental processes brought on by a variety of factors, not a single, work-related event or stimulus.

In *Diaz v. IWCC*, 370 Ill. Dec. 845, 989 N.E.2d 233 (2013), the petitioner, a police officer, filed a claim for post-traumatic stress disorder after a standoff with a citizen holding what appeared to be a handgun but was later

determined to be a BB gun. The claimant testified that he did not immediately experience anxiety after the incident, but, during the next few days, he began to have more nervousness and anxiety when he was responding to calls. He eventually told the deputy chief supervisor that he did not think he could perform the job of a police officer due to his anxiety he was experiencing. The petitioner was diagnosed with PTSD. The court held: "whether a worker has suffered the type of emotional shock sufficient to warrant recovery should be determined by an objective, reasonable person standard, rather than a subjective standard that takes into account the claimant's occupation and training." Here, the police officer was allowed to potentially recover for his PTSD because he was exposed to a citizen pointing what appeared to be a gun in his direction.

The Arbitrator here finds that the Petitioner failed to prove that the incident in this case. First of all, the Arbitrator notes that there are different versions of the facts surrounding the events of 10/16/14. This includes what was said between Petitioner and Dixon, the location Dixon brought the Petitioner to, and what the situation was between the Petitioner and the Teamsters prior to the incident at issue. It appears to the Arbitrator that there was a natural tension between laborers and Teamsters because of the laborers reliance on the Teamsters for rides when they felt they were busy, and it appears that there may have been somewhat greater tension with the Petitioner specifically, as she has been described as being more needy than other laborers, or more forceful in pushing to get a ride. This does not seem to the Arbitrator to be a situation that is beyond the day to day tensions that occur in many jobs between co-workers. What appears to be unusual was the Petitioner's reaction to it on 10/16/14.

Even taking all of the evidence most favorably towards the Petitioner, the Arbitrator does not believe that Mr. Dixon's conduct rose to the level of a sudden, severe, emotional incident as contemplated by *Pathfinder* and its progeny. Here, at worst, Dixon initially ignored the Petitioner, then snapped at her in the truck and put his hand very close to her face in a quacking-type motion. The Petitioner also has indicated that she felt trapped and in danger in the truck when Dixon declined to stop until the route was completed. The Arbitrator believes that while the conduct of Dixon may have been inappropriate, it simply does not rise to the level of a sudden, severe emotional shock. At no time did Mr. Dixon strike or threaten to strike the Petitioner. The trip from Mud Point to either the warehouse or the ice house was quite short, no more than a couple of minutes. The Petitioner had a phone and radio with her. The idea that she felt kidnapped, in the Arbitrator's opinion, would have been a significant overreaction to the situation. As noted in *Diaz*, whether the emotional shock warrants recovery is to be based on an objective, reasonable person standard. Here, it seems to the Arbitrator that this type of situation is not at all uncommon in the workplace when there may be tension between workers. Ms. Charles' statement to Petitioner when she learned what occurred with her and Mr. Dixon was apropos: why are you crying? Her statement acknowledges the inference that the incident was not one that would normally have been expected to cause such an emotional reaction. Instead, it appears to the Arbitrator that the Petitioner took what would have been a somewhat stressful confrontation with a co-worker and turned it into something much bigger than it was.

As the Arbitrator finds the Petitioner failed to prove accident, benefits are denied.

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

Based on the Arbitrator's finding that the Petitioner failed to prove accident, this issue is moot.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's finding that the Petitioner failed to prove accident, this issue is moot.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's finding that the Petitioner failed to prove accident, this issue is moot.

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

Based on the Arbitrator's finding that the Petitioner failed to prove accident, this issue is moot.

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RAMONA SERNA,

Petitioner,

vs. NO: 11 WC 40885

FED EX GROUND,

17IWCC0828

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, temporary disability, medical, and prospective medical, and being advised of the facts and law, modifies the Amended Decision of the Arbitrator as stated below and otherwise affirms and adopts the Amended 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, 35 Ill.Dec. 794 (1980).

"Every natural consequence that flows from an injury that arose out of and in the course of one's employment is compensable under the Act absent the occurrence of an independent intervening accident that breaks the chain of causation between the work-related injury and an ensuing disability or injury." *National Freight Industries v. Illinois Workers' Compensation Commission*, 2013 IL App (5th) 120043WC, ¶26, 993 N.E.2d 473. Where the work injury itself causes a subsequent injury the chain of causation has not been broken: "In this context, the cases have applied a 'but for' test, basing compensability for an ultimate injury or disability upon a finding that it was caused by an Event which would not have occurred had it not been for the original injury…Clear illustrations of this chain of causation relationship are cases where a second injury occurs due to treatment for the first (Citations)…." *International Harvester v. Industrial*

Commission, 46 Ill. 2d 238, 245, 263 N.E.2d 49 (1970). The Commission affirms the finding that Petitioner's left knee condition of ill-being is a treatment-related sequela of her October 5, 2011 shoulder injury. However, the Commission views the temporary disability evidence differently.

The Commission first emphasizes the functional capacity evaluation conducted on January 31, 2013 was a "whole body assessment." This FCE was a valid representation of Petitioner's capabilities and evidenced Petitioner can work at the Light demand level. Significantly, Petitioner demonstrated a workday sitting tolerance of eight hours. PX8.

When Petitioner saw Dr. Giannoulias on March 11, 2013, her knee complaints were described as "standing aggravates her." PX9. Despite the objective FCE evidence demonstrating Petitioner's sitting capabilities, Dr. Giannoulias did not release Petitioner to seated work but rather authorized Petitioner off work. PX9. The Commission is troubled by Dr. Giannoulias' failure to attempt a sedentary or seated-work restriction prior to taking the precipitous step of fully restricting Petitioner from all work.

The Commission emphasizes the record establishes Respondent has an extensive accommodated duty program. For instance, significant restrictions were imposed on October 11, 2011 (no lifting, pushing, or pulling over 10 pounds; no reaching above shoulder with left arm; and limited use of left arm), yet Respondent was able to provide an accommodated position. PX2; T. 12-13. This is certainly consistent with Respondent's Counsel's description of Respondent's comprehensive accommodated duty program at oral arguments. Based on the evidence establishing Respondent's ability to accommodate severe and stringent restrictions, the Commission infers an accommodated position would have been provided.

The Commission finds the FCE is the most credible evidence of Petitioner's work capabilities, and the FCE established Petitioner remained able to work. PX8. The Commission further notes Dr. Kornblatt's June 19, 2013 report is consistent with the FCE: while Petitioner was "not capable of carrying out her normal job activities as a package handler," there is no indication the doctor concluded Petitioner was unable to perform any work. RX4.

In light of the valid FCE from six weeks prior which established Petitioner remained capable of Light work and had an eight-hour workday sitting tolerance, the Commission finds Dr. Giannoulias' conclusion Petitioner was totally incapable of any work is contrary to the objective evidence and not persuasive. Therefore, the Commission finds Petitioner entitled to temporary total disability benefits from November 14, 2011 through June 19, 2013, the date of Dr. Kornblatt's Section 12 examination. The award of temporary total disability from June 20, 2013 through July 13, 2016 is hereby vacated.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $301.62 per week for a period of 83 3/7 weeks, representing November 14, 2011 through June 19, 2013, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further

17IWCC0828

hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall provide and pay for arthroscopic examination and repair of Petitioner's left knee as recommended by Dr. Giannoulias, pursuant to §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $19,990.65 for medical expenses, as provided in §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of 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 $23,600.00. 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: DEC 22 2017

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

LEC/mck

O: 11/1/17

43

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

SERNA, RAMONA
Employee/Petitioner

Case# **11WC040885**

FED EX GROUND
Employer/Respondent

17IWCC0828

On 11/29/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0274 HORWITZ HORWITZ & ASSOC
TYLER BERBERICH
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

1401 SCOPELITIS GARVIN LIGHT
ROBERT RUBIN
30 W ONROE ST SUITE 600
CHICAGO, IL 60603

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
AMENDED
ARBITRATION DECISION
19(b)

Ramona Serna
Employee/Petitioner

v.

Fed Ex
Employer/Respondent

Case # 11 WC 40885

Consolidated cases:

17IWCC0828

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica A. Hegarty**, Arbitrator of the Commission, in the city of **Geneva**, on **July 13, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **10/5/11**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$23,526.36**; the average weekly wage was **$452.43**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$21,748.89** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of **$21,748.89**.

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

ORDER

1. Respondent shall pay reasonable and necessary medical services of $19,990.65, as provided in Sections 8(a) and 8.2 of the Act.

2. Respondent shall approve and pay for arthroscopic examination and repair of the Petitioner's left knee, as recommended by Dr. Giannoulias, pursuant to Section 8(a) of the Act.

3. Respondent shall pay Petitioner temporary total disability (TTD) benefits of $301.62/week for 243 2/7 weeks, commencing November 14, 2011 through July 13, 2016 as provided in Section 8(b) of the Act. Respondent shall receive a credit for TTD benefits already paid in the amount of $21,748.89 (72-4/7 weeks).

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.

Jason C. Hyatt

Signature of Arbitrator

11/29/16
Date

ICArbDec19(b)

NOV 29 2016

BEFORE THE WORKERS' COMPENSATION COMMISSION

RAMONA SERNA,	)	
	)	
Petitioner,	)	
	)	
v.	)	11 WC 40885
	)	
FED EX GROUND	)	
	)	17IWCC0828
Respondent	)	

ADDENDUM TO ARBITRATION DECISION

STATEMENT OF FACTS

On October 5, 2011, the Petitioner, Ramona Serna, was employed by the Respondent, Fed Ex Ground, as a package handler. In that roll, the Petitioner was tasked with unloading trailers and moving all sizes of packages. The Petitioner testified that the packages could weigh anywhere from 5 to 100 pounds. While performing this work, the Petitioner was required to be on her feet 7 to 8 hours per day, constantly bending and kneeling to pick up or move packages.

Petitioner testified that on October 5, 2011, she was unloading a truck which had pulled up to the loading area. She explained that there was space between the floor and the trailer of the truck that she was working on. While the Petitioner was unloading the truck, her left foot got stuck in the space between the trailer and the floor, causing her to twist her left knee and fall backward onto her left side.

Following the accident, the Petitioner continued working and noticed that her left knee had started to swell, making it more difficult to walk, and that her left arm was painful and unable to move normally.

On October 11, 2011, the Petitioner was seen at Concentra Medical Centers where it was noted that she had sustained an accident on October 5, 2011 when her foot got stuck while taking boxes off a trailer, leading her to fall backward and catch herself with her left arm. The record further reflects that the Petitioner felt pain in the left shoulder which had gradually worsened along with worsening range of motion, secondary to pain. Physical therapy was recommended for the Petitioner's left shoulder. She was placed on light duty restrictions of no lifting over 10 pounds, no pushing or pulling over 10 pounds and no reaching above the shoulders. (PX 1). The Petitioner did return to work within these restrictions with the Respondent.

On October 13, 2011, the Petitioner was seen by Dr. Christos Giannoulias at G and T Orthopedics and Sports Medicine. Dr. Giannoulias reviewed the Petitioner's history of falling in a crack between a truck and a dock, landing on her left arm, with continued pain since that time. Dr. Giannoulias recommended that the Petitioner undergo left shoulder MRI and returned her to work with a restriction of no use of the left arm. (PX 9).

On October 21, 2011, the Petitioner underwent an MRI of the left shoulder at Swedish Covenant Hospital, which revealed high-grade partial tearing of the supraspinatus tendon, with only a few tendon fibers remaining along the articular surface of the tendon. The MRI also revealed subdeltoid and subacromial bursitis. (PX 3).

On October 31, 2011, the Petitioner followed up with Dr. Giannoulias, who reviewed the MRI and diagnosed a complete full thickness tear of the supraspinatus tendon. He recommended surgical repair of the tendon. (PX 9).

On November 14, 2011, Dr. Giannoulias took the Petitioner off work in anticipation of a November 16, 2011 left shoulder surgery. (PX 9).

On November 16, 2011, the Petitioner underwent left shoulder arthroscopic rotator cuff repair and subacromial decompression, performed by Dr. Giannoulias. The post-operative diagnoses were left rotator cuff tear and left shoulder subacromial impingement. (PX 4).

The Petitioner continued following up with Dr. Giannoulias post-surgically in November and December of 2011. Dr. Giannoulias kept the Petitioner on an off-work status and recommended a course of physical therapy, which was performed at ATI Physical Therapy. (PX 9, PX 7).

On January 30, 2012, Dr. Giannoulias noted that the Petitioner had been making some progress with therapy and was out of her arm sling. However, the Petitioner sill had limited range of motion and further therapy was recommended. (PX 9).

On February 27, 2012, Dr. Giannoulas again saw the Petitioner and noted continued difficulty for her with overhead activity. Dr. Giannoulias placed her on an off-work status and recommended continued therapy. (PX 9).

The Petitioner continued a course of physical therapy at ATI Physical Therapy through March 22, 2012. At that time, the therapists recommended that the Petitioner transition into a course of work hardening treatment. (PX 7).

On April 8, 2012, Dr. Giannoulias recommended that the Petitioner undergo another short course of physical therapy to improve her range of motion in the left shoulder, then begin work hardening. (PX 9).

After another course of therapy, the Petitioner was seen again by Dr. Giannoulias on May 7, 2012, who noted that she was 50%-60% improved after surgery, but had continued pain with overhead activity. Dr. Giannoulias administered a subacromial injection to help some of the Petitioner's left shoulder inflammation and recommended that she begin a work conditioning program. He further recommended an updated MRI to make sure that the Petitioner's rotator cuff had healed. (PX 9).

On May 21, 2012, the Petitioner began a work conditioning program at ATI Physical Therapy. A review of these work conditioning records reveal that while performing lifts from the floor, the Petitioner began complaining of bilateral knee pain, which the therapists thought was caused by poor body mechanics as well as general lower extremity deconditioning. The records further reflect continued pain and weakness in the left shoulder. (PX 7). At hearing, the Petitioner testified that her knee had started to hurt in therapy when lifting heavy objects, using the treadmill, or performing certain leg lifts. She began to notice swelling and pain in her left knee. She explained that she could not lean over and lift something heavy due to pain in her left knee.

The Petitioner continued work conditioning into June of 2012. The work conditioning summary for June 4, 2012 through June 10, 2012 shows complaints of clicking in the Petitioner's left knee with repeated lifting, in addition to continued issues with pain, weakness and limited range of motion in the left shoulder. (PX 7).

On June 11, 2012, the Petitioner was seen by Dr. Giannoulias, who administered an AC joint injection and recommended that the Petitioner undergo another left shoulder MRI. The Petitioner was kept off work. (PX 9).

The Petitioner continued work conditioning at ATI through June of 2012 and underwent a MRI of her left shoulder on June 23, 2012. (PX 7, PX 3). Following the left shoulder MRI, the Petitioner followed up with Dr. Giannoulias on July 9, 2012. Dr. Giannoulias reviewed the updated MRI and spoke with the Petitioner about the results which showed marked edema of her AC joint. The Petitioner continued to experience pain and limited range of motion in the left shoulder. Dr. Giannoulias recommended that the Petitioner stop work conditioning and undergo an AC joint resection surgery due to the failure of conservative care on her shoulder. (PX 9).

On August 14, 2012, the Petitioner underwent a left shoulder arthroscopic subacromial decompression and distal clavicle excision, performed by Dr. Giannoulias. (PX 5).

On August 20, 2012, the Petitioner followed up with Dr. Giannoulias. At that time, the Petitioner complained of continued pain in the left shoulder in addition to anterior left knee pain. Dr. Giannoulias noted that the Petitioner had some patellofemoral crepitation in the left knee. The Petitioner was prescribed Mobic and kept off work. (PX 9).

On September 17, 2012, Dr. Giannoulias recommended that the Petitioner begin a course of physical therapy, which was performed at ATI Physical Therapy.

On November 19, 2012, the Petitioner was again seen by Dr. Giannoulias, who found that she had plateaued with therapy and continued to have decreased range of motion in the shoulder. He recommended left shoulder x-rays. (PX 9).

Following the administration of left shoulder x-rays, the Petitioner followed up with Dr. Giannoulias on December 17, 2012. At that time, Dr. Giannoulias found that the Petitioner continued to have decreased range of motion and pain in the left shoulder, which had improved some with therapy but was still present. He recommended a work conditioning program to establish what the Petitioner could or could not do at work. (PX 9).

The Petitioner began a work conditioning program at ATI Physical Therapy on December 24, 2012. In addition to continued issues with the left shoulder, the work conditioning records again show that he Petitioner had increased left knee pain during certain lifts, or with use of the stationary bike and treadmill. (PX 7).

On January 8, 2013, the Petitioner underwent a left knee MRI at the referral of Dr. Striedinger, her primary care physician. (PX 6, PX 16).

On January 17, 2013, Dr. Giannoulias reviewed the Petitioner's left knee MRI and diagnosed the Petitioner with left knee chondromalacia and meniscus tear, in addition to her left shoulder rotator cuff tear. Dr. Giannoulias administered an injection of Depo-Medrol and Lidocaine into the Petitioner's left knee. Due to the continued issues with her left shoulder, Dr. Giannoulias

recommended that the Petitioner finish work conditioning and undergo a functional capacity evaluation (FCE). (PX 9).

The Petitioner finished a course of work conditioning at ATI through January 27, 2013. On January 31, 2013, the Petitioner underwent a FCE at ATI, which indicated that she was able to lift 10.4 pounds above shoulder height, 2.8 pounds from desk to chair, and 30.2 pounds from chair to floor. In addition, the Petitioner could lift 21.8 pounds above shoulder height with the right arm, but only 5.6 pounds above shoulder height with the left arm. It was noted that these abilities fall below the light to medium level when lifting above shoulder level. The Petitioner was not able to meet the medium physical demand level required of a warehouse worker. (PX 7).

On February 25, 2013, the Petitioner was placed on permanent light duty restrictions by Dr. Giannoulias with regard to her left shoulder. The Petitioner is limited to lifting and carrying 15 pounds, no squatting, no climbing, overhead work limited to 10 pounds for 1 to 3 hours, and sitting, standing, walking, driving, bending and push/pull limited to 5-8 hours. (PX 9).

On March 3, 2013, the Petitioner was seen again by Dr. Giannoulias for the pain in her left knee. From March 4, 2013 through March 11, 2013, Dr. Giannoulias administered 3 Hyalgan injections into the Petitioner's left knee. On March 11, 2013, Dr. Giannoulias placed the Petitioner back off work, stating "I do not think she is going to be able to return to her occupation given the fact that she has both knee and shoulder problems and that the type of work that she does is repetitive by definition." (PX 9).

On March 25, 2013, the Petitioner was again seen by Dr. Giannoulias who noted the Petitioner's continued left knee pain after injections. Due to the failure of conservative treatment, he recommended the Petitioner undergo an arthroscopic evaluation of the medial meniscus and chondromalacia. He continued to keep the Petitioner off work.

On June 9, 2013, the Petitioner was seen for a Section 12 examination by Dr. Ira Kornblatt at the request of the Respondent. Dr. Kornblatt diagnosed the Petitioner with pre-existing chondromalacia patella with symptomatic exacerbation. Due to the lengthy period of time between the Petitioner's work accident and the complaints of left knee pain, Dr. Kornblatt opined that there was no causation between her work accident and her knee complaints. He also felt there was no evidence of an injury to her knee during work conditioning. He felt all symptoms and diagnoses were from a preexisting problem. Based upon the Petitioner's ongoing symptoms despite conservative treatment, Dr. Kornblatt believed arthroscopic surgery, as had been recommended, was appropriate. He further believed the Petitioner could return to her previous employment as a package handler. (RX 4).

After seeing Dr. Giannoulias in early 2015, the Petitioner followed up for treatment with her primary care physician, Dr. Striedenger. The records reflect that she was seen on December 21, 2013, July 5, 2014, March 21, 2015, June 20, 2015, October 9, 2015 and December 14, 2015 by Dr. Striedenger with complaints of knee pain, among other ailments.

At trial, the Petitioner testified that she stopped regular follow-ups with Dr. Giannoulias after March 25, 2013 due to lack of approval for treatment by the workers' compensation insurance carrier. However, on March 10, 2014, Dr. Giannoulias did draft a narrative report detailing his opinions regarding the Petitioner's left shoulder and left knee conditions. Dr. Giannoulias diagnosed the Petitioner with left shoulder rotator cuff tear, AC joint arthrosis and adhesive capsulitis, in addition to left knee patellar chondromalacia and a medial meniscus tear.

Dr. Giannoulias opined that the condition of ill-being in her left arm is directly related to her October 5, 2011 work accident. In addition, he opined that the current condition of Mrs. Serna's left knee was more likely than not causally related to her work conditioning activities, which were performed for her left shoulder. Dr. Giannoulias recommended an arthroscopy to evaluate the medial meniscus and the patellar chondromalacia. He felt that he need for this treatment was causally related to the October 5, 2011 accident in that the knee pain was certainly aggravated in work conditioning. (PX 10).

On March 30, 2015, the Petitioner presented to Dr. Giannoulias who noted her report of difficulty going up and down stairs and left knee weight bearing. Dr. Giannoulias again discussed with the Petitioner that the only option he could offer was knee arthroscopy and recommended that the surgery be scheduled. (PX 9).

On November 18, 2015, the Petitioner was seen for another Section 12 examination by Dr. Kornblatt. Dr. Kornblatt diagnosed the Petitioner with preexisting chondromalacia patella. He again stated that there was no evidence of any knee injury during work conditioning and he did not feel that the condition of her knee or any of the treatment for her knee was causally related to her work accident or the therapy she received after that accident. However, Dr. Kornblatt did opined that it would be appropriate for the Petitioner to undergo further treatment for the left knee, including injections and a possible arthroscopic surgery of the left knee. Due to her pain behaviors, Dr. Kornblatt stated that he was unable to opine whether the Petitioner was capable of a full duty return to work. (RX 8).

The Petitioner was again seen by Dr. Giannoulias on January 11, 2016. At that time, the Petitioner was experiencing continued left shoulder and left knee pain and had developed some back pain secondary to her limp. Dr. Giannoulias reviewed the report from Dr. Kornblatt and agreed that arthroscopy was needed on the left knee. However, he disagreed with Dr. Kornblatt's causation opinion. Dr. Giannoulias opined that while the Petitioner did have preexisting chondromalacia in the left knee, her work injury aggravated the condition and the Petitioner's symptoms had persisted to the point where she had significant atrophy. (PX 9).

On March 15, 2016, Dr. Giannoulias drafted another narrative report. After reviewing his course of care with Mrs. Serna, Dr. Giannoulias noted that there was no evidence of knee issues prior to the Petitioner's work accident. Dr. Giannoulias was of the opinion that the condition of ill-being in her left knee is causally related to her October 2011 work accident. Dr. Giannoulias also authored an addendum to this report on April 4, 2016, which states, "Regarding Mrs. Serna's knee, there was an aggravation to her chondromalacia during her work condition (sic) that she was doing for her shoulder surgery. There are multiple notes in PT that discuss her knee pain with exercises." (PX 11).

At arbitration, the Petitioner testified that she had never sustained any injury to her left knee or left shoulder prior to October 5, 2011. She further testified that she had sustained no new injuries to her left shoulder since October 5, 2011 and no new injuries to her left knee since she began to experience issues in work conditioning.

The Petitioner wishes to undergo the surgical procedure for her left knee that has been recommended by Dr. Giannoulias.

As she goes about her day to day activities, the Petitioner testified that she cannot perform her normal activities due to both her knee and her shoulder issues. She has pain and inflammation in the left knee when she bends the knee to go upstairs or if she stands or walks for a long period

of time. She also notices pain and swelling in her left shoulder with almost any activity. She takes Ibuprofen and uses Volatren cream.

The Petitioner continues to live within the restrictions placed on her by Dr. Giannoulias.

Deposition Testimony of Dr. Christos Giannoulias

Dr. Giannoulias testified via evidence deposition on June 16, 2014. Dr. Giannoulias is a board certified orthopedic surgeon who began treating the Petitioner in October of 2011. (PX 12 @ 5-6). When the Petitioner first began treating with Dr. Giannoulias, she had complaints of left shoulder pain from her October 13, 2011 accident. (PX 12 @ 7). The Petitioner underwent a left shoulder rotator cuff repair surgery and, after that surgery, she developed some adhesive capsulitis which he tried to treat with injections, but eventually had to perform a second surgery to resect her AC joint and collar bone joint. Due to continued complaints after both surgeries, she underwent an FCE. (PX 12 @ 7-8).

Between the two surgeries, Dr. Giannoulias testified that the Petitioner underwent physical therapy and work conditioning. (PX 12 @ 9). While in physical therapy and work conditioning, Dr. Giannoulias would review the records from her therapy providers. (PX 12 @ 9). Dr. Giannoulias reviewed records from ATI Physical Therapy in May and June of 2012 which showed increased left knee pain while performing therapy activities. (PX 12 @ 10-12). The Petitioner began complaining knee pain to Dr. Giannoulias in August of 2012. (PX 12 @ 10).

Dr. Giannoulias sent the Petitioner for a MRI of the left knee, which he testified showed some patellar chondromalacia and the possibility of a meniscal tear. Dr. Giannoulias initially wanted to pursue conservative treatment, beginning with a cortisone injection. (PX 12 @ 13). His diagnosis of a possible meniscal tear was based upon the signal in the meniscus from the MRI, in addition to the Petitioner's medial joint line pain and positive McMurray's test, which are signs of a possible meniscal tear. (PX 12 @ 13-14). He explained that those positive findings are not consistent with chondromalacia alone, but are more likely signs of a meniscus problem. (PX 12 @ 14).

The Petitioner did undergo the cortisone injection and a series of Hyalgan injections, performed by Dr. Giannoulias, but did not have a resolution of her knee symptoms. (PX 12 @ 15). Therefore, Dr. Giannoulias recommended an arthroscopic surgery to evaluate the medial meniscus. (PX 12 @ 15).

Following the Petitioner's January 31, 2013 FCE, Dr. Giannoulias placed permanent restrictions on the Petitioner of 10 pounds lifting over shoulder height, 25 pounds lifting from desk to chair, and 30 pounds lifting from chair to floor, which is the light to medium level of work. (PX 12 @ 18).

Dr. Giannoulias opined that the rotator cuff tear and subsequent treatment for the Petitioner's left arm was causally related to her work accident. (PX 12 @ 20).

Dr. Giannoulias further opined that the Petitioner's work accident or the activities that she was performing in work conditioning caused an aggravation of the preexisting chondromalacia in her left knee and caused a tear her medial meniscus. (PX 12 @ 20-21).

Dr. Giannoulias further explained that the Petitioner did not have any significant chondromalacia of the medial compartment. The chondromalacia she has is in the patellar area. As the majority of her pain was in the medial compartment, and based upon the MRI and his physical examination findings, he felt that the Petitioner's condition was more meniscus related. Further, Dr. Giannoulias explained that someone of her age, without any significant arthritis or chondromalacia, should not have a degenerative meniscus problem. Therefore, he felt that the meniscus injury was traumatic in nature. (PX 12 @ 22).

Dr. Giannoulias disagreed with Dr. Kornblatt's opinion that the Petitioner's symptoms were solely caused by the chondromalacia in her left patella based upon multiple physical examinations showing medial joint line pain and a positive McMurray's test which indicate more of a meniscus problem. (PX 12 @ 23).

On cross-examination, Dr. Giannoulias testified that he had never noticed any exaggerated pain behavior from the Petitioner. (PX 12 @ 25).

Dr. Giannoulias agreed that the report from the January 8, 2013 MRI did not itself indicate a specific finding of a meniscus tear, but it did discuss intersubstance changes. (PX 12 @ 27).

Dr. Giannoulias agreed that the Petitioner's fall did not cause the knee condition for which he is now recommending surgery. (PX 12 @ 31).

Dr. Giannoulias agreed that activities of daily life could cause a preexisting chondromalacia to exacerbate or get aggravated. (PX 12 @ 30).

Dr. Giannoulias specifically explained that in the Petitioner's case, absent any prior problems or injuries to the knee, with symptoms starting after working conditioning, more likely than not the work conditioning was the reason her knee pain started, not something else. (PX 12 @ 31-32).

Regarding the adhesive capsulitis in the Petitioner's left shoulder, Dr. Giannoulias explained that some people simply form scar tissue that can lead to it. Since the Petitioner was pretty consistent with her therapy for the shoulder, he did not feel the adhesive capsulitis formed due to lack of effort, but rather the Petitioner just got stiff. (PX 12 @ 35).

Based upon the whole picture with the Petitioner's left shoulder, it was Dr. Giannoulias' opinion that the Petitioner could not return to her previous job. (PX 12 @ 36).

On re-direct examination, Dr. Giannoulias again explained that his diagnosis for the Petitioner's left knee was based on the signal change on the MRI in addition to his findings on physical examination. (PX 12 @ 37-38).

Dr. Giannoulias also explained that the surgery he recommends for the Petitioner's knee is an arthroscopy and partial medial menisectomy to debride or resect the portion of the meniscus that is torn. (PX 12 @ 38).

Deposition Testimony of Dr. Ira Kornblatt

Dr. Kornblatt testified via evidence deposition on October 22, 2014.

Dr. Kornblatt is a board certified orthopedic surgeon who performed a Section 12 examination on the Petitioner at the request of the Respondent on June 19, 2013. (RX 7 @ 9). He testified that he performs 5 Section 12 examinations per week, which equates to around 20 per month, virtually all of which are on behalf of defendants. (RX 7 @ 5, 8, 23).

Dr. Kornblatt examined the Petitioner and reviewed medical records and the Petitioner's January 8, 2013 MRI films and report. (RX 7 @ 11-14).

Dr. Kornblatt opined that the Petitioner may have a degenerative meniscal tear. (RX 7 @ 14). Although he had previously opined in his Section 12 report that there was no meniscal tear, he explained that he felt her symptoms were consistent with chondromalacia patella and that he MRI did not show a meniscal tear, but MRIs are not 100% accurate, so he couldn't say for certain that there wasn't a small meniscal tear. However, if there was a tear, his opinion would be that it was degenerative in nature. According to Dr. Kornblatt, the Petitioner had a negative McMurray's test upon physical examination. (RX 7 @ 15).

Dr. Kornblatt felt that he Petitioner presented with exaggerated pain behavior, with complaints of pain all around the knee that did not fit any pathology. (RX 7 @ 16).

Regarding the left knee MRI results, Dr. Kornblatt stated that whenever there is a degenerative change in the posterior horn of the meniscus, there is always a chance that there is a tear. However, if the Petitioner had a tear, Dr. Kornblatt opined that it was due to a degenerative process alone based upon her weight and other degenerative findings, i.e. the chondromalacia patella. (RX 7 @ 17).

Dr. Kornblatt agreed that activities of daily living could cause an aggravation of preexisting chondromalacia patella and that the Petitioner's fall did not cause the chondromalacia itself. (RX 7 @ 18-19).

Dr. Kornblatt disagreed with Dr. Giannoulias that the Petitioner's work conditioning or therapy caused her knee pain. The basis of this disagreement was that the Petitioner did not complain of knee pain until a long time after the accident and that he felt there was no documented injury during the course of her work conditioning. (RX 7 @ 19-20). Dr. Kornblatt thought it was unlikely that the activities performed by the Petitioner during work hardening or physical therapy could have caused a meniscal tear. (RX 7 @ 20-21).

Dr. Kornblatt did recommend that the Petitioner undergo an arthroscopic procedure on her left knee. This recommendation was based upon the extensive conservative treatment the Petitioner had undergone without relief. He noted that the arthroscopy could be both diagnostic and therapeutic in nature. (RX 7 @ 21-22).

On cross-examination, Dr. Kornblatt agreed that he saw the Petitioner on only one occasion prior to his deposition. (RX 7 @ 23).

Although Dr. Kornblatt's type-written report stated that he Petitioner claimed an injury to her left knee at the time of her fall, he agreed that his hand-written notes showed the Petitioner told him she had injured her left knee during work conditioning. (RX 7 @ 24-25).

Dr. Kornblatt agreed that performing lifts such as deep squats can cause a meniscal tear, but doubted the Petitioner's ability to perform such a lift. (RX 7 @ 26).

Dr. Kornblatt was not aware of any record of pain in the Petitioner's knee prior to work conditioning. (RX 7 @ 26-27).

The only therapy or work conditioning records that Dr. Kornblatt had the opportunity to review were the January 31, 2013 FCE and the work conditioning/work hardening progress report from July 2, 2012 through July 6, 2012. (RX 7 @ 29-30).

On re-direct examination, Dr. Kornblatt reviewed the work hardening note from May 21, 2012 and stated that it did not change his causation opinion. (RX 7 @ 30-31). He also specifically stated that he felt it was unlikely the Petitioner was performing a deep squat on that date. (RX 7 @ 33).

CONCLUSIONS OF LAW

(F) Causal Connection

After reviewing all evidence and testimony in evidence, the Arbitrator finds that the current conditions of the Petitioner's left shoulder and left knee are causally related to her October 5, 2011 work accident.

There is no dispute that the current condition of the Petitioner's left shoulder is causally related to her October 5, 2011 work accident. (Arb. Ex. 1). This includes a rotator cuff tear which required surgical repair, in addition to AC joint arthrosis and adhesive capsulitis which required a second surgical procedure to repair. Due to this injury, the Petitioner has permanent physical restrictions of lifting and carrying 15 pounds, no squatting, no climbing, overhead work limited to 10 pounds for 1 to 3 hours, and sitting, standing, walking, driving, bending and push/pull limited to 5-8 hours, as placed on the Petitioner by Dr. Giannoulias on February 25, 2013. (PX 9).

Following her first left shoulder surgery, the Petitioner underwent a course of physical therapy followed by work conditioning. The records from work conditioning, beginning on May 21, 2012, reflect that the Petitioner complained of knee pain while performing certain lifting activities. These complaints continued throughout the remainder of the Petitioner's work conditioning course, with clicking in the left knee reported in June of 2012 and reports of pain with work conditioning to Dr. Giannoulias in August of 2012. The Petitioner also complained of left knee pain with lifting, using the stationary bike, or using the treadmill during work conditioning following her second left shoulder surgery. (PX 7, PX 9).

During his deposition testimony, Dr. Giannoulias explained that while the Petitioner was going through her course of work conditioning he had the opportunity to review the records from that treatment, which showed pain in her left knee while performing therapy activities. (PX 12 @ 9-12).

After attempting a series of injections to treat the symptoms in the Petitioner's left knee without relief, Dr. Giannoulias recommended that the Petitioner undergo an arthroscopic procedure to evaluate the Petitioner's medial meniscus and patellar chondromalacia. (PX 12 @ 15).

Dr. Giannoulias testified that his diagnosis of a possible meniscal tear was based upon the signal in the meniscus from the MRI, in addition to the Petitioner's medial joint line pain and positive McMurray's test, which are signs of a possible meniscal tear. (PX 12 @ 13-14). He explained that

those positive findings are not consistent with chondromalacia alone, but are more likely signs of a meniscus problem. (PX 12 @ 14).

Dr. Giannoulias further opined that the Petitioner's work accident or the activities that she was performing in work conditioning caused an aggravation of the preexisting chondromalacia in her left knee and a tear her medial meniscus. (PX 12 @ 20-21).

The Respondent in this case disputes the causal relationship between the Petitioner's work accident and her left knee condition based upon the opinion of Dr. Ira Kornblatt. Dr. Kornblatt opined that the Petitioner's left knee symptoms were due to purely degenerative processes. While Dr. Kornblatt had opined in his IME reports that there was no meniscal tear at all and that all symptoms were from Petitioner's preexisting patellar chondromalacia, he admitted in his deposition testimony that there may be a meniscal tear, but that he felt the tear would have been caused by degenerative processes alone, not from any accident. (RX 7 @ 14-15).

Of importance to the Arbitrator is that Dr. Kornblatt's conclusions were based upon his opinion that there was no evidence of any documented injury to the left knee during work conditioning. (RX 7 @ 19-20). However, in forming these opinions, Dr. Kornblatt had only reviewed the Petitioner's January 2013 FCE and the work conditioning/work hardening progress report from June 2, 2012 through June 6, 2012. (RX 7 @ 29-30). While the Petitioner performed therapy, work hardening and work conditioning activities from May 21, 2012 through July 6, 2012 and from August 23, 2012 through January 13, 2013, Dr. Kornblatt had only been provided one FCE report and one summary of 4 days of work conditioning treatment to review. Prior to his deposition, Dr. Kornblatt had not reviewed the initial work conditioning notes reflecting pain in the Petitioner's knee during lifting activities, and at no point has Dr. Kornblatt ever reviewed any of the work conditioning or therapy notes after June 6, 2012. In contrast, Dr. Giannoulias, the Petitioner's treating physician, had the opportunity to review all of these reports while also regularly examining the Petitioner during that time. The Arbitrator finds that Dr. Giannoulias was clearly in a better position to determine whether the activities performed by the Petitioner in work conditioning caused an injury to her left knee.

Dr. Kornblatt's opinion discounts the facts that the Petitioner had no history of left knee injury or treatment prior to her symptoms beginning during work conditioning and that her symptoms began while performing lifting activities in work conditioning and persisted through the date of arbitration.

The reasonable opinion of Dr. Giannoulias in this case, which was based upon regular examinations of the Petitioner, in addition to reviewing the Petitioner's left knee MRI and work conditioning records, holds more weight than that of Dr. Kornblatt.

Based upon all evidence and testimony in the record, the Arbitrator finds that the current condition of ill-being in the Petitioner's left knee, including an aggravation of preexisting patellar chondromalacia and a possible meniscal tear, was caused by her work conditioning activities. As the Petitioner was undergoing that work conditioning to treat her undisputed left shoulder injury, stemming from her October 5, 2011 accident, the Arbitrator finds that the left knee injury sustained during work conditioning is also causally related to her October 5, 2011 work accident.

(J) Medical Bills

As detailed above, the Arbitrator has found that the current conditions of ill-being in the Petitioner's left shoulder and left knee are causally related to her October 5, 2011 work accident.

The Respondent in this case has offered no evidence or testimony to dispute the reasonableness or necessity of any treatment provided to the Petitioner for her left shoulder or left knee.

After reviewing the record, the Arbitrator finds that all treatment for the Petitioner's left shoulder and left knee has been reasonable, necessary and causally related to her October 5, 2011 work accident. Therefore, the Arbitrator orders Respondent to pay unpaid medical expenses of $19,990.65, as detailed in Petitioner's Exhibit 14, pursuant to Sections 8(a) and 8.2 of the Act.

(K) Prospective Medical

Both Dr. Giannoulias and Dr. Kornblatt have opined that the Petitioner should undergo an arthroscopic surgery on her left knee. (PX 12 @ 15, RX 7 @ 21-22).

As detailed above, the Arbitrator has found that the current condition of ill-being in the Petitioner's left knee is causally related to her October 5, 2011 work accident in that she injured her left knee while performing work conditioning activities.

Therefore, the Arbitrator hereby orders Respondent to approve and pay for the left knee arthroscopic procedure recommended by Dr. Giannoulias, namely an arthroscopy and partial medial menisectomy to debride or resect the portion of the meniscus that is torn (as detailed by Dr. Giannoulias at PX 12 @ 38).

(L) TTD

There is no dispute that the Petitioner was temporarily and totally disabled due to her October 5, 2011 work accident from November 14, 2011, when she was first placed off work by Dr. Giannoulias, through March 9, 2013. (Arb. Ex. 1).

As detailed above, the Arbitrator has found that the current conditions of ill-being in both the Petitioner's left shoulder and left knee are causally related to her October 5, 2011 work accident.

In reviewing the records, the Arbitrator notes that from March 3, 2013 through March 11, 2013, the Petitioner was on work restrictions, per Dr. Giannoulias, and undergoing a series of 3 Hyalgan injections into the left knee. On March 11, 2013, Dr. Giannoulias placed the Petitioner back on an off work status, stating "I do not think she is going to be able to return to her occupation given the fact that she has both knee and shoulder problems and that the type of work that she does is repetitive by definition." (PX 9).

Since that time, the Petitioner has remained off work due to the permanent restrictions on her left shoulder and the current condition of her left knee which has not yet undergone the surgical repair that has been recommended by Dr. Giannoulias since March 25, 2013. (PX 9).

The Arbitrator has found the opinion of Dr. Giannoulias concerning the condition of the Petitioner's left knee to be more credible than the opinion of Dr. Kornblatt, Respondent's Section 12 examiner. Dr. Giannoulias kept the Petitioner on an off work status as of March 25, 2013 and has not specifically cleared the Petitioner to work in any capacity since that time. Furthermore, the Petitioner is under permanent physical restrictions for her left shoulder and no evidence has been provided of any light duty work offered by Respondent within those restrictions.

Based upon a review of all evidence and testimony in the record, the Arbitrator finds that the Petitioner has been temporarily and totally disabled from November 14, 2011 through July 13, 2016, the date of arbitration.

The Petitioner has been unable to return to work due to her left shoulder and left knee conditions, each of which are causally related to her October 5, 2011 work accident.

Therefore, the Arbitrator orders Respondent to pay temporary total disability benefits of $301.62 per week for 243 2/7 weeks from November 14, 2011 through July 13, 2016, pursuant to Section 8(b) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gregory Dotson,
Petitioner,

vs. NO: 10 WC 21807

White County Coal Co.,
Respondent.

17IWCC0829

DECISION AND OPINION ON REVIEW

A Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission first addresses the timeliness of the filing of the Petition for Review and the Commission's jurisdiction to review the Decision of the Arbitrator filed April 14, 2016.

The parties agreed to receive the Decision of the Arbitrator via electronic mail (email). Commission records show the email to the parties with the Decision of the Arbitrator attached was originally sent at 4:30 PM on April 14, 2016, the day the Decision was filed at the Commission. The claimant, through counsel, filed a Petition for Review on June 1, 2016, with a mailing date of May 25, 2016. The respondent objects to further proceedings on review based on a lack of subject matter jurisdiction pursuant to Section 19(b) of the Act, as the review was filed more than 30 days following receipt of the Decision.

The respondent received the email on April 15, 2016; the petitioner's counsel, in his Petition for Review, alleges receipt of the Decision on May 24, 2016. The Commission's April 14, 2016 email shows it was sent to the address kirk.caponi@wcflaw.com for the claimant; a follow-up email, apparently sent at the claimant's attorney's request, was sent on May 24, 2016 at 2:56 PM to the email address culleyandwissore@myfrontiermail.com. The Commission further observes Mr. Caponi had, on the trial stipulation sheet, provided an email address of culleyandwissore@frontier.com.

17IWCC0829

If the claimant's attorney did receive the April 14, 2016 email either that day or the next morning (April 15, 2016 was a Friday) then clearly the Petition for Review would be untimely and therefore void. Claimant's counsel avers receipt of the Decision on or about May 24, 2016; based on that date of receipt, the Petition for Review would clearly have been timely filed.

While the respondent's concerns are well founded, the Commission notes a lack of proof that the claimant's counsel in fact received the originally sent April 14, 2016 email. Moreover, the claimant's attorney asserts receipt on May 24, 2016, supported by his signature on the filing. There does not appear to be any bad faith, malfeasance or abuse of the process being demonstrated. The Commission accepts the May 24, 2016 date for purposes of the receipt of the Decision; as such, jurisdiction before the Commission is extant.

Finding jurisdiction to have been properly established, after considering the issues of occupational disease, causal connection, and permanent partial disability, and being advised of the facts and law, the Commission 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 14, 2016 is hereby affirmed and adopted.

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

DATED: DEC 26 2017

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

o-12/05/17
jdl/ac
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DOTSON, GREGORY
Employee/Petitioner

Case# **10WC021807**

17IWCC0829

WHITE COUNTY COAL LLC
Employer/Respondent

On 4/14/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.35% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
HARRISBURG, IL 62946

2742 KEVIN M HAZLETT LLC
1167 FORTUNE BLVD
SHILOH, IL 62269

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Gregory Dotson
Employee/Petitioner

v.

White County Coal, LLC
Employer/Respondent

Case # 10 WC 21807

Consolidated cases: n/a

17IWCC0829

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **February 11, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

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

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

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

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

In the year preceding the injury, Petitioner earned **$57,609.24**; the average weekly wage was **$1,107.87**.

On the date of accident, Petitioner was **51** years of age, *married* with **0** dependent children.

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

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

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

ORDER

Petitioner failed to prove that he suffers from coal workers' pneumoconiosis or chronic bronchitis that arose out of and in the course of the exposures of his coal mine employment, and that his current condition of ill-being is casually related to his employment. All benefits are denied; the remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

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

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

Melinda M. Pope-Gillivan

Signature of Arbitrator

4/12/16

Date

APR 14 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Gregory Dotson
Employee/Petitioner

Case # 10 WC 21807

v.

Consolidated cases: N/A

White County Coal, LLC
Employer/Respondent

17IWCC0829

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he lives in Springerton, Illinois and that he is currently 57 years of age. He testified that he is married and has no dependent children. He testified that he went to seventh grade in school in West Virginia. He testified that he worked 30 years in the coal mines, all of which were underground.

Petitioner testified that in addition to coal dust, he was regularly exposed to silica rock dust, roof bolting glue fumes, and diesel fumes. He testified that his last shift in a coal mine was on March 11, 2010 at White County Coal in Carmi, Illinois. He testified that he would have been 51 at the time, and that he was a belt greaser. He testified that he was exposed to coal dust on that date.

Petitioner testified that he was let go on March 11, 2010, and that that was the last day he worked in any coal mine. He testified that he was let go over a dispute over time. He denied going back to work at any other coal mine in part due to health concerns. He testified that the rock dust would give him heartburn, that he would get sick every night and that it affected his breathing. He testified that he decided not to go back to work in the coal mines anywhere, and maintained that no one would have hired him anyway given his health. He denied having worked anywhere else since.

Petitioner testified that when he left school in the seventh grade, he worked on his dad's farm and then worked at a sawmill for a while in West Virginia. He testified that he then went to Ohio and worked in a plastic processing factory, after which he went to work in Kentucky for five years in the mine. He testified that in 1985, he went to work for Respondent and stayed there until he left their employment. He testified that when he hired in at White County Coal, he was a roof bolter. He testified that as a roof bolter he was directly under where he was drilling in the roof of the mine, and that the rock dust that was coming from the drilling came down directly on top of him. He testified that he used a glue pin to support the post he was putting in, and that it was an epoxy-type glue that had an odor. He testified that the glue would burn if left on the skin too long, and that it also affected his breathing. He testified that he was a roof bolter for Respondent for approximately five years.

Petitioner testified that after being a roof bolter, he drove a shuttle car. He testified that he drove the car that pulled up to where they were cutting the coal out of the face of the mine, and that the coal was loaded onto his shuttle car. He testified that he took the coal to where the belts were, where it was unloaded and put onto the belts to be taken out of the mine. He testified that he was exposed to the same amount of rock and coal dust as the people that were cutting the coal out of the face of the mine. He

testified that he drove a car for approximately 11 years. He testified that he then went to third shift, which was putting in belts and setting headers. He testified that he was constructing the belts that took the coal out of the mine, and that there was a lot of rock dust around that area. He testified that he then took the job of a greaser, which was the last job that he held for Respondent. He testified that he would grease and clean the bearings and belts, which would kick up dust.

Petitioner was unable to testify when he first started noticing breathing problems at work, but testified that he had had breathing problems for a long time. He testified that he was driving the shuttle car when he first noticed problems at the mine. He testified that from the time he first noticed breathing problems until when he left the mine, his breathing difficulties got worse as he went along working in the mine. He testified that his breathing problems were worse when he left the mine than when they first started. He testified that since he left, his breathing problems have been the same. He testified that he uses an inhaler that was prescribed for him by his doctor and that he did not know the name, but it was something that helped him breathe.

Petitioner testified that he thought he could walk on level ground at a normal pace for 50-100 feet before he became short of breath. He testified that he could climb 5-6 stairs, and that his breathing affected his daily activities. He testified that he can do nothing without being out of air, and that it affected him working around the house as well.

Petitioner testified that his primary care provider was at Hamilton Memorial Hospital Clinic, and that one was by the name of Dr. Alverez. He testified that he talked to Dr. Alverez about his breathing difficulties. Petitioner admitted that he is a smoker, and that he smoked for at least 30 years. He testified that he smoked on average a pack a day. He testified that when he was working in the mine, he could not smoke during the day. He agreed that he has increased smoking since he left the mine. He also testified that he has other health issues, that he had a heart attack and back surgery, that he was diabetic and that he has high blood pressure.

On cross-examination, Petitioner testified that he had his heart attack while working as a coal miner, but could not remember the specific year. He testified that he worked as a coal miner for approximately 10 years after his heart attack. He testified that he had his back surgery before he had his heart attack, but did not know the date. He testified that he smoked about a pack a day for a long time, but did not know exactly when he started. He testified that the medical records that indicated that he started at age 15 seemed reasonable to him, and agreed it had been about 40-41 years instead of 35.

On cross-examination, Petitioner testified that his current primary care physician was at Hamilton Memorial Family Clinic, and that it used to be Dr. Alverez. He testified that he could not remember when he last saw a physician for his breathing problems. He testified that he worked in the coal mines in Kentucky before White County Coal for about five years. He agreed that on March 11, 2010, his employment was terminated and that it was due to something involving his time cards. He agreed that shortly after that, he met with attorneys about filing for black lung benefits. He testified that a few days after he was fired, he went to an attorney and was sent to get a chest x-ray. He denied going to a doctor to get a script for the x-ray. He testified that after his employment was terminated, he almost immediately filed for Medicaid benefits in either March or April of 2010. He agreed that he was approved for Medicaid benefits for his medical treatment in approximately April of 2010, but denied having those benefits since then. He testified that his benefits now were Social Security, but he did not know for how long he had had them. He testified that he did not know for how long he had Medicaid benefits because his wife took care of it.

On cross-examination when asked if he told the doctors that he could not get his breathing medication because he did not have insurance coverage, Petitioner agreed that he did. Petitioner denied

being able to afford to buy his medications without insurance and admitted that he had Medicaid within about six weeks after leaving the coal mine, but testified that he did not know for how long he had Medicaid coverage. He testified that he had no reason to dispute the records from the Illinois Department of Health Care and Family Services, which indicated that they paid for medical treatment in 2010, 2011 and 2014. He agreed that for the four years indicated he had insurance coverage through Medicaid, and they were paying for his medical treatment and prescriptions.

On cross-examination, Petitioner agreed that when he was still working for White County Coal in 2009, he was seeing Dr. Kolb and the other practitioners at Hamilton Memorial. He agreed that he filed the Application for his case in June of 2010, and that the first time he saw Dr. Alverez was about five months later in November of 2010. He did not disagree that his records indicated that he did not have any complaints and was there just to get his medications refilled for his other medical problems and not his breathing issues. He agreed that the first time he received any breathing medication was when he went to see Dr. Alverez in November of 2010, approximately seven months after he stopped working. He agreed that he did not seek any medical treatment for his breathing problems while he was working as a coal miner.

On cross-examination, Petitioner testified that his breathing problems included the lack of air. He agreed that his breathing problems were the same while working as a coal miner. Petitioner agreed that he recalled that on February 17, 2009 while he was working as a coal miner, he went to his doctor and complained of a cough. He recalled being told that his cough was due to the medication that he was taking for his high blood pressure. He denied recalling that about a month later having gone back to the doctor's office for cough complaints and their having indicated that they thought he had pleurisy, but agreed that he had no reason to dispute the records. He agreed that in October of 2009 while he was still working as a coal miner he reported that he was having a cough that he noticed when he was lying down, but denied that that the doctor thought it was possibly caused by a condition called GERD. He agreed, however, that he had no reason to dispute the records.

On cross-examination, Petitioner agreed that when he saw Dr. Alverez for the first time in November 2010 he again complained of a cough, and that this was the first time that he prescribed an inhaler for him. He agreed that he then got the medication and used it because it was covered under Medicaid. He agreed that he obtained the refills over the next several months through Medicaid. He agreed that the next time he went back to Dr. Alverez was in June of 2011 again for a cough, and that he again prescribed the same breathing medication. He agreed that he recalled telling Dr. Alverez that the medications he had been prescribing did not help his cough. He agreed that he last saw Dr. Alverez in November of 2012 for his diabetes, hyperlipidemia and hypertension, and agreed that at that time he still had Medicaid coverage as far as he knew. He agreed that Dr. Alverez stopped his Lisinopril because one of the side effects was that it caused coughing, but testified that the coughing did not stop when he changed medications.

On cross-examination, Petitioner agreed that Dr. Alverez continued to prescribe his inhalers, and that he got the inhalers throughout 2012 and 2013. He agreed that in January of 2014 he went back to the clinic, but Dr. Alverez had left by then. He agreed that according to the record of January 8, 2014, he went back just for a medication refill, told them he ran out of his medication and that he had not taken any medication for one month due to lack of insurance. He testified that Medicaid was not still paying for his prescriptions at that time because if they were, he would have had his medicine. He did not disagree, however, that the records from Medicaid indicated that they paid for the medications throughout 2014.

On cross-examination, Petitioner agreed that during all of the time subsequent to his coal mining employment, he has continued to smoke. He agreed that in April of 2014, the medical providers at Hamilton Memorial decided that he should see a pulmonologist by the name of Dr. David Chiraq (who he

knew as "Dr. Dave"). He agreed that at that time he was still covered under Medicaid and that Dr. Dave was being paid by Medicaid at that time. He agreed that all of his medications were at the Wal-Mart pharmacy in Fairfield. He agreed that after seeing him once, Dr. Dave wanted him to have a pulmonary function study and a chest x-ray. He agreed that this was the only time anyone sent him for a chest x-ray and pulmonary function studies.

On cross-examination, Petitioner agreed that he returned to Dr. Dave after the studies and that he reviewed them with him. He agreed that Dr. Dave said that the chest x-ray was normal, and that the pulmonary function studies were normal. He agreed that Dr. Dave stated that he thought his cough was due to medication or GERD, and that he changed his medication to a drug called Dulera. He testified that he remembered Dr. Dave telling him he was going to change his medication, but testified that he did not know why. He agreed that the last office note from any physician was dated June 11, 2014, and that when he went to see Dr. Dave he told him that he was taking his medications regularly and that he was doing well on those medications. He agreed that he was still smoking cigarettes and taking Dulera in June of 2014.

On cross-examination, Petitioner testified that he was taking one "spray" medication for his breathing problems but that he did not know the name. He agreed that it was a rescue inhaler, and that he only took it when he was really short of breath. He denied telling his physicians that he thought his problems were caused by working in a coal mine. He denied having had any employment anywhere since March of 2010, and further denied looking for a job. He did, however, file for unemployment. He testified that his source of income between March of 2010 and the date of arbitration included his unemployment until it ran out. He further testified that when he turned 55, he started drawing his retirement from White County, and that he had been receiving Social Security Disability for approximately two years. He testified that he drew unemployment and did not know for how long, but knew it was more than one year. He testified that his retirement benefits through White County Coal were approximately $900 per month, and that his Social Security Disability benefits were approximately $2,460 per month.

The Application For Adjustment of Claim was entered into evidence at the time of arbitration as Arbitrator's Exhibit 2. The alleged date of accident under the Occupational Diseases Act was noted to be that of March 11, 2010, and it was alleged that the accident occurred through the inhalation of coal mine dust including but not limited to coal dust, rock dust, fumes and vapors for a period in excess of 30 years. (AX2).

The evidence deposition of Dr. Glennon Paul was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. He testified that he has worked in Springfield for 32 years, that he is the medical director of St. John's respiratory therapy and is also a clinical assistant professor of medicine at SIU Medical School where he teaches pulmonary medicine. (PX1).

Dr. Paul testified that he is a senior physician at the Central Illinois Allergy and Respiratory Clinic, which consisted of six physicians specializing in allergy and pulmonary diseases. He testified that he has written a book concerning asthma, and that he has 50,000 patients in his patient census. He testifies that he performs chest x-rays and reads them on a regular basis, and typically reads 15-20 x-rays per day, approximately 100 per week or approximately 5,000 per year. He testified that he also reviews approximately the same number of pulmonary function tests. (PX1).

Dr. Paul testified that he has examined coal miners for federal black lung claims as well as state black lung claims, and has had occasion to treat coal miners for coal mine-induced lung disease. He testified that the vast majority of the examinations that he has performed have been at the request of coal companies, including Freeman, Peabody, Zigler, Monterey and Consolidated Coal. (PX1).

Dr. Paul testified that he charged $600 for the examination and report, and that he also charged $600 for the deposition. He testified that his board certification is in allergy, immunology and asthma, and that he is the chief medical officer at his clinic which takes care of pulmonary diseases. He agreed that since he prepared his report he was shown the records of the primary care physician, Dr. Alex Alverez, in addition to his opinion letter. (PX1).

Dr. Paul testified that Petitioner gave complaints of shortness of breath on exertion, and that he experienced coughing and wheezing. He testified that Petitioner told him he had been taking Flovent two inhalations twice a day, and Proventil two inhalations 4 times if needed. He testified that Petitioner reported that he worked in the coal mine approximately 30 years, and that he retired in 2010 and had not worked since that time. (PX1).

With respect to the pulmonary function studies, Dr. Paul testified that Petitioner had abnormalities of his diffusing capacity which were very significant. He testified that Petitioner had a moderate degree of decrease in the carbon monoxide diffusing capacity, which was a measurement of carbon monoxide diffused across the alveolar capillary membrane. He testified that what made it reduced was emphysema and/or interstitial fibrosis like one would see in coal workers' pneumoconiosis. He testified that in this case, it was probably the coal workers' pneumoconiosis because Petitioner did not have pulmonary function studies showing any significant emphysema and he did have an x-ray which showed interstitial lung disease. (PX1).

Dr. Paul testified that Petitioner has coal workers' pneumoconiosis which was caused by coal dust. He further testified that upon review of the treatment records and opinion letter of Dr. Alverez, he was also of the opinion that Petitioner has chronic bronchitis which he believed was caused by smoking as well as coal mining exposure. He testified that Petitioner's spirometry results were borderline, but still within normal limits. He testified that Petitioner's chronic bronchitis and recurrent pulmonary symptoms put an extra burden on the functioning of his heart. He testified that Petitioner did not have the pulmonary capacity necessary to perform the heavy manual labor of a coal miner on a full-time basis, and opined that he could not have any further exposure to the environment of a coal mine without endangering his health. (PX1).

Dr. Paul testified that in light of Petitioner's reduced diffusing capacity, he could not have any further exposure to the environment of a coal mine without endangering his health. He testified that Petitioner has clinically significant pulmonary impairment in the form of pulmonary symptoms and complaints, to which he would attribute the coal mine environment. He agreed that some of those impairments would be attributable to his smoking. He testified that Petitioner had x-ray evidence that was consistent with radiographically apparent pulmonary impairment, and that the cause was coal dust inhalation. He testified that Petitioner has physiologically significant pulmonary impairment demonstrated on objective testing, which was caused by coal dust. (PX1).

Dr. Paul testified that Petitioner is totally disabled from working as a coal miner, and that it is permanent in nature. He testified that there was no cure for coal workers' pneumoconiosis. He testified that if Petitioner continued to smoke after he left the coal mine, his continued smoking would make his condition worse. He testified that cigarette smoking would not prevent lung disease from coal mining. (PX1).

Dr. Paul testified that in order to have pneumoconiosis you must have, in addition to coal mine dust deposit in the lungs, a tissue reaction to it called scarring or fibrosis. He testified that the scarring of coal workers' pneumoconiosis could not perform the function of normal healthy tissue, and that the scarring of coal workers' pneumoconiosis was associated with a focal emphysema. He testified that if you

have coal workers' pneumoconiosis, you necessarily have some impairment in the function of the lung at the site of the scarring whether it could be measured by spirometry or not. He testified that spirometry measured global impairment of the lung, and that it was possible to have injury or disease in the lung despite having normal pulmonary function test results. (PX1).

Dr. Paul testified that a person can have shortness of breath despite having pulmonary function tests within the range of normal, and that a person can have a lobe of a lung surgically removed and still have pulmonary function tests within the range of normal. He testified that the range of normal represented a bell-shaped curve, and that the bell-shaped curve covered 95% of the population in terms of age, height, race and sex. He testified that 2.5% of the population would be lower than the range of normal and that 2.5% would be above. He testified that in addition to a range of normal, there was also a specific predicted normal value for each test, and that it was possible that a patient could be well below the predicted normal but still be within the normal range of normal. He testified that when you had pulmonary function tests and you compared them to a range of normal, it did not tell you anything about what the prior position of the specific miner was. He testified that if you wanted to know whether or not a specific exposure had caused impairment of a miner's lungs, you would need to have serial pulmonary function tests. (PX1).

Dr. Paul testified that pulmonary function testing would tell the type of abnormality as to whether it was obstructive or restrictive and its severity, but it would not tell the etiology of the abnormality. He testified that emphysema in any of its forms, if significant enough to cause a measurable defect, would be obstructive. He testified that scarring of pneumoconiosis can be both obstructive and restrictive. He testified that a person can have coal workers' pneumoconiosis that is radiographically significant but not have shortness of breath, and that a person can have radiographically significant coal workers' pneumoconiosis and have normal pulmonary function testing, normal blood gases and normal physical examination of the chest. He testified that coal workers' pneumoconiosis was considered to be a progressive disease, and with further exposure it can progress to progressive massive fibrosis or complicated pneumoconiosis which can be life-threatening. He testified that with further exposure it can progress and involve the heart in a condition called cor pulmonale, which can be life-threatening. He testified that there was no cure for coal workers' pneumoconiosis. (PX1).

Dr. Paul testified that if a coal worker has coal workers' pneumoconiosis and ends his exposure to coal mine dust, it can still progress. He testified that if a person has coal workers' pneumoconiosis that is progressing, there is no way to stop the progression. He testified that if a coal miner has coal workers' pneumoconiosis, further exposure to coal mine dust may increase the progression of the disease. He testified that generally the progression of coal workers' pneumoconiosis was usually gradual. He further testified that it was true that when one first developed coal workers' pneumoconiosis, it would come on so slowly that one could have it for a period of time before one recognized it. (PX1).

Dr. Paul testified that there were exposures in the environment of a coal mine that could injure the lungs in addition to coal mine dust, including silica, diesel fumes, fumes from other petroleum products, smoke and fumes from sulfur coal fires, smoke and fumes from electrical cable fires, fumes from the glues used in the roof bolting process and welding fumes. He testified that chronic obstructive pulmonary disease (COPD) was an umbrella term for a number of obstructive diseases, including emphysema, chronic bronchitis and asthma. (PX1).

Dr. Paul testified that when one has scarring in the lungs, it decreases the ability of the lungs to expand. He testified that with obstructive lung disease the elasticity was gone, and that some of the small airways were destroyed like that which occurred with cigarette-induced emphysema. He testified that when a person has an obstructive lung disease and the elasticity is destroyed, it can actually result in what a layman might call "holes" in the lungs. He testified that it can progress through a series of central

lobular, panlobular and bolus emphysema. He testified that bolus emphysema was represented by spaces in the lungs of 1cm or larger. (PX1).

Dr. Paul testified that obstructive lung disease can be multi-factorial in origin, and that the inhalation of coal mine dust can result in shortness of breath. He testified that the inhalation of coal mine dust could result in chronic cough, as well as emphysema and chronic bronchitis. He further testified that there were exposures in the environment of a coal mine and that could result in occupational asthma, and that the exposures that could be found in the environment of a coal mine could aggravate the diseases of emphysema, chronic bronchitis and asthma. (PX1).

Dr. Paul testified that medical records could not change what was seen on the x-rays, and that no matter what would be contained in treatment records, it would not change the results obtained on pulmonary function testing or on physical examination. He further testified that treatment records would not change his diagnosis based on his reading of the x-rays, the pulmonary function tests and the physical examination. (PX1).

Dr. Paul testified that if a person had chronic obstructive pulmonary disease or obstructive lung disease, the best medical practice was to avoid any further exposure to the agents that caused or aggravated it. When asked how long it took to develop pneumoconiosis once one began to mine and was a susceptible host, Dr. Paul responded that it varied from individual to individual. (PX1).

Dr. Paul testified that CT scans were not recognized by NIOSH for the purposes of making B-readings. He testified that there are no protocols for standardizing the equipment used for taking CT scans like those pertaining to analog chest x-rays. He testified that he was not a B-reader, but was familiar with NIOSH and its standards. He testified that he has been doing examinations for black lung for approximately 30 years and has been familiar with the NIOSH standards throughout that time. He testified that a CT scan has approximately 100 times more radiation exposure than a regular chest x-ray, and that one of the advantages of a CT scan is that it can be adjusted to emphasize certain types of diseases that you may be looking for. He testified that at the same time you were adjusting it to better look for some diseases, you were also making it less able to see for other diseases. He testified that the same issues would be present for digital chest x-rays as for CT scans. (PX1).

Dr. Paul testified that chronic bronchitis was one of the chronic obstructive pulmonary diseases, and that one could have chronic bronchitis and have normal pulmonary function testing, blood gas testing and a normal physical exam of the chest. He testified that if you had further exposure to coal mine dust after having chronic bronchitis, anything that was inhaled that was dusty, such as coal dust, could make chronic bronchitis worse. When asked if chronic bronchitis could progress to the point that it began to develop as a fixed obstructive pulmonary defect, Dr. Paul responded that it could but that was usually what was seen in asthma when it was severe and prolonged, but he suspected chronic bronchitis could do the same thing. (PX1).

Dr. Paul testified that reactive airway disease was characterized by asthma attacks or responses to triggers in the environment, and that it was when an individual had a major infection or was exposed to fumes or odors that the bronchospasm worsened. He testified that a restrictive airway disease was also called bronchospasm. He testified that when one had a reactive airways disease, bronchospastic disease or asthma, the condition could be aggravated by the environment such as the dust, smoke and fumes of a coal mine. He testified that if a person had repeated bronchospasms or asthma attacks there could be a medical phenomenon called remodeling in which the reactive airway disease became a fixed obstruction. He further testified that based on all of the diagnoses that he had made, Petitioner could not have had any further exposure to coal mine dust without endangering his health. (PX1).

Dr. Paul testified that if a person had severe bronchospastic or reactive airway response to triggers in the environment, if serious enough it could be fatal. He admitted that while he was not a B-reader, he typically read 100 chest x-rays per week and had been doing it for 35 years. He testified that he read more chest x-rays than the radiologists at local hospitals because they were doing other readings while he was doing only chest x-rays. He testified that he failed to find pneumoconiosis in a majority of the cases referred to his office by Petitioner's counsel. (PX1).

On cross-examination, Dr. Paul agreed that his involvement in the case began in December of 2012. He testified that as of the day that he saw Petitioner, he was provided no medical records as part of that evaluation. He testified that he was not able to say when he saw any medical records from any other physician, but testified that it was more recently than remotely. He testified that Petitioner's attorney showed them to him in person at recent meeting, which was held prior to a deposition. He testified that he did not have Dr. Alverez's records with him at the time of the deposition, and denied recalling the records. He testified that he had a letter in which the records were summarized, and then denied having personally seen the records himself. (PX1).

On cross-examination, Dr. Paul testified that Petitioner did not tell him when he began having breathing problems, but rather just told him about the types of symptoms he had. He admitted that he did not know how long he had been having issues, but testified that Petitioner was having them at the time that he saw him. He agreed that Petitioner gave him a history that he was still smoking cigarettes, and that Petitioner also told him about the two breathing medications that he was taking, Flovent and Proventil, which he agreed required a prescription. He further agreed that Petitioner did not tell him and he did not ask how long Petitioner had been taking those medications. (PX1).

On cross-examination, Dr. Paul admitted that the chest x-rays that he reviewed were not taken at his office. He testified that he did not know the exact date of the films, but testified that they had been taken sometime prior to the evaluation on December 5th. He testified that he did not know where the films were taken, nor did he know whether it was taken by a doctor or was done as part of his screening for black lung by a B-reader. He admitted that he did not know if the x-rays he reviewed were a month or years before he saw Petitioner, but testified that he gave them to Petitioner for safekeeping after he reviewed them. (PX1).

On cross-examination, Dr. Paul admitted that he did not provide a diagnosis of chronic bronchitis when he authored his report. He testified that Petitioner had symptoms of chronic bronchitis, but he did not know if he had chronic bronchitis for certain. He admitted that he had not seen any medical records other than a legal opinion letter from any other physician diagnosing chronic bronchitis. (PX1).

On cross-examination, Dr. Paul agreed that Petitioner's pulmonary function studies performed on December 4, 2012 indicated that Petitioner's height was 5'6" and that his weight was 240 pounds. He agreed that an individual's weight can affect pulmonary function studies. When asked if a 20- or 30-pound weight differential could may any difference in the studies, Dr. Paul responded that it might make a little difference but it would only be in his vital capacity and his FEV1, which in this case were normal. (PX1).

On cross-examination, Dr. Paul agreed that from his report the significant abnormality was the carbon monoxide diffusion aspect but testified that it was not an unusual finding overall in spirometry. He testified that it was not unusual to have someone with a carbon monoxide diffusing capacity decreased without other things being abnormal, and that you would see this in someone who had interstitial lung disease such as coal workers' pneumoconiosis or someone who had the beginning of emphysema. He testified that you could see a decreased carbon monoxide diffusing capacity in someone who had congestive heart failure with pulmonary edema as well. When asked if that was an abnormality that

should show up on each and every pulmonary function study if he had coal workers' pneumoconiosis, Dr. Paul responded that he did not know but it depended on how bad the coal workers' pneumoconiosis was. When asked if he would expect to see that type of abnormality in the carbon monoxide diffusion capacity part of the test one year earlier, Dr. Paul responded that it was not necessarily the case because if Petitioner did not have the fibrosis developing, then you would not see the abnormal carbon monoxide diffusing capacity. (PX1).

On cross-examination, Dr. Paul admitted that he did not know when Petitioner's pulmonary fibrosis would have developed to be seen on x-rays, but testified that Petitioner had it when he saw him. He testified that comparing x-rays would not help with determining when his pulmonary fibrosis would have developed to be seen on x-rays. He testified that if Petitioner had a series of x-rays taken a year apart or five years apart with his being the last year, you may or may not see progression. (PX1).

On cross-examination, Dr. Paul agreed that his connection of the diffusion capacity abnormality was hand-in-hand with the abnormal x-ray that he reviewed. He agreed that in his report, he described fibrous lesions throughout both lung fields along with bilateral plaque, and testified that Petitioner had lesions compatible with coal workers' pneumoconiosis. He testified that Petitioner had fibrous lesions throughout both lung fields, but that they were diffuse. He testified that there were pleural plaques on the outside of the lung which may or may not interfere with the pulmonary function study. (PX1).

On cross-examination, Dr. Paul agreed that if he performed pulmonary function studies on Petitioner in the next couple of weeks, he would expect to see the same abnormality in the carbon monoxide diffusing capacity. He admitted that he did not know that Petitioner had had two prior pulmonary function studies performed, but testified that he was not interested in seeing those reports. (PX1).

On cross-examination, Dr. Paul testified that carbon monoxide diffusion capacity should not be part of all spirometry testing because you could do a spirometry without it if you were just looking for obstructive airway disease or restrictive airway disease. He testified that if the carbon monoxide diffusing capacity was decreased with obstructive airway disease it would mean emphysema, and that if the carbon monoxide diffusing capacity was decreased with some restrictive airway disease it would mean that there was more interstitial inflammation. He testified that in this case the carbon monoxide diffusing capacity was associated with neither severe obstruction or restriction, so he thought because of the x-ray showing interstitial fibrosis at the time he performed the pulmonary function study it was more compatible with coal workers' pneumoconiosis and early restrictive lung disease. (PX1).

On cross-examination, Dr. Paul testified that the purpose of the methacholine challenge test was to determine if there were hyperreactive airways like asthma, and that the finding was that there was not. He testified that the x-rays findings that he described could be seen on a high resolution CT scan. When asked if x-rays were taken the next week and whether he would expect to see the same or perhaps worse interstitial fibrosis findings, Dr. Paul responded in the affirmative. He testified that Petitioner implied that he was having breathing problems while he was actually working as a coal miner up until his retirement in 2010, as he told him that he had shortness of breath in walking a block and when going up three stairs. He agreed that Petitioner did not state to him that he was having problems working or performing his normal job duties, but suggested that Petitioner had implied it. (PX1).

On cross-examination, Dr. Paul admitted that he did not know how long Petitioner had been prescribed his medications for inhalation. He agreed that his opinions in the case were essentially based on his review of an x-ray and his pulmonary function studies and also the history from Dr. Alverez in a letter that he reviewed. He testified that Dr. Alverez stated that Petitioner had a problem with coughing, wheezing and shortness of breath. He testified that Dr. Alverez indicated in the letter that Petitioner had

been prescribed the inhalation medications on November 12, 2010, and that Petitioner indicated that he had coughing when he laid down and that it was worse in the fall. (PX1).

On redirect examination, Dr. Paul testified that Petitioner's coal workers' pneumoconiosis that he diagnosed in 2012 would have been present on some level when Petitioner left the coal mine in 2010. He testified that chronic bronchitis in a clinical sense would be someone who coughed and wheezed when they had an upper respiratory infection, so the "legal definition of two years" did not hold. He agreed, however, that it was a fair statement that Petitioner's chronic bronchitis would have at least been present for two years prior to his examination. He testified that a regular chest x-ray that was read properly was better for making a diagnosis of pneumoconiosis as compared to a CT scan that was not read properly. (PX1).

On further cross-examination, Dr. Paul admitted that a properly read CT scan would show coal workers' pneumoconiosis. He testified that Flovent was typically prescribed for asthma and that Proventil was typically prescribed for either asthma or bronchitis. (PX1).

With respect to Dr. Paul's report dated December 5, 2012 (which was attached to the transcript of the deposition of Dr. Paul as Exhibit 2), Dr. Paul noted that a black lung evaluation was performed on Petitioner and that he spent 30 years in the coal mines in Wood Coal Company as well as White County Coal Mine, all of which was underground. He noted that Petitioner worked as a roof bolter for at least 10 years, a shuttle car operator for 10 years and a belt mechanic for several years. It was noted that Petitioner retired in 2010 and had not worked since that time. (PX1/Deposition Exhibit 2).

In his report, Dr. Paul noted that Petitioner had smoked one pack of cigarettes per day for approximately 30 years, and that he was still smoking cigarettes. Pulmonary function studies were noted to be normal except for a significant decrease in carbon monoxide diffusing capacity of 56% of predicted. Chest x-rays (the date of which was not indicated) were noted to show fibrous lesions throughout both lung fields along with bilateral plaques. Dr. Paul opined that Petitioner had coal workers' pneumoconiosis with a decreased carbon monoxide diffusing capacity suggesting that the lung disease was quite significant. (PX1/Deposition Exhibit 2).

The transcript of the evidence deposition of Dr. Alejandro Alverez was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. Dr. Alverez testified that he was a family practitioner currently practicing in DeMotte, Indiana at DeMotte Physicians Group, and that he had privileges at Porter Hospital. He testified that before August of 2013, he was located in Illinois and an employee at Hamilton Memorial Hospital in McLeansboro for three years. He testified that this was an area that had coal mining activity, and that a large degree of his practice had to do with coal miners. He testified that he had experience in treating people with chronic bronchitis and other lung diseases as well as heart diseases, and that he had treated people who had had both heart problems and lung problems at the same time. (PX2).

Dr. Alverez testified that he prepared a letter dated February 14, 2013 which contained his medical opinions concerning Petitioner. He testified that Petitioner had chronic bronchitis, and that his diagnosis was contained in his treatment records. He testified that Petitioner's chronic bronchitis was caused or aggravated by his 30 years of underground coal mine work, and that he knew Petitioner also to be a smoker that he stated was "bad" for him. He testified that in light of the diagnosis of chronic bronchitis and the pulmonary history documented in his records, he believed that if Petitioner were to attempt to return to work in the coal mine environment it would present a risk to his health in terms of a potential worsening of his chronic bronchitis. (PX2).

Dr. Alverez testified that Petitioner's chronic bronchitis with its recurrent pulmonary symptoms put an extra burden on the functioning of his heart, and confirmed that Petitioner had coronary artery disease. He testified that he did not believe that Petitioner had the pulmonary capacity necessary to perform the heavy manual labor of a coal miner on a full-time basis in light of his diagnoses and complaints. He testified that he prescribed medications for his breathing problems, but did not know if Petitioner took them because he had difficulty affording his medications given he had no insurance and was unemployed. He testified that he prescribed Flovent, ProAir and Albuterol. (PX2).

Dr. Alverez testified that the wheezing noted in the medical records was related to his chronic bronchitis. He testified that chronic bronchitis caused a chronic alteration in the lining of the bronchials called the mucosa. He testified that chronic bronchitis also caused a chronic change in the glands that secrete mucous, becoming hypertrophic and producing more sputum. He testified that if a person had chronic bronchitis, it would be considered an impairment in the tissue and that it could progress and result in a permanent obstructive defect. He testified that chronic bronchitis could affect a person's susceptibility to pulmonary infections making them more susceptible, and that it made it more difficult for them to recover from those infections. (PX2).

Dr. Alverez testified that regarding the coronary artery disease and the co-existing bronchitis, if Petitioner were having an acute heart event and entered into a coughing spasm or fit resulting from his chronic bronchitis, it could put an extra burden on his heart and could be life-threatening in his condition. He agreed that it would be best for Petitioner not to smoke. He testified that there was no way to tell which was the biggest problem Petitioner had between his 30 years of coal mining or his 30 years of smoking. He agreed that Petitioner had continued to smoke since he left the mine, and testified that it would worsen his chronic bronchitis from his coal mining. He testified that if Petitioner had never been a smoker but had chronic bronchitis resulting from his coal mining, it was possible it could progress even without going back to a coal mine. He further testified that even if someone opined that Petitioner's chronic bronchitis was caused completely by smoking, there was no way to rule out coal mining as an aggravating factor which would have made it worse. (PX2).

On cross-examination, Dr. Alverez agreed that he was forwarded a copy of the records from his prior clinic in Illinois, and that the timeframe for which he had records included February 17, 2009 through June 14, 2011. He testified that he remembered Petitioner because he was unemployed and had no insurance, so treating him with medications that he could not afford was difficult. He testified that he did not recall that Petitioner had any other source to pay for medication, and did not recall whether Petitioner's wife had insurance. He testified that he did not believe that the State of Illinois or Medicaid was paying for medications because otherwise he would not have had such a difficult time. (PX2).

On cross-examination, Dr. Alverez agreed that he took over Petitioner's care on November 12, 2010. He agreed that the medications that were documented in his prior clinic records were important given Petitioner's several different medical conditions, including heart problems and hypertension. He testified that he did not recall ever seeing any other physician's records suggesting a diagnosis of chronic bronchitis. He testified that he did not know that Petitioner had been examined by pulmonary specialists after he treated him. (PX2).

On cross-examination, Dr. Alverez testified that Petitioner met the criteria for the diagnosis of chronic bronchitis based on the history that he took. He testified that he recalled Petitioner telling him that he had been having coughing difficulties for years, but it was not documented in his records. He agreed that individuals had coughs for many different reasons, and he further testified that it was referenced in Dr. Cope's note of February 17, 2009 that there was mention of a cough. He testified that his records did not include a report of Dr. Sanjabi, and he denied knowing or ever hearing of Dr. Sanjabi.

He testified that he was not aware that Dr. Sanjabi had examined Petitioner and thought there was another cause for his complaints of coughing. He further agreed that he was not aware that Dr. Sanjabi directed his office to send a copy of his report to the treating family physician, nor did he know that Dr. Sanjabi directed Petitioner to report the problem and to seek medical treatment from his family physician. (PX2).

On cross-examination, Dr. Alverez testified that it was his impression that Petitioner had chronic bronchitis, which was multi-factorial. He testified that tobacco smoke played a role, but so did inorganic particles like coal dust that he spent many years underground breathing daily. He testified that he did not recall why he did or did not take a more expanded history and include that within his medical records. He agreed that he last saw Petitioner on June 14, 2011 and that he left the clinic approximately two years later in July of 2013. He agreed that, to his knowledge, Petitioner never returned. (PX2).

On cross-examination, Dr. Alverez agreed that Petitioner's cough could be due to esophageal reflux disease, and should be looked into as part of the differential diagnosis. He agreed that the condition was contained in the medical history that he obtained from Petitioner. He agreed that he did not recall whether Petitioner obtained the breathing medications he prescribed. He testified that when he first met Petitioner, he documented a 35-pack-year history. (PX2).

On cross-examination, Dr. Alverez agreed that when he saw Petitioner on June 14, 2011, Petitioner reported that he had a chronic cough for approximately one month and that he had taken Flovent and Albuterol in the past which did not help. He testified that if Petitioner's coughing was due to his gastroesophageal reflux, this would not explain why the breathing medications were not helping his cough. He denied seeing any chest x-rays, and he further denied ordering any type of breathing treatments for Petitioner other than the medications. He also denied ordering any pulmonary function studies and further testified that he had never seen those studies. He agreed that he had never seen any x-ray reports for Petitioner. He also testified that there was no medical testing to establish a diagnosis of chronic bronchitis, but rather it was a historical diagnosis. (PX2).

On redirect examination, Dr. Alverez he confirmed that he felt Petitioner's diagnosis of chronic bronchitis was confirmed by the clinical presentation on the date that he saw Petitioner as well as his history. (PX2).

On further cross-examination, Dr. Alverez testified that when he saw Petitioner on June 14, 2011, he denied that Petitioner was in the middle of an acute medical situation but rather it was a chronic complaint of no improvement of his cough. (PX2).

The transcript of the evidence deposition of June Blaine was entered into evidence at the time of arbitration as Petitioner's Exhibit 3. She testified that she was a vocational rehabilitation counselor and had been so for 33 years. She testified that she rendered opinions for petitioners as well as insurance companies and believed it was a pretty even split, but in the past had been more towards the company side. (PX3).

Ms. Blaine testified that she performed a vocational assessment of Petitioner, and that her report was dated November 29, 2013. She agreed that she was asked to assume that Petitioner could no longer work as a coal miner anymore, and that she was further to construe any physical limitations most favorably for the coal company. She agreed that she was not given any medical records in this case to review. She testified that if she was assuming that Petitioner had no physical limitations beyond what a person his age would have, it was not necessary to have records. She agreed that her assessment was based primarily on his age, education, training, work experience, and transferable skills. (PX3).

Ms. Blaine testified that she met Petitioner on November 19, 2013. She testified that he was 54 years of age, lived with his wife in Springerton, Illinois and had worked for Respondent since approximately 1985. She testified that Petitioner had no education after seventh grade, and indicated that he had problems learning when he was in school. She testified that he did not have the ability to do any type of reading, and that he had no experience with using either cell phones or computers. She testified that Petitioner reported that if something came up in the mine that required him to read, Petitioner would get another miner or his supervisor to help him. She testified that it was her understanding that it was not a surprise to the supervisor that Petitioner was not able to read. (PX3).

Ms. Blaine testified that Petitioner reported a work history which included driving a shuttle car and being a roof bolter for approximately five years for Wood Coal Company, and that in 1985 he began working for White County Coal. She testified that he described working in various positions for White County, including being a roof bolter for about five years and being a shuttle car operator for about 10 years. She testified that Petitioner operated a scoop and a continuous miner, and then worked on the belt crew. She testified that he reported he was with White County Coal a total of 25 years, and that in 2010 he was terminated by the company over what he described as some kind of a time card-related issue. She testified that she performed the vocational testing, on which Petitioner scored grade 1.7 on math computation, a kindergarten level in reading and below kindergarten level in comprehension. She testified that she did not think she had tested anyone that ever tested that low. (PX3).

With respect to the subjective information, Ms. Blaine testified that she asked Petitioner about some of the breathing problems he was having, and that he reported he had coughing spells where he would almost pass out. She testified that he talked about having difficulty getting enough air when breathing and that cold weather bothered him. She testified that he reported having prescriptions for inhalers but that he was only able to pay for one of them. She testified that he applied for Social Security, was denied and had reapplied. (PX3).

Ms. Blaine testified that Petitioner was embarrassed by the fact that he could not read and was very nervous about trying to do any testing. She testified that she did not question that he was not being straightforward about his lack of literacy. She testified that she believed that Petitioner was at a severe disadvantage in terms of his ability to find a job in the open labor market, and that the main reason was his literacy. She testified that she did not think that Petitioner was going to be able to find work, and that there were a number of factors involved including his extremely limited education, his lack of computer experience, his lack of a GED and the fact that he was functionally illiterate. She testified that if Petitioner did find something, she would assume it would be a minimum wage-type position and would be entry level. (PX3).

On cross-examination, Ms. Blaine testified that if Petitioner was 40 years of age, she would look at some type of remedial reading in order to move towards a GED. When asked if there were innumerable jobs that people without the ability to read could do, Ms. Blaine responded that the fact that Petitioner did not have a GED put him at a disadvantage. She agreed that there could be positions available in his geographical area that did not require any formal education. She testified that Petitioner did not tell him what he had been doing to find employment since 2010. She denied being aware that Petitioner's wife worked outside the home, but that she babysat for her daughter so she could work. She testified that she did not go into the specifics of Petitioner's financial situation. (PX3).

On cross-examination, Ms. Blaine agreed that the testing she administered was not completely objective in that there might be some individuals that would say they could not perform something. She testified that the testing took approximately 30 minutes to administer. She denied that Petitioner told her when he initially filed for Social Security and admitted that she did not ask the year. She denied that

Petitioner told her why he had filed for Social Security. She testified that she did not ask whether Petitioner had any other possible medical disabilities. (PX3).

On cross-examination, Ms. Blaine denied that Petitioner went into any further detail about what happened with his termination from Respondent beyond saying it was an issue with a time card. She testified that she understood that he was assisted in obtaining his certificates or passing his tests by co-workers. She testified that Petitioner reported that he had the driver's license test read to him in order to obtain his license. She testified that it was her understanding was that as long as you could pass the written test and could see the signs and understand what they meant, you could get a driver's license in the State of Illinois. (PX3).

On cross-examination, Ms. Blaine agreed that because she did not review any medical records, her opinions were based on what Petitioner told her and therefore his credibility and honesty was important. She agreed that if Petitioner exaggerated his inability to perform things or was not honest with her on certain factors, it could affect her opinions. She agreed that if a couple of the supervisors testified that he did not have any problem reading things in the coal mine her opinions could be affected, but added that the testing that she performed also confirmed for her that he had difficulty reading. She testified that she did not go into any discussion with Petitioner about what he had been doing about trying to make a living in the three years between when he stopped working for Respondent and the day that she saw him. (PX3).

The medical records of Smith Radiology, Inc. were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner's chest x-rays were reviewed on April 20, 2010 by Dr. Henry Smith, whose impression was that of simple coal worker's pneumoconiosis with interstitial fibrosis with small opacities p/s, all zones involved bilaterally with a profusion 1/10, bilateral chest wall plaques in profile and face on. It was noted that the date of the radiographs was that of March 30, 2010. (PX4).

The medical records of Smith Radiology reflect that Dr. Smith also reviewed a CT of the chest performed on March 21, 2012 at Methodist Hospital in Henderson, KY, which was interpreted as revealing simple coal worker's pneumoconiosis with interstitial fibrosis p/p, all zones involved, profusion of at least 1/0 to possibly 1/1 with no other significant associated abnormalities according to the letter directed to Petitioner's attorney dated February 5, 2014. (PX4).

The medical records of Dr. Alverez/Hamilton Hospital Family Practice were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner was seen on February 17, 2009 at which time he reported a chief complaint of nausea, and also that he noted coughing that came and went and that he sometimes coughed until he vomited. The assessment was that of uncontrolled hypertension, non-insulin dependent diabetes mellitus, coronary artery disease, hyperlipidemia, history of back surgery and coughing, medication-induced. (PX6).

The records of Dr. Alverez/Hamilton Hospital Family Practice reflect that Petitioner was seen on March 4, 2009, at which time Petitioner reported complaints of bilateral rib pain every time he coughed. Petitioner was assessed with cough, Type II diabetes and pleurisy without mention of effusion. Petitioner was seen on October 16, 2009, at which time he reported increased coughing when lying down and that his cough was worse that time of year, among other issues. It was noted that Petitioner needed an upper GI due to his persistent supine cough to reassess his GERD status. Petitioner was seen on May 14, 2010 for a medication refill, at which time it was noted that he lost his job and could not afford his medications. It was noted that he had not been taking his medications because he lost his job and could not afford them, but that he now had the medical card. (PX6).

The records of Dr. Alverez/Hamilton Hospital Family Practice reflect that Petitioner was seen on November 12, 2010, at which time it was noted that Petitioner had a one pack per day for 35 years smoking history, and that he had an acute complaint of chronic cough especially during the wintertime. Petitioner reported that the cough was productive of phlegm. It was noted that for Petitioner's chronic bronchitis, he was prescribed ProAir and Flovent. The records reflect that Petitioner was seen on June 14, 2011, at which time it was noted that Petitioner was without medical insurance and had not filled his diabetic medications for four months. Petitioner also reported a chronic cough that he had had for a month, and that he had taken Flovent and Albuterol in the past and had not helped with the cough. Petitioner was assessed with cough and uncontrolled diabetes. (PX6).

The medical records of Hamilton Memorial Family Clinic were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner was seen on November 27, 2012 with issues related to diabetes, hyperlipidemia and hypertension. It was noted that Petitioner had a chronic cough, and that his Lisinopril was stopped secondary to suspicion of captopril cough. Petitioner was seen on April 7, 2014 for a cough with a noted onset of three months ago. It was noted that he had smoked for years and had a chronic cough. Petitioner was assessed with chronic bronchitis and referred for a pulmonary consult. Petitioner was seen on June 9, 2014, at which time it was noted that he was to see the pulmonologist that week and was on inhaled steroids. Also included within the medical records was an interpretive report for chest x-rays performed at Hamilton Memorial Hospital on May 7, 2014, which were interpreted as revealing no acute cardiopulmonary process. (PX6).

The medical records of Crossroads Physicians Corporation were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records reflect that Petitioner was seen on June 11, 2014 for a follow-up visit for chronic obstructive pulmonary disease and GERD. Petitioner was also seen on May 7, 2014 for a follow-up visit for chronic obstructive pulmonary disease and GERD. Petitioner's cough was noted to be improving in severity, and that his pulmonary function testing was normal. The assessment was that of GERD vs. eosinophilic bronchitis. (PX7).

The records of Crossroads Physicians Corporation reflect that Petitioner was seen on April 16, 2014 for a follow-up visit for chronic obstructive pulmonary disease and GERD. It was noted that Petitioner was doing much better, and that his cough and shortness of breath was much improved. Petitioner was seen on April 9, 2014 for a chief complaint of cough. Petitioner was recommended to start taking Prednisone and inhalers.

The Subrogation Notice from the Illinois Department of Healthcare and Family Services dated September 8, 2010 was entered into evidence at the time of arbitration as Petitioner's Exhibit 9.

The deposition of Dr. Jeffrey Selby was entered into evidence at the time of arbitration as Respondent's Exhibit 1. Dr. Selby testified that he is board-certified in internal medicine and pulmonology. He testified that he has been a certified B-reader since 1985. (RX1).

Dr. Selby testified that he examined Petitioner on March 21, 2012, and that as part of the evaluation he ordered a multitude of testing including pulmonary function testing, chest x-rays and a CT of the chest, among others. He testified that the objective abnormal findings on physical examination included obesity with a protuberant abdomen and the tobacco smoke smell on his hand. He testified that the obesity had an impairing quality to exercise ability and gas exchange. He testified that the smoking history obtained by Petitioner included smoking ½-1 pack a day off and on for five years, and that he had not smoked in 2-3 years. He testified that Petitioner changed his history after confronted with his carbon monoxide level, and admitted that he was still smoking. (RX1).

Dr. Selby testified that the pulmonary function studies were normal, and his medical interpretation of those studies was that Petitioner had no lung disease. He testified that following his evaluation and after reviewing all of the studies and testing that had been performed, he believed that Petitioner did not suffer from any respiratory abnormality. He further testified that he did not believe that Petitioner had coal workers' pneumoconiosis. He testified that with respect to Petitioner's shortness of breath, shortness of breath was totally subjective and that if Petitioner had true shortness of breath then the likely cause was his obesity, his deconditioned state and his cigarette smoking. (RX1).

Dr. Selby testified that he later authored a supplemental report dated April 2, 2014 based on his review of additional information including Dr. Paul's report and his deposition. He testified that the significant difference was that Dr. Paul thought that Petitioner had fibrosis on his x-ray that also accounted for the abnormal diffusion capacity that he noted, while he did not feel either one of those truly reflected the condition of Petitioner. He agreed that Dr. Paul's pulmonary function study showed an abnormal diffusion capacity result, while his study showed a normal one. He testified that for a diffusion capacity to be valid there needed to be curves included on the report, and that the graphs or readings from the machine were vital to fully evaluate the accuracy of the testing. He testified that the graph was not present in Dr. Paul's report. (RX1).

Dr. Selby testified that the diffusion capacity, depending on the disease that caused the abnormality of the diffusion capacity, could wax and wane due to mucus plugging, blocking of particular parts of the airway, congestive heart failure, pneumonia or an acute inflammatory reaction or infection. He testified that when it was used to look at a chronic illness, it did not wax and wane. (RX1).

Dr. Selby testified that if a patient smoked a pack or two of cigarettes in the day or so before a pulmonary function study, it would affect the study. He testified that the diffusion capacity was geared towards carbon monoxide in the lungs because carbon monoxide so quickly attached to the red blood cells. (RX1).

Dr. Selby testified that the New England Journal of Medicine article attached to his supplemental report was given to show the good correlation between a normal diffusion capacity and the lack of dropped PO2 with exercise. He testified that in this case, they could predict, according to the article, with 100% accuracy that Petitioner's oxygen level would go up or at least not desaturate with exercise, and he confirmed that it happened in this case and showed that his diffusion capacity was accurate. (RX1).

Dr. Selby testified that after he was provided with Dr. Paul's report and deposition transcript, none of his opinions or diagnoses changed in this case. He testified that there was nothing in the pulmonary function study that caused him any concern about being inaccurate in any way. (RX1).

On cross-examination, Dr. Selby agreed that for a person to have coal workers' pneumoconiosis, in addition to having coal mine dust in the lungs a tissue reaction was also required. He agreed that the tissue reaction was called scarring or fibrosis. He agreed that around the coal mine dust and the scarring that developed, there would be a halo of emphysema around the scarring. He disagreed, however, that the scarring of coal workers' pneumoconiosis could perform the function of normal, healthy lung tissue. (RX1).

On cross-examination, Dr. Selby agreed that if a person had pneumoconiosis, they would necessarily have impairment in the function of their lung at the very site of the scarring. He testified that spirometry measured the function of the entire lung. He agreed that a person can have shortness of breath and have pulmonary function tests within the range of normal, and that a person could have a lobe of the lung surgically removed and still have pulmonary function tests within the rage of normal. (RX1).

On cross-examination, Dr. Selby agreed that the predicted range of normal covered 95% of the population with 2.5% below the range and 2.5% above, and that the middle of the bell-shaped curve was 100%. He agreed that pulmonary function tests indicated the kind of abnormality and the severity, but did not indicate the etiology. He also agreed that if one wanted to know if a miner's pulmonary function was impaired from what it used to be, the way to measure that would be to compare the pulmonary function to what it was before the injury rather than comparing it to a range of normal. (RX1),

On cross-examination, Dr. Selby agreed that it was possible that a person could have injury or damage to their lungs and could lose from 110% of predicted value down to 85% of predicted and still be in the range of normal but they would have some injury or pulmonary problem. He testified that emphysema if causing any kind of a ventilator defect would be obstructive but did not totally exclude the possibility of restrictive functional defect. He testified that scarring in the lungs tended towards restrictive defect, but there were shades of gray. He agreed that removal of any further exposure to coal dust was the only treatment for coal workers' pneumoconiosis and that coal workers' pneumoconiosis did not have a cure. He agreed that if a person continued their exposure after they have coal workers' pneumoconiosis, it is a chronic, slowly-progressive disease. He agreed that continued exposure and progressing pneumoconiosis could progress to conditions called progressive massive fibrosis or cor pulmonale. He testified that progressive massive fibrosis was potentially life-threatening, but that cor pulmonale was not life-threatening but was an indicator that there was possibly something else that was life-threatening. (RX1).

On cross-examination, Dr. Selby testified that if an individual left the mine with category 1 pneumoconiosis and did not have any more exposure, he thought that the vast majority did not progress any further. He agreed that it was generally true that if someone was diagnosed with coal workers' pneumoconiosis at some time in their life, they probably had the same level of pneumoconiosis when they left the mine. He agreed that it was possible for a person to have radiographically-significant coal workers' pneumoconiosis and have normal findings on physical examination of the chest, and that it was possible for a person to have radiographically-significant coal workers' pneumoconiosis and have normal pulmonary function arterial blood gas testing. He agreed that a miner could have coal workers' pneumoconiosis for a long time before he even knew that he had radiographic changes. (RX1).

On cross-examination, Dr. Selby agreed that it would be his expectation that if an individual had category 1 radiographic coal workers' pneumoconiosis that he probably would not be having abnormal pulmonary function tests, blood gases or physical examination of the chest or symptoms. He testified that CT scans were not officially recognized by NIOSH for the purpose of making B-readings, nor were digital chest x-rays. He agreed that NIOSH had sample films for reading analog chest x-rays for guidelines for the reader, but they had no such films for digital x-rays or CT scans. He agreed that NIOSH had standards for the equipment used and how one was supposed to take analog chest x-rays, but that no such protocols existed for the machines that take CT scans or digital x-rays or the machines that displayed them. (RX1).

On cross-examination, Dr. Selby testified that the cuts were to be 1-2mm to qualify as a high-resolution CT scan, but each institute tended to have their own protocol. He agreed that the reports typically did not indicate the intervals between slices. He testified that in the intervals between the cuts, there was no radiographic presentation and that this was the protocol that was used for any interstitial lung disease and was acceptable by the American College of Radiology. (RX1).

On cross-examination, Dr. Selby agreed that his typical practice was to complete the examination and report prior to looking at the individual's treatment records in order to assure that his opinions were not biased by anything that may be contained in the records. He agreed that he was familiar to some degree with the December of 2000 *Federal Register*, which contained the position of the Department of

Labor and NIOSH concerning the role of coal mine dust in the development of obstructive lung disease as well as the review of literature that supported those issues. He testified that the global literature was being applied to a specific region of the country, and that it was never intended for that. He testified that there was no hard coal in the tri-state region, and that his experience from this region was that they saw nothing near the degree of obstruction purely from coal mine exposure as what was purported to occur in the literature. (RX1).

On cross-examination, Dr. Selby agreed that the ratio of two years of coal dust exposure to one year of cigarette smoking was greater than that in the tri-state area. He testified that in his experience, it rarely occurred that someone had chronic obstructive pulmonary disease purely from coal mining. He agreed that he was familiar with the American Thoracic Society's official position statement in 2002 concerning obstructive lung disease in the workplace, but disagreed that the risk from inhalation of mine dust was as great as the risk from cigarette smoking at least in the tri-state area. (RX1).

On cross-examination, Dr. Selby agreed that while there were many insults that the lung may suffer, there were only a relatively few reactions it could have to those different insults. He testified that the 3,500 chemicals that were known to be contained in cigarette smoke could incite their own chemical reactions different than the inert carbon from coal dust. (RX1).

On cross-examination, Dr. Selby testified that he worked a period of time as an emergency room doctor in Henderson, Kentucky, and that he did so for the time period of May 15, 2001 through November 15, 2002. He testified that his son and a friend were starting out their Internet business, and that he allowed them to use him as their test site with respect to his availability for testimony and travel to court. (RX1).

On cross-examination, Dr. Selby agreed that at the time of the examination, Petitioner's main complaint was coughing and back pain, and that he wheezed and coughed every day. He agreed that Petitioner reported taking Flovent and Ventolin, and that the medicines could be used for coughing. He testified that Ventolin and ProAir were both forms of Albuterol, and that Flovent was an inhaled steroid. He testified that it was used to decrease the inflammation of the airways, and that it may affect the mucus. (RX1).

On cross-examination, Dr. Selby agreed that he found Petitioner's EKG to be abnormal, which was not unexpected given his myocardial infarction, cardiac catheterization and stent placement. He agreed that chronic lung disease could put a burden on the functioning of the heart. He testified that he did not know why Karen Bickett read the CT scan instead of Anthony Perkins, but that she filled in for him sometimes. He agreed that the reason Petitioner stopped his exercise testing was because he was out of air, and that the exercise test was submaximal. (RX1).

On cross-examination, Dr. Selby agreed that Petitioner's baseline or resting PO2 was 65, which was below the lower limit of normal of 80 at his lab. He agreed that a person can experience shortness of breath with normal pulmonary function testing. He testified that he thought that Petitioner had about 30 years of underground coal mining, and agreed that this could be sufficient to cause shortness of breath in a susceptible person. He agreed that a person could have a reduction in exercise tolerance despite having a normal diffusing capacity, and that a person could have a diffusing capacity below 55% and still have no desaturation with exercise. (RX1).

On cross-examination, Dr. Selby agreed that in the article in his supplemental report the study included only individuals with moderate to severe COPD. He denied that Petitioner had moderate to severe COPD, and further denied that Petitioner had COPD at all. He agreed that the purpose of the study was to try to determine ways to predict a need for oxygen therapy, and that was what a person with severe

COPD might have. He denied that Petitioner had a need for oxygen therapy. He agreed that the study was to predict whether there would be arterial oxygen desaturation with exercise based on what the diffusing capacity was. He further agreed that he tested Petitioner for desaturation and found none. (RX1).

On cross-examination, Dr. Selby agreed that a person can have coal workers' pneumoconiosis or chronic bronchitis with a normal diffusing capacity and no desaturation. He agreed that if a person wanted to do the best thing they could to keep coal workers' pneumoconiosis or chronic bronchitis from progressing, they should avoid getting around exposures that could cause or aggravate chronic bronchitis or coal workers' pneumoconiosis. (RX1).

On cross-examination, Dr. Selby denied currently being associated with Select Specialty Hospitals but agreed that he was at one time for a few years. He testified that his association ended 2-3 years ago. He testified that after he left, there was something brought into question about the bronchoscopies that he was performing. He testified that lawsuits were filed in which he was involved, but denied that it included "bad results" that he had had from bronchoscopies. (RX1).

On redirect examination, Dr. Selby testified that cigarette smoking caused an acute inflammatory response to the airways, producing more mucus and thus the production of coughing and spitting which would lead to the diagnosis of chronic bronchitis. With respect to Petitioner's cigarette smoking history, Dr. Selby testified that Petitioner told him that he only smoked ½-1 pack a day for about 5 years and that he quit smoking 2-3 years before he saw him. He testified that if his pack year was really 35 pack years or greater, it would help him to understand better why his carbon monoxide levels and nicotine levels were in the range that they were and that he was in fact smoking when he saw him, as opposed to what Petitioner reported. (RX1).

On further cross-examination, Dr. Selby agreed that in addition to smoking, inhalation of coal mine dust and the exposure in a coal mine could also cause or aggravate chronic bronchitis, and that chronic bronchitis could result in mucus plugging in the lungs. He further agreed that mucus plugging could result in a reduced diffusing capacity measurement. (RX1).

CONCLUSIONS OF LAW

With respect to disputed issues of disease and causal connection, to recover compensation under the Workers' Occupational Diseases Act, a claimant must prove that he suffers from an occupational disease and that a causal connection exists between the disease and his employment. An occupational exposure need not be the sole or principal causative factor, as long as it was a causative factor in the condition of ill-being. *Bernardoni v. Indus. Comm'n*, 362 Ill.App.3d 582, 596 (2005).

In this case, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he suffers from coal workers' pneumoconiosis that arose out of and in the course of the exposures of his coal mine employment, and that his current condition of ill-being is casually related to his employment. In so concluding, the Arbitrator finds the x-ray interpretation of Dr. Selby to be more persuasive than the interpretations of Drs. Smith and Paul in this case. While Dr. Paul opined that Petitioner has coal workers' pneumoconiosis, he completely failed to identify the date of the x-rays that he reviewed in coming to his conclusion. Furthermore, Dr. Paul admitted on cross-examination that he is not a B-reader, and that he is not board-certified in pulmonary disease. (PX1).

The Arbitrator notes that Dr. Selby, on the other hand, is board-certified in pulmonology, which the Arbitrator finds to be significant in this case. (RX1). Dr. Selby was thorough in his evidence deposition testimony regarding the basis for his finding of a lack of causal connection based on his interpretation of the chest x-rays and CT scans reviewed, whereas the reports of Dr. Smith were very cursory in providing the basis for his opinions. (PX4). As such, the Arbitrator places greater weight on the testimony of Dr. Selby in support of the finding of Petitioner's failure to prove that he suffers from coal workers' pneumoconiosis that is casually related to his coal mine employment.

Based upon the foregoing, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that he suffers from coal workers' pneumoconiosis that is casually related to his coal mine employment.

The Arbitrator further finds that Petitioner failed to prove by a preponderance of the evidence that he has chronic bronchitis causally related to the exposures of his coal mine employment. In making such a conclusion, the Arbitrator finds the opinions of Dr. Selby to be more informed and well-founded in the records than the opinions of Dr. Paul. The Arbitrator notes that Dr. Selby reviewed Petitioner's treating records, whereas Dr. Paul admitted that he did not review any medical records at the time that he saw Petitioner, but that later Petitioner's attorney sent him a letter referencing medical records of Dr. Alverez. The Arbitrator notes that Dr. Selby's opinion that Petitioner does not suffer from chronic bronchitis is consistent with the lack of reported consistent symptomatology in Petitioner's treating records. The Arbitrator recognizes that there are several notations within Dr. Alverez's records suggesting that Petitioner voiced complaints of coughing which appeared to be intermittent in nature, but the Arbitrator also notes that the records suggested that Petitioner's coughing was related to either his medications or his other co-morbidities such as GERD.

Additionally, the Arbitrator notes that Dr. Paul originally only diagnosed Petitioner with coal workers' pneumoconiosis in his report dated December 5, 2012 and that he did not even suggest the diagnosis of chronic bronchitis until the time of his evidence deposition on November 11, 2013. As such, the Arbitrator is not persuaded by the causation opinion tendered by Dr. Paul on behalf of Petitioner as it pertains to the issue of chronic bronchitis.

Finally, the Arbitrator notes that the testimony of Dr. Selby that the smoking history obtained from Petitioner included smoking ½-1 pack a day off and on for five years, that he had not smoked in 2-3 years, and that Petitioner changed his history after confronted with his carbon monoxide level and admitted that he was still smoking caused the Arbitrator to call into question the veracity of entirety of Petitioner's testimony at the time of arbitration. (RX1).

Based upon the foregoing and the record in its entirety, the Arbitrator concludes that Petitioner failed to prove that he suffers from coal workers' pneumoconiosis or chronic bronchitis that arose out of and in the course of the exposures of his coal mine employment, and that his current condition of ill-being is casually related to his employment. All benefits are denied. The remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

WANDA BYRD,

Petitioner,

vs. NO: 08 WC 44720

KEEPERS INSTITUTE FOR DEVELOPMENT AND SAFETY and STATE TREASURER AS *EX-OFFICIO* CUSTODIAN OF INJURED WORKERS' BENEFIT FUND,

Respondent.

17IWCC0830

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 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 following corrections:

1 – The phrase "as a matter of law" is hereby stricken from the first sentence of the second paragraph of the Nature and Extent section.

2 – The medical expenses award contained in the body of the decision is hereby incorporated into the Order.

IT IS THEREFORE ORDERED BY THE COMMISSION that the decision of the Arbitrator filed March 28, 2017, with the above corrections, is hereby affirmed and adopted.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit

17IWCC0830

for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $24,900.00. 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: DEC 26 2017

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

LEC/mck

D: 12/13/17

43

Charles J. DeVriendt

Charles J. DeVriendt

Joshua D. Luskin

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BYRD, WANDA
Employee/Petitioner

Case# **08WC044720**

17IWCC0830

ILLINOIS STATE TREAS AS EX OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND AND KEEPERS INSTITUTE FOR DEVELOPMENT AND SAFETY
Employer/Respondent

On 3/28/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.90% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

2221 VRDOLYAK LAW GROUP LLC
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CHICAGO, IL 60654

0863 ANCEL GLINK
BRIT ISALY
140 S DEARBORN ST SUITE S-600
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CHRISTOPHER FLETCHER
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CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Wanda Byrd
Employee/Petitioner

v.

Case # **08** WC **44720**

Consolidated cases: **None**

Illinois State Treas. as ex officio custodian of the Injured Workers Benefit Fund and Keepers Institute for Development and Safety
Employer/Respondent

17IWCC0830

An *Application for Adjustment 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 **10/24/16 and 11/21/2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☒ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☒ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☒ What was Petitioner's age at the time of the accident?
I. ☒ What was Petitioner's marital status at the time of the accident? How many dependents on accident date?
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 _____

17IWCC0830

FINDINGS

On **9/10/2008**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$13,119.60**; the average weekly wage was **$252.30**.

On the date of accident, Petitioner was **49** 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 **$8600.54** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$8600.54**.

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

ORDER SEE ATTACHED ADDENDUM ORDER

Respondent shall pay Petitioner temporary partial disability benefits of $237.67/week for 46 1/7 weeks, commencing 9/11/08 through 7/30/09, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $237.67 /week for 75.15 weeks, because the injuries sustained caused the 45% loss of use of the left foot, as provided in Section 8(e) of the Act.

Injured Workers Benefit Fund see attached addendum order.

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 George J. Andros — **March 28, 2017**

Signature of Arbitrator — Date

MAR 2 8 2017

STATEMENT OF FACTS 08 WC 44720

Petitioner testified before the arbitrator who had opportunity to view her demeanor, listen to speech patterns, voice inflection plus her assured and forthright responses. This was done under well organized direct examination plus insightful , focused cross-examination.
Ann Campbell was called as an adverse witness by petitioner. The arbitrator observed the demeanor of Ann Campbell under direct examination and under cross-examination.

Ann Campbell testified: on September 10, 2008 she was the owner of Keepers Institute for Development and Safety; this was a business operating in the State of Illinois in which services were rendered to the public at large; for the year preceding September 10, 2008 the payroll for that entity was in excess of $1000. T 10-11. She testified: this was a child care agency; on September 10, 2008 Wanda Byrd worked for Keepers Institute for Development and Safety; petitioner provided childcare services. The witness testified she set the schedule of when petitioner would start and when she would finish. T 11-12. Witness testified: she paid petitioner salary of nine dollars per hour on September 10, 2008; she withheld from her salary federal income tax and Social Security wage; she paid petitioner as an employee not as an independent contractor; petitioner rendered services to Keepers Institute for Development and Safety at a facility in Chicago located at 2718 W. 59th St. T-12. The witness testified: Keepers Institute for Development and Safety maintained the interior parts of that facility; on September 10, 2008 petitioner was working as an employee and was injured at the facility when she slipped on water that was soaked into a carpet pad in the break room of the facility. T 13. The witness testified: petitioner gave her notice of the fact that she was injured; the witness came into the break room and saw petitioner lying on the ground. T 13-14. The witness agreed that if records during the one year prior to the date of the accident of September 10, 2008 indicate petitioner was paid $13,119.60 she has nothing to dispute that; petitioner worked for respondent for at least one year before the date of the accident; that petitioner worked through the summer through all 52 weeks of that year. T 15. The witness testified that after September 10, 2008 petitioner never returned to work for Keepers Institute for Development and Safety. T 15-16. The witness testified that on September 10, 2008 Keepers Institute for Development and Safety did not have any active workers compensation insurance. T-16. The witness testified in her capacity as owner of the entity she would be knowledgeable of whether or not there was workers compensation insurance on September 10, 2008. T 17. The witness's office with Keepers Institute for Development and Safety was executive director; it was a not-for-profit corporation. T 17-18.

On cross-examination Ann Campbell testified Keepers Institute for Development and Safety is a corporate entity; she was the president of that entity and the executive director. T-19.

Wanda Byrd testified she is 50 years old born in September 27, 1958; she is 5'9" tall and at hearing weighed 370 pounds; on September 10, 2008 she was 250 pounds. T 21.

Petitioner testified: before September 10, 2008 she had no problems with her left ankle or foot; she had not sought medical treatment for her left ankle or foot for any reason from any medical doctor prior to September 10, 2008;

On September 10, 2008 she was involved in an accident at work; subsequent to September 10, 2008 she did not injure her left ankle in any other accidents; before September 10, 2008 she had no problems with her right ankle or foot. T 22-23. She worked for Keepers Institute for Development and Safety as a teacher at the facility on 59th St. in Chicago; she had worked there for one year prior to September 10, 2008. T 23. Her job was a teacher in a classroom working with toddlers anywhere from one year old to 2 ½ years old; this is the job she had with keepers Institute from the time she was hired up until September 10, 2008; she was hired by Ann Campbell; Ms. Campbell paid her a salary of nine dollars per hour; the nine dollars per hour was paid based upon the number of hours she worked. T 24-25. She worked for keepers Institute from 9 o'clock to 6 o'clock five days a week; those hours were set by Ms. Campbell. T 25. The facility where she rendered those services was maintained by Keepers Institute for Development and Safety. T 25. There were 20 students in her class; there were four classes of 15 to 20 students per classroom for a total of approximately 80 students. T 26-27. Ann Campbell was the person in charge of keepers Institute for development and safety; Ms. Carr was the second in charge; Ms. Carr was the director. T 27-28.

On September 10, 2008 she was single; she had one dependent under the age of 18 years who she supported. T 28.

She injured herself on September 10, 2008 and gave oral notice of the injury to Ann Campbell on September 10, 2008; Ms. Campbell saw her lying on the floor at accident time. T 29.

On September 10, 2008 she started work at 9 o'clock in the classroom; at approximately 4 o'clock to 5 o'clock in the evening class was still in session; the accident occurred in the break room of the facility operated by Keepers Institute for Development and Safety. T 30-31. Petitioner testified: there was water coming out of a wash machine in the break room; she had taken her children to the playground approximately 2 o'clock; on the way back into the facility around 4 o'clock there was a teacher in front leading the children from the front and petitioner was in the back; she turned to close the door and as she turned she stepped onto a rug in the doorway and her foot slipped; she went into the air and came down on her left ankle. T 32. There was water underneath the rug that caused her foot to slip; the rug was saturated with water. T 33. Petitioner testified: her right foot slipped and went straight up and she came down; the water that was coming from the wash machine had saturated the rug. T 34. The only way to get the children in and out from taking them to the playground is through the break room. T 35. Petitioner testified when she fell to the ground she felt pain in her left ankle and heard a crack and snap in her left ankle; she had never felt pain in that left ankle prior to this incident. T 36. Petitioner testified a coworker came into the room and went to get Ms. Campbell who came in to the break room where petitioner was on the ground; petitioner talked to Ms. Campbell there; she left the break room of the facility in an ambulance and was taken to Holy Cross Hospital. T 36-37. (2)

Petitioner testified she was treated at the emergency room of the Holy Cross Hospital. These records reveal as Px.1: petitioner gave history on 9/10/2008 slipped on wet rug at work, PX 1, p 8; complained of numbness to the left leg, PX 1, p 9. X-ray of the left ankle was interpreted to reveal: very marked swelling of the lower leg and ankle with a fracture dislocation noted with the posterior portion of the tibia being fractured off and there is a lateral dislocation of the talus with marked widening of the medial aspect of the ankle mortise, which could indicate accompanying severe ligamentous injury; at the tip of the medial malleolus is a small bony density which could represent an avulsion fracture or perhaps even some chronic arthritic changes. PX 1, p 15. Petitioner was diagnosed with a left ankle fracture and ordered crutches, Vicodin and follow-up with her HMO. PX 1, p 12. The bill for services rendered at Holy Cross Hospital is in the amount of $1002.25. PX 1, p 17. The Argent crutch bill is $56.63. PX 2.

Petitioner testified her nephew drove her home. Next day she made an appointment to see a doctor. She filled the prescription for medication through Walgreens. T 40-41. Petitioner testified her sister took her to the Provident Hospital of Cook County the next day September 11, 2008 where she was treated in the emergency room. T 41. See record plus bill as Px. 3. These records reveal petitioner gave history: slipped and fell yesterday was seen at Holy Cross was told left ankle is chipped. PX 3, p 8. Petitioner was ordered to follow up with Orthopedic Fracture Clinic on 9/16/8; take Vicodin as already prescribed; return to ER if swelling/pain/numbness of left leg worsens with diagnosis of left distal tibial fracture. PX 3, p 6. X-ray of the left ankle was interpreted to reveal fracture of the posterior malleolus, evidence of avulsion fracture from the tip of the medial malleolus, overlying soft tissue swelling, superior and inferior calcaneal spus. PX 3, p 15. Bill in the amount of $361.50 was issued by Provident Hospital of Cook County for the services rendered. PX 3, p 106. Petitioner testified she left Provident Hospital that day and made an appointment at the Stroger Hospital Orthopedic Department. T 44. Petitioner testified that the first date available at Stroger hospital was September 16, 2008. She was using crutches and taking Vicodin. T 44-45.

The medical records and bill of John H Stroger Hospital are Px. 4. On 9/16/2008 petitioner gave history: left ankle pain one week ago fell left foot turning out laterally with audible crack; extreme pain. PX 4, p 71. X-ray of the left ankle was interpreted to reveal widening of the ankle mortise; posterior malleolar fracture. PX 4, p 73. Surgery was ordered. PX 4, p 71. On 10/3/2008 surgery was performed on petitioner by Jorge Xavier Prieto, M.D. consisting of open reduction and internal fixation of Maisonneuve injury/syndesmotic rupture, left ankle on postoperative diagnosis: Maisonneuve injury, left ankle with ruptured syndemosis. PX 4, p 36-37. (Emphasis added)

On 10/16/2008 a cast was applied and she was ordered to return in four weeks. Examination indicated the injury was healing. PX 4, p 30. On 11/3/2008 x-ray shows well aligned; use of the cast was discontinued and ankle range of motion exercises were ordered. PX 4, p 26.
12/11/2008 doing okay; still has pain; x-rays demonstrate screws in place. Petitioner was ordered to return in three months. PX 4, p 22.

On 2/26/2009 a follow-up note shows Vicodin once a day to relieve pain; also complaining of nerve pain extending to her hip; PT was ordered. PX 4, p 18. Progress note of 2/26/2009 indicates: continued pain most common with weight-bearing however does have pain without weight-bearing; denies paresthesias; spasms in the leg occasionally. PX 4, p 19.
On 3/20/2009 physical therapy started and agan on 4/7/09. PX 4, p 14 16. On 4/9/2009 follow-up note indicates: due to her weight still has problems standing and ambulating; since the interval and February, she has not had any acute event; slowly has progressed not as quickly as she wanted. Examination revealed good range of motion, neurally intact no pain with squeezing of her syndesmosis; no prominent hardware is visible. X-ray of the ankle was interpreted to reveal break of the most proximal syndesmotic screw. It was determined that the broken screw would be left. Work restrictions of no standing more than 30 minutes were ordered. She was ordered to return in three months. PX 4, p 9. (emphasis added) .PT continued with plate and screw present. One screw had broken. T 49.

Upon discharge from Stroger hospital on April 9, 2009 she had work restrictions of no standing more than 30 minutes at a time; her job with respondent as a teacher of toddlers and young children required her to be on her feet for more than 30 minutes at a time; she was not offered any accommodating position at work by her employer. T 51-52.

Bill from Stroger Hospital for services rendered was issued in the amount of: $277.20 2/26/09 PX4, p 105; $376.80 9/16/08 and 9/24/08 PX 4p 103; $230.40 4/9/09 and 4/11/09 PX 4p 98; $72.07 4/8/2009 PX 4, p 95; $123.73 3/20/09 PX 4, p 92; $130.80 12/11/2008 PX 4, p 89; $230.40 11/13/2008 PX 4, p 86; $230.40 10/16/2008 PX 4, p 83; $288 10/3/2008 PX 4, p 79.

The medical records and bill of University of Chicago Medical Center, Px.5, show she was examined on July 30,09. She gave history of injury at work on September 10, 2008 from wetness on the floor on a carpet and twisting and falling injuring her left ankle with this fall. Physical examination revealed tenderness over the anterior aspect of the joint line; pain that radiates up over the syndesmosis; posterior scar on the fibula that appears to be well healed; tenderness in the locations above. X-rays were interpreted to demonstrate broken hardware one of the screws is broken; persistent diastasis and there is medial clear space widening; bipolar cystic osteochondral lesion in the talar dome as well. PX 5, p6-7. Dr. Toolan assessment was: failed hardware; early posttraumatic arthritis with osteochondral lesion within the ankle joint; at this time she needs to consider surgery which would probably include a syndesmotic reconstruction with distal syndesmotic fusion, essentially an open treatment of her dislocated ankle with perhaps creation of a bony syndestosis/ syndesmotic fusion; may benefit from ankle arthroscopy to evaluate osteochondral lesions in her talus and tibia; purpose of surgery would allow her to return to work although she would not be pain free nor she would not have issues with swelling but should be able to return to work in some capacity and that would be ultimate long-term goal for her. PX 5, p 7. Bill from University of Chicago Medical Center, Brian Toolan for services rendered was in the amount of $674 PX 4, p 11, and $489 PX 4, p 10. (emphasis added)

Petitioner testified she saw Dr.Toolan one time and did not proceed with any more surgery. The only surgery she had was at Stroger Hospital T 52-53.
Petitioner testified she did have an x-ray at Stroger Hospital on November 12, 2009. T-53. That x-ray showed no significant change from prior study; again noted is a fractured syndesmotic screw as well as an intact syndesmotic screw; degenerative changes are present in the ankle; there is no evidence of acute injury. PX 4, p 6.

Petitioner testified: as of the date of hearing she had not sought any other medical treatment for her left ankle; she had not injured her left ankle in any other accidents up to the date of hearing. T 53-54. She continues to have pain in the left ankle in the same area where she was experiencing pain on the day of the accident and after the surgery; she has pain when it's cold outside or inside with air-conditioning; activities of walking and standing causes pain in the left ankle; she can walk or stand for about an hour before the pain begins in the left ankle; if there is pain in the left ankle she shifts her weight to the right side so as not to put weight on her left ankle; when she shifts her weight off her left ankle she starts to get pain in her right hip; she had no pain in her right hip before the accident and surgery; she has no aching in her left hip as of the date of hearing; she takes aspirin to relieve the pain; no doctor has changed the restrictions that were placed on her by Stroger Hospital on April 9, 2009; some of her bills were paid by the state of Illinois public medical services for prescription medication. T 54-57.

On cross-examination petitioner testified Ms. Campbell met her at Holy Cross Hospital; no one from respondent tried to contact her after the accident; petitioner did not contact respondent after the accident; she did not want to go back to respondent to work. T 59-61.

On additional cross-examination petitioner testified she does not work now; the last time she worked was September 10, 2008, her last job was at Keepers Institute; Upon leaving Holy Cross Hospital after the examination and x-ray Ms. Campbell asked if petitioner had medical insurance and petitioner responded she did; Ms. Campbell told her good because she did not have any insurance; petitioner had no other conversation with Ms. Campbell about insurance; Ms. Campbell was with her the entire time she was in Holy Cross Hospital. T 63-76.

Ann Campbell was called as a witness by respondent. The witness testified she was executive director of Keepers Institute for Development and Safety; the corporation was in business from 2004 until 2012; in 2012 it was dissolved; she requested insurance coverage for the business from Olympia Fields insurance; she paid premiums from 2004 through 2012 on the insurance; when she could no longer pay Ms. Byrd her salary she called the insurance company to see how one would claim workers comp insurance and that's when she discovered that she didn't have it; when she purchased insurance she thought it was comprehensive; when petitioner was off work she paid her wages. T 77-82. The witness identified Respondent Exhibit 1 as a tally of salaries that was paid to Wanda Byrd in the year 2008 two 2010, January 2010; she filled it out with totals from ADP; the handwriting is hers; signature at the bottom is hers; the numbers add up to $15,125; monies were paid to petitioner by several checks picked up by her friends; respondent had 13 employees.

The petitioner never called her to discuss job restrictions; staff of respondent tried to call petitioner to see how she was; staff called her one day and was told she couldn't come and wouldn't answer the phone; the president of the company wrote her a letter and the witness did not receive a response; petitioner would not talk to them. T 77-88. A letter was sent to petitioner to contact respondent by March 31, 2010. The witness had to fill her position to have a teacher in the classroom. The letters that were sent out in February and March 2010 were intended to see if petitioner was coming back because respondent needed a teachers aide in that classroom. One telephone call was made on September 30, 2008; she knew that petitioner was still treating with the doctor; she never wrote a check for workers compensation insurance prior to petitioner's accident. The witness testified she did not know where petitioner was staying after the accident; she filled out the form labeled SS A-L/725 to get an accurate account of how much money she paid petitioner from 2008 two 2010; she couldn't say exactly why she requested that form she withheld taxes but everything was done through ADP; ADP gave her the total and she filled out the form.

The witness testified after the accident petitioner was no longer being paid through ADP; she generated the document because ADP was no longer paying petitioner; she did not recall whether when she was paying petitioner directly if she withheld taxes and Social Security from the checks she was sending; she continue to pay petitioner despite having no contact with her because she was concerned; she stopped paying petitioner when she had to hire another person to take her class; she could not tell where she got the document that reported to show money paid to petitioner. T 89-103.

Petitioner Ex. 1 medical records and bill of Holy Cross Hospital, Px. 2 medical records and bill of Argent Care Inc., Px. 3 medical record and bill of Provident Hospital of Cook County, Px. 4 medical record and bill of John H Stroger Hospital and Px. 5 medical record and bill of University of Chicago Medical Center & Brian Toolan were admitted in evidence. See above.

Admitted in evidence as Px.6 is the Illinois Worker's Compensation Commission Certified Copy of the Proof of Coverage Search for Keepers Institute for Development and Safety and multiple variations on that name. The documents demonstrate that the first policy issued to cover respondent was effective 9/19/2008, eight days after the date of this accident.

Admitted in evidence as Petitioner Exhibit 7 is the itemized statement of medical bills paid by Healthcare and Family Service in the amount of $46.11 for medication.

Admitted in evidence as Respondent Exhibit 2 is a 52 week wage statement prior to the accident date.

CONCLUSIONS OF LAW

The Decision of the Arbitrator is based upon a careful consideration of the totality of the evidence. Wanda Byrd testified before the arbitrator who had opportunity to view her demeanor under direct examination and cross-examination. The arbitrator considered her testimony in light of all of the other evidence in this record. The arbitrator finds that Wanda Byrd was a credible witness.

A. Was Respondent Operating under and Subject to the Illinois Worker's Compensation or Occupational Disease Act?

The arbitrator finds based upon the testimony herein adopted, of Ann Campbell, owner, president and director of respondent, that on September 10, 2008 respondent was a business operating in the State of Illinois in which services were rendered to the public at large and for the year preceding September 10, 2008 payroll for the entity was in excess of $1000. The weight of credible evidence demonstrates that respondent was operating under and subject to the Illinois Worker's Compensation act pursuant to Section 3(17)(a) of the Workers Compensation Act.

B. Was There an Employee-Employer Relationship?

Based upon the totality of the evidence, the Arbitrator finds the worker at bar was an employee under the act by that evidence including that respondent scheduled the times and dates of petitioner's work, paid petitioner an hourly rate based upon the number of hours worked, withheld Social Security and payroll taxes from petitioner's salary, and respondent considered petitioner to be an employee as testified to by Ann Campbell. The petitioner testified that she was an employee of respondent on the accident date of September 10, 2008 rendering services as a teacher for respondent's childcare services facility. Ann Campbell testified that the respondent was a business rendering childcare services. Again,the arbitrator finds based upon the totality of the evidence in this record that there was an employee-employer relationship between petitioner and respondent on September 10, 2008.

C. Did an Accident Occur That Arose Out Of and in the Course of Petitioner's Employment by Respondent?

A compensable injury occurs in the course of employment when it is sustained while a claimant is at work or while he performs reasonable activities in conjunction with his employment. Wise v. Industrial Commission, 54 Ill. 2d 138, 142, 295 N. E 2d 459, 461 (1973). An accident arises out of one's employment if its origin is in some risk connected with or incidental to the employment so as to create a causal connection between the employment and the accidental injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 58 (1989). When an injury to an employee takes place in an area that is the usual route to the employer's premises, and the route is attendant with a special risk or hazard, the hazard becomes part of the employment. Litchtfield Health Care Center v. Industrial Commission, 349 Ill. App. 3d 486, 489 (2004). Proof of a condition on respondent's premises that constitutes special risk or hazard is sufficient evidence of increased risk to the employee. Springfield Urban League v. Industrial Commission 2013 Ill. App 4th 120219 (2013). (7)

The arbitrator finds based upon the totality of the evidence including testimony of petitioner that on September 10, 2008 petitioner was working as an employee of respondent in her job as a teacher of toddlers and small children at respondent's childcare services facility located at 2718 W. 59th St., Chicago, IL. The arbitrator finds that respondent maintained the facility where petitioner was working on that date. The arbitrator finds that while bringing a class of children back into the facility through the breakroom of respondent's facility a rug that was saturated with water from a leaking wash machine cause petitioner to slip; she went into the air and came down on her left ankle. The arbitrator finds that there was a special risk or hazard from a defective condition on the premises maintained by the respondent, a rug saturated with water in the break room which was the route to lead the children back from the playground into the classroom. The arbitrator finds that the weight of credible evidence demonstrates that petitioner was on duty in her job as a teacher for respondent at the time of the accident and that she was performing services in her job as a teacher for respondent and that her action in walking through the break room escorting a class of children back into the facility from the playground was an activity reasonably connected to her employment and that exposure to the defective condition in the break room of respondent's facility exposed her to a special hazard and risk incidental to her employment. The arbitrator finds based upon the totality of the evidence, the weight of that evidence demonstrates that on September 10, 2018 petitioner was injured in an accident that arose out of and in the course of petitioner's employment by respondent.

D. What Was the Date of the Accident?

Petitioner and Ann Campbell testified that petitioner was injured when she slipped on the saturated rug/carpet in the break room on September 10, 2008. The medical records of the initial medical provider Holy Cross Hospital corroborates that testimony that the accident occurred on September 10, 2008. The arbitrator finds based upon the totality of the credible evidence that the accident occurred on September 10, 2008.

E. Was Timely Notice of the Accident Given to Respondent?

Ann Campbell the owner director of respondent testified that she came to the breakroom and saw petitioner lying on the floor after the fall and that she went to Holy Cross Hospital Emergency Room on the day of the accident and spoke to petitioner in the hospital about the accident. That testimony was corroborated by the petitioner. The arbitrator finds that the weight of credible evidence demonstrates that petitioner gave notice of the accident to respondent.

F. Is Petitioner's Current Condition of Ill-Being Causally Related to the Injury?

A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. International Harvester v. Industrial Commission, 93 Ill. 2d 59, 63-64 (1982)

Petitioner testified she had no problem with her left ankle prior to the accident date. The onset of pain in her left ankle was immediate with her fall to the ground after she slipped on the water saturated rug. She heard a crack in the left ankle on hitting the ground. Her testimony at hearing as to how the accident occurred and onset of pain is consistent with the history she gave to all of the medical providers. She was diagnosed with a fractured ankle confirmed by x-ray for which she ultimately underwent surgery consisting of an open reduction with internal fixation of plate and screws. She suffered no injury to her left ankle subsequent to the date of the accident. She has no complaint or problems with her right ankle before the accident and at hearing.

Based upon the totality of the evidence the arbitrator finds under a chain of events analysis hat petitioner's current condition of ill-being of petitioner's left ankle is causally related to the work injury of September 10, 2008 in the case at bar.

G. What Were Petitioner's Earnings?

Petitioner testified that she earned nine dollars per hour and work from 9 o'clock to 6 o'clock five days a week. Based on that testimony her weekly wage was $405. Petitioner testified she worked through the summer for respondent. Respondent Exhibit 2 is a 52 week wage statement which shows petitioner earned $13,119.60 for the 52 weeks prior to the date of the accident. That document gives rise to an average weekly wage of $252.30. The arbitrator finds based upon the totality of the evidence that petitioner's average weekly wage was $252.30 under section 10 of the Act.

H. What Was Petitioner's Age at the Time of the Accident?

Petitioner testified she was born on September 27, 1958. That date is corroborated by the medical records. The arbitrator finds based upon the totality of the evidence petitioner's age on September 10, 2008 was 49 years.

I. What Was the Petitioner's Marital Status on the Date of the Accident? How Many Dependents Did Petitioner Have on the Day of the Accident?

Petitioner testified she was single on the date of the accident and that she had one dependent on the day of the accident. T 28.

The medical records of Holy Cross Hospital (PX 1, p 4) and of Provident Hospital of Cook County (PX 3, p 4) indicate that petitioner was unmarried at the time of the accident. The arbitrator finds based upon the totality of the evidence on the date of accident petitioner's marital status was single and that she had one dependent for purposes of the Act.

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 medical bills admitted in evidence attached to the medical records were admitted pursuant to the provisions of Section 8 of the workers compensation act. These are the medical records were received in response to Commission Subpoena.

Pursuant to the provisions of Section 16 they are proof of evidence of the medical and surgical matters therein and the bills are certified to be true and correct. The bills correspond to the dates of service as indicated in the attached records. The medical records demonstrate treatment of petitioner's left ankle and the billing as provided in the admitted exhibits demonstrate that the charges are for the treatment rendered to the left ankle.

The arbitrator finds based upon the totality of the evidence that the medical services as demonstrated in Petitioner Exhibits 1,2,3,4 and 5 are reasonable and necessary in the case at bar. The arbitrator finds that the following bills are appropriate charges for the reasonable and necessary medical services; Thus, respondent is ordered to pay them in reasonable time hereafter pursuant to the fee schedule: Holy Cross Hospital $1002.25; Argent care $56.63; Provident Hospital of Cook County $361.50; John H Stroger Hospital $277, $376.80, $230.40, $72.07, $123.73, $130.80, $230.40, $230.40, $288; University of Chicago Medical Center $674, $489.

K. What Temporary Benefits Are in Dispute?

Petitioner testified on the date of accident she was diagnosed with a fractured left ankle given a crutch and ordered to follow up with orthopedic surgeon. She testified she was unable to walk on the ankle. Surgery was performed consisting of open reduction and internal fixation that was performed on 10/3/2008. The records of John H Stroger Hospital indicate on 9/26/2008 she was ordered a heavy duty walker without wheels. After the surgery 10/3/2008 she followed at Stroger hospital and was not allowed to return to work until 4/9/2009 when it was noted that she was slowly progressing but could return to work with restrictions of no standing more than 30 minutes at a time. Petitioner testified that her job respondent required her to stand more than 30 minutes at a time so she would be unable to return to that job with the restriction. Petitioner consulted with Dr.Toolan his records at the University of Chicago on 7/30/2009. His record indicates that he was recommending another surgery to address petitioner's pain and functional limitations to try to get her to be able to return to work in some capacity and that would be the long-term goal. PX 5, p 7. Petitioner testified she never returned to work with respondent after the accident and has not returned to any type of work after the accident, corroborating the statement of Dr. Toolan that surgery was needed to be able to return her to work some capacity. The Commission has held that even in the absence of formal work status reports a period of total incapacity can be inferred from the nature of the injury and TTD can be awarded based upon that. Michael Eisenhower v. Kreitner Construction Company. 07 WC 4296, 2010 Ill. Wrk Comp LEXIS 136. Petitioner claims TTD from 9/11/2008 through 7/30/2009 representing 46 1/7 weeks.

The arbitrator finds based on the totality of the evidence petitioner is entitled to TTD for the period from 9/11/2008 through 7/30/2009; Thus, Respondent is hereby ORDERED TO PAY to Petitioner and her attorney the accrued and unpaid TTD for that period.

L. What Is the Nature and Extent of the Injury.

The medical records demonstrate that petitioner suffered a left ankle fracture which required surgery on 10/3/2008 consisting of open reduction and internal fixation of Maisonneuve injury/syndesmotic rupture, left ankle on postoperative diagnosis: Maisonneuve injury, left ankle with ruptured syndemosis. PX 4, p 36-37. X-ray examination revealed that after the surgery one of the two screws holding the plate in place fractured. A second surgery was recommended by Dr.Toolan whose assessment was: failed hardware; early posttraumatic arthritis with osteochondral lesion within the ankle joint; at this time she needs to consider surgery which would probably include a syndesmotic reconstruction with distal syndesmotic fusion, essentially an open treatment of her dislocated ankle with perhaps creation of a bony syndestosis/ syndesmotic fusion; may benefit from ankle arthroscopy to evaluate osteochondral lesions in her talus and tibia; purpose of surgery would allow her to return to work although she would not be pain free nor she would not have issues with swelling but should be able to return to work in some capacity and that would be ultimate long-term goal for her. PX 5, p 7. Petitioner chose not to undergo that second surgery. She testified she has never returned to work and continues to have pain in the left ankle. She has pain when it's cold outside and when she is inside with air-conditioning. Activities of walking and standing cause pain in the left ankle. After she walks or stands for an hour she begins to experience pain in the left ankle. She has shifted her weight to her right side to avoid causing pain in the left ankle and now is beginning to experience pain in her right hip. She had no pain in her right hip before the accident and surgery. She has no left hip pain. She takes over-the-counter medication to relieve her pain. Petitioner testified she could not return to her job with respondent with the restrictions imposed on 4/9/2009.

The arbitrator finds as a matter of law that petitioner has sustained an injury that resulted the permanent partial loss of use of the left foot to the extent of 45 per cent thereof under section 8(e) of the Act. It is hereby ORDERED that said ppd that is accrued is payable to the Petitioner and her attorney of record.

N. Is Respondent Due Any Credit?

Petitioner stipulated that respondent is due a credit in the amount of $8600.54 for TTD paid from 9/11/08 through 1/16/2010. Respondent is given a credit in the amount of $8600.54 for TTD paid. It is hereby ORDERED THAT Respondent shall pay the balance of TTD due to the petitioner and his attorney of record.

O. Injured Workers Benefit Fund

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

STATE OF ILLINOIS)
) SS.
COUNTY OF Champaign)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Shevita Bynum,
Petitioner,

vs.

NO: 11WC 22048

17IWCC0831

Pepsico,
Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 5, 2016 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $56,100.00. 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: DEC 27 2017

Charles J. DeVriendt

Joshua D. Luskin

o120617
CJD/rlc
049

17IWCC0831

CONCURRENCE IN PART / DISSENT IN PART

Elizabeth Coppoletti, concurring in part and dissenting in part.

I concur with the majority's opinion as it relates to all issues other than the nature and extent of the injury. I would reduce the award of permanent partial disability benefits to 10% person as a whole. Petitioner testified she returned to work in the sanitation department. T. 52. Her work duties require her to mop, sweep, shovel, operate an automatic floor scrubber, and painting. T. 53. Petitioner testified undertaking some duties cause her pain. T. 54-55. Petitioner testified she makes a few dollars less in her new job. T. 68.

The medical records evidence Petitioner underwent surgery on September 21, 2015 consisting of a rotator cuff repair. PX7. Following a short course of physical therapy from which Petitioner discharged herself, she returned to work without restrictions. T. 69. As such, I would affirm and adopted the arbitrator's decision but decrease the award of permanent partial disability benefits to 10% loss use of person as a whole.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BYNUM, SHEVITA
Employee/Petitioner

Case# **11WC022048**

PEPSICO
Employer/Respondent

17IWCC0331

On 7/5/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1551 STOKES LAW OFFICES
GARY JOE STOKES
200 N GILBERT
DANVILLE, IL 61832

0522 THOMAS MAMER & HAUGHEY LLP
ERIC S CHOVANEC
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CHAMPAIGN, IL 61820-3629

STATE OF ILLINOIS)
)SS.
COUNTY OF Vermilion)

☐ 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

SHEVITA BYNUM
Employee/Petitioner

v.

PEPSICO
Employer/Respondent

Case # 11 WC 022048

Consolidated cases: ____

17IWCC0831

An *Application for Adjustment 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 **Urbana**, on **April 13, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **April 11, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$48,360.00**; the average weekly wage was **$930.00**.

On the date of accident, Petitioner was **39** 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, however, Respondent's group health insurance has paid all outstanding medical charges.

Respondent shall be given a credit of **$6,392.29** (as stipulated) for Short Term Disability paid and for all medical paid by Respondent's group health insurance.

ORDER

Medical benefits
Respondent shall pay all reasonable and necessary medical services, pursuant to the medical fee schedule, of all medical charges incurred by Petitioner (PX10) as provided in Sections 8(a) and 8.2 of the Act and shall be given a credit for medical benefits that have been paid by 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 Section 8(j) of the Act.

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits of $620.00/week for 21 & 6/7ths weeks, commencing May 24, 2011 through July 17, 2011, and September 21, 2015 through December 27, 2015, 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 $558.00/week for 87.5 weeks, because the injuries sustained caused a 17.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act (*Will County Forest Preserve District v. Illinois Workers' Compensation Commission*, 2012 IL App (3d) 110077WC, 970 N.E.2d 16, 361 Ill. Dec. 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.

17IWCC0831

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 the respondent**, and (D) **What was the date of the accident,** the Arbitrator finds the following facts:

Petitioner sustained a full thickness tear of the supraspinatus tendon, a partial tear of the infraspinatus tendon and impingement syndrome of the right shoulder, all of which manifested themselves on April 11, 2011 (PX2) (*Peoria County Bellwood Nursing Home v. Industrial Commission*, 115 Ill.2d 524 (1987)).

Petitioner testified that she has been employed with Respondent for approximately eleven years. Respondent owns and operates a facility in Danville, Illinois manufacturing various food products, including cereal and granola bars. Respondent's facility operates on twelve-hour shifts with employees working four days on and four days off.

Six to eight months prior to April 11, 2011, Petitioner was assigned to a position identified as "relief operator." Relief operators rotate every 30 minutes between four jobs; A.C.T. (Automatic Case Tender), Bar Reclaim, Inspection and general labor. If production is operating smoothly, each employee will have a 30-minute break after each 90 minutes of work. Petitioner provided detailed descriptions of each job with photographs illustrating co-workers performing each job (PX 12).

In A.C.T., Petitioner stood facing a table with stacks of flattened cardboard that the machine would shape into boxes for shipping. Petitioner grasped five boxes at a time from chest high, turned 180 degrees and reached overhead to place the stack up and over a Plexiglas shield and into the machine. Petitioner estimated the weight of each stack to be approximately ten pounds. Petitioner would then turn and repeat the process six to seven times to fill the machine. Petitioner then stepped over to a second machine and repeated the entire process on machine #2 before returning to machine #1. Petitioner estimated that it took approximately five minutes at each machine, a process that was repeated over and over for the full thirty-minute session.

Petitioner identified the gentleman in photographs 12a and 12b as a co-worker named Carlos. Petitioner testified that Carlos is a large man that stands six foot tall or taller. Petitioner is five feet five inches tall and weighed approximately 130 pounds in 2011.

Petitioner identified the young lady in photographs 12c and 12d as Amanda, another co-worker working in Bar Reclaim. In Bar Reclaim, a conveyer belt is constantly moving granola bars that the wrapper machines failed to catch. The bars fall into white barrels at the end of the conveyor. As each barrel fills, Petitioner would bend over and grasp the barrel with both hands and arms. Petitioner then lifted and carried each barrel to a pallet where they were stacked two high, sixteen barrels per pallet. Petitioner estimated the weight of a full barrel to be between 30 and 50 pounds. Petitioner would also empty each 30 to 50-pound barrel by lifting the barrel up, neck-high, and pouring the contents into a large black tote. Finally, while the barrels were filling, Petitioner would remove all bad bars by reaching out and across the four-foot-wide conveyor with her right arm, grasping the bars, and placing them into a waste barrel (as reflected in photograph 12d).

In general labor, Petitioner emptied defective cartons of granola bars by opening each carton, dropping the bars into a tote and then repeatedly tossing the empty boxes into a recycle bin. The process was often

performed throughout the shift. Petitioner was also responsible for assembling large plastic totes and then lifting the lids overhead to place them onto the totes (photograph 12f). Finally, Petitioner cleared cardboard jams by climbing ladders and reaching overhead to yank the cardboard as hard as she could to free it from overhead conveyors.

As Inspector, Petitioner repeatedly reached across a four-foot conveyor belt to remove damaged granola bars from the 26 rows of bars that were moving across the operator's station. An Inspector is observed in photograph 12e reaching out to remove a damaged bar. Petitioner estimates that she would typically fill an entire barrel with granola bars during each thirty-minute session. Petitioner would occasionally utilize an arm's length paddle with her right arm to reach bars on the opposite side of the conveyor.

Once Petitioner had rotated to all four jobs, the entire process would be repeated until the twelve-hour shift was completed.

Early in calendar year 2011, while performing her duties as a relief operator, Petitioner began noticing right shoulder pain that would progressively worsen over the course of her eight to twelve-hour shift, becoming excruciating by the end of the day. The pain would improve on her days off but then worsen again after her return to work. The repetitive overhead lifting and reaching associated with A.C.T., and certain duties in general labor, caused most of the pain.

Petitioner initially self-treated with over-the-counter pain medications, including *pain zappers* purchased from a vending machine at work. On April 11, 2011, Petitioner consulted Deb O'Brien, her primary care physician's assistant (PX1). Petitioner complained of right shoulder pain as well as right knee pain. Ms. O'Brien noted the repetitive lifting and extension of the shoulder associated with Petitioner's job duties as a relief operator. Ms. O'Brien diagnosed Petitioner's shoulder condition as probable tendinitis and referred her to Orthopedics (PX1, 4/11/11).

On April 20, 2011, Petitioner saw Dr. Plattner, an orthopedic surgeon. Dr. Plattner also noted Petitioner's work, which he described as hard labor, pushing, pulling and tugging repeatedly throughout the entire 12-hour shift (PX3). Dr. Plattner injected Petitioner's right shoulder and ordered an MRI. An MRI, taken on April 27, 2011, revealed a full thickness tear of the supraspinatus tendon and partial tear of the infraspinatus tendon in Petitioner's right rotator cuff. Rotator cuff impingement was evident as well (PX2).

Dr. Plattner performed surgery on Petitioner's right knee on May 3, 2011. In his follow-up on May 23, 2011, Dr. Plattner noted Petitioner's ongoing right shoulder complaints and then referred Petitioner to Occupational Medicine to determine her ability to return to work (PX3). Dr. Allison Jones examined Petitioner on May 24, 2011, restricting Petitioner from lifting, pushing or pulling more than 15 to 25 pounds with her right shoulder (PX4). Petitioner attempted a return to work with Dr. Jones' restrictions but was told by Respondent's nurse that she would not be allowed to return to work with those restrictions.

Petitioner was seen by orthopedic surgeon, Dr. Robert Gurtler, on July 14, 2011 (PX6). Dr. Gurtler reviewed Petitioner's MRI and diagnosed her with a torn rotator cuff. Dr. Gurtler recommended surgery. Dr. Gurtler testified that it is quite uncommon for a 40-year-old woman to have the damage evident on Petitioner's MRI (PX11, p.15). Dr. Gurtler explained that work, at or above shoulder height, is a specific cause of rotator cuff injuries (PX11, p. 22). Dr. Gurtler stated that Petitioner's job was a "major" contributing cause of her

rotator cuff tears (PX11, DepX6). Dr. Gurtler repeated his opinion in sworn testimony on November 1, 2011 (PX11, p.17).

Respondent introduced a written job description of one of the jobs performed by relief operators, Bar Reclaim (RX2). Petitioner noted that the document is dated 2003 and fails to provide an accurate description of how the job was performed on and after calendar year 2005. The references to loading, pushing and pulling trays are all obsolete. The description pre-dates the lifting, carrying or handling of barrels that now catch the bars at the end of the conveyors.

Respondent also introduced a job site analysis dated December 14, 2011 that scores the risks of injury in the various jobs performed by relief operators. Respondent's evaluators scored Bar Reclaim and Inspection as having a "medium" risk level for work related musculoskeletal disorders and a "concern" for potential risk of injury with the lifting tasks required. There is no mention in either of Respondent's exhibits of the repetitive work performed at or above shoulder height testified to by Petitioner and evidenced by the photographs introduced at trial.

Respondent retained the services of Dr. D. Hauter, an occupational medicine physician, as an expert witness in the claim. Dr. Hauter opined that Petitioner's right shoulder condition was not attributable to her work duties. Dr. Hauter stated that Petitioner's shoulder injuries were attributable to an arthritic condition caused by the normal aging and wear and tear of the shoulder joint (RX1, p. 10, 12).

Dr. Hauter testified that he had received a written job description prior to drafting his report, however, no job video was provided. Dr. Hauter admitted that the written job description he reviewed failed to make any mention of repetitive work at or above shoulder level (PX1, p. 40). Dr. Hauter agreed that his opinions were based upon an assumption that Petitioner's job duties did not include work at or above shoulder height during most of her work day (RX1, p. 48).

Dr. Hauter agreed that repetitive work, particularly forceful repetitive work at or above shoulder height, is a known cause of shoulder impingement (RX1, p.19) and he admitted that his opinions regarding the cause of Petitioner's shoulder injuries could change if most of Petitioner's work involved activities at or above shoulder height (RX1, p. 48, 49).

The Arbitrator finds the opinions of Dr. Gurtler more credible than those of Dr. Hauter. The Arbitrator finds that the hypothetical provided to Dr. Gurtler was a more accurate description of Petitioner's job duties than the descriptions provided to Dr. Hauter. Petitioner sustained work-related injuries to her right shoulder, including torn rotator cuff tendons and impingement syndrome, that manifested themselves on April 11, 2011 with her initial visit to her primary care physician's assistant, Ms. O'Brien.

In support of the Arbitrator's decision relating to: (F) **Is Petitioner's current condition of ill-being causally related to the injury**, the Arbitrator finds the following facts:

Petitioner was diagnosed by MRI in April, 2011 with a full thickness tear of the supraspinatus and a partial tear of the infraspinatus and impingement syndrome, all of the right shoulder (PX2). Dr. Gurtler recommended surgical repair (PX6). Respondent contested Petitioner's claim that her shoulder injuries were work related.

17IWCC0831

Petitioner credibly testified that she was single and purchasing a home in 2011 and could not afford to be off work for four to six months with the limited benefits of sick pay. Medical notes corroborate her testimony, "She knows she needs surgery but cannot afford it at this time." (PX5, 12/21/11). Petitioner returned to work at a light-duty job that was predominantly sitting. Petitioner was able to work for several years before having the surgery recommended by Dr. Gurtler on July 14, 2011. Dr. Gurtler explained, in his 2011 report, that rotator cuff tears do not heal themselves and only get worse over time (PX11, Dep. X6, p. 2).

There is no evidence of an intervening injury between Dr. Gurtler's recommendations for shoulder surgery on July 14, 2011 and his actual surgery on September 21, 2015 (PX7). Petitioner testified that her shoulder pain never went away and she elected to proceed with surgery in 2015 when she could afford to be off work for an extended period of time.

Petitioner has sustained no injuries involving her right shoulder since her surgery. Petitioner's current condition of ill-being is causally related to the injury of April 11, 2011.

In support of the Arbitrator's decision relating to: (G) **What were Petitioner's earnings,** the Arbitrator finds the following facts:

The parties advise that after receiving and reviewing the wage records (RX4), they have reached an agreement and are stipulating to an average weekly wage of $930.00.

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

There is no dispute regarding the reasonableness and necessity of the medical treatment received by Petitioner or the itemized medical bills for that treatment (PX10). The only dispute is liability. In light of the decision herein regarding accident and causal connection, the medical is awarded and Respondent shall be responsible for same per the applicable fee schedule. The parties confirm that all medical is paid by group and Respondent shall receive the appropriate 8(j) credit for same and protect Petitioner from any claim of subrogation by the group carrier.

In support of the Arbitrator's decision relating to: (K) **What amount of compensation is due for temporary total disability,** the Arbitrator finds the following facts:

Petitioner was temporarily totally disabled from May 24, 2011 through July 17, 2011 and September 21, 2015 through December 27, 2015.

The medical note of the Occupational Medicine department dated May 24, 2011 clearly indicates Petitioner's restrictions were attributable to her right arm and shoulder (PX4). Petitioner credibly testified that she was not allowed to return to work with those shoulder-related restrictions. Phone notes from Carle Clinic dated June 27, 2011 corroborate Petitioner's testimony (PX5).

Petitioner testified that she was only able to return to work after assuring the Occupational Medicine physician that she would not return to her former job as a relief operator but, rather, as a light-duty wrapper

operator (PX4). Dr. Gurtler's note of July 14, 2011 confirms that Petitioner remained off work at that time (PX6).

Petitioner's shoulder surgery took place on September 21, 2015 (PX7). The stipulation sheet lists December 27, 2015 as Petitioner's return to work date (Arb.X1). Respondent presented no evidence to the contrary.

In support of the Arbitrator's decision relating to: (L) **What is the nature and extent of the injury**, the Arbitrator finds the following facts:

Petitioner has sustained a permanent partial disability of 17.5% person as a whole pursuant to Section 8(d)(2) of the Act.

Though improved since her surgery, Petitioner describes significant difficulty with many activities of daily living including reaching up with her right arm to wash her hair or retrieve items from overhead cabinets. Petitioner notices weakness with almost all lifting that becomes painful if she continues. Even driving her car for long distances causes discomfort with her right shoulder.

Though Petitioner no longer performs the job of relief operator, some aspects of her job in sanitation continue to cause pain including shoveling and painting. Petitioner must take frequent breaks when performing either activity due to increasing pain in the right shoulder. Petitioner continues to take over-the-counter pain medications on a daily basis for relief of shoulder pain. Petitioner has sustained a permanent wage loss since sanitary workers are paid less per hour than other jobs at Respondent's plant.

The Arbitrator finds Petitioner to be credible. There has been no evidence presented contradicting Petitioner's testimony regarding her current difficulties and limitations.

Edward Lee
Signature of Arbitrator

6/27/16
Date

JUL 5 - 2016

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jesse Ruch,
Petitioner,

vs. No: 16 WC 32669

17IWCC0832

State of Illinois,
Menard Correctional Center,
Respondent.

DECISION AND OPINION ON REVIEW

A Petition for Review having been filed timely by Petitioner herein and notice given to all parties, the Commission, after considering the sole issue of the nature and extent of Petitioner's permanent partial disability, and being advised of the facts and law, modifies the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The underlying facts of this claim were well laid out in the Arbitrator's Decision, which is incorporated herein, and the Arbitrator's findings of fact are adopted. Regarding the nature and extent of the injury, however, the Commission reviews and weighs the facts somewhat differently than did the Arbitrator. Specifically, the Commission notes the factors identified in Section 8.1b of the Act, as did the Arbitrator. No AMA impairment rating was submitted, so the Arbitrator properly assigned no weight to that factor. The Arbitrator further noted the petitioner's employ as a correctional officer, in which position he continued to work with no evidence of earnings impairment in that capacity.

17IWCC0832

However, the claimant did note that he might face difficulty in his position in the National Guard. As such, the Commission places greater weight on these factors than did the Arbitrator. The Arbitrator, as does the Commission, further noted the claimant's relative youth (28 years old on the date of loss). Given that no further information about how his youth impacted the case is immediately obvious, the Commission places little weight on this as either an aggravating or mitigating factor. Lastly, the Arbitrator placed "lesser weight" on the last factor, that being the complaints and evidence of disability corroborated by the treating medical records. The Commission notes the claimant described residual complaints to the back and leg that were consistent with the surgery he underwent. Given the credible residual complaints and the Petitioner's legitimate concerns about his physical requirements as a member of the National Guard, the Commission places somewhat greater emphasis on this factor than did the Arbitrator.

In light of the above, the Commission finds an award of permanent partial disability of 20% loss to the person under Section 8(d)2 to be more in line with the extent of the injuries sustained, and modifies the Arbitrator's award accordingly. All other findings of the Arbitrator are affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on June 14, 2017, is modified as stated above and otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $558.00 per week for a period of 100 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of use of person as a whole to the extent of 20%.

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

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

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

DATED: DEC 27 2017

o-12/13/17
jdl/mcp
68

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RUCH, JESSE
Employee/Petitioner

Case# **16WC032669**

SOI/MENARD CORRECTIONAL CENTER
Employer/Respondent

17IWCC0832

On 6/14/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

0558 ASSISTANT ATTORNEY GENERAL
AARON L WRIGHT
102 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JUN 14 2017

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Jesse Ruch
Employee/Petitioner

v.

State of Illinois/Menard Correctional Center
Employer/Respondent

Case # 16 WC 32669

Consolidated cases: N/A

17IWCC0832

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 **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **May 9, 2017.** By stipulation, the parties agree:

On the date of accident, **September 7, 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's earnings were **$48,360.19** and the average weekly wage was **$930.00**.

At the time of injury, Petitioner was **28** years of age, ***single,*** with **1** dependent child.

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

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

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

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 **$558.00/week** for a further period of **62.5** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **12.5% loss of use of the person-as-a-whole.**

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.

Melinda M. Pope-Sullivan
Signature of Arbitrator

6/12/17
Date

JUN 14 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Jesse Ruch
Employee/Petitioner

Case # **16** WC **32669**

v.

Consolidated cases: **N/A**

State of Illinois/Menard Correctional Center
Employer/Respondent

17IWCC0832

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

At the time of the underlying accident, Petitioner was employed as a Correctional Officer at Respondent's Menard Correctional Center facility. The parties stipulated that on September 7, 2016, Petitioner sustained accidental injuries at work when, while moving ammunition bags in the main armory, he attempted to lift two ammunition bags and heard and felt a pop in his lower back. (AX1).

Petitioner testified to continued symptoms of soreness and tightness in the hamstring of his right leg. He described it as being similar to the leg pain/sciatica he experienced after the injury occurred. He testified that he also experiences tightness in his low back. He testified that he takes Norflex, Gabapentin or Soma for his symptoms, but only if they become severe.

Petitioner testified that he is also in the Army and is required to complete a physical fitness test every three months. He testified that since he has returned back to work full duty, he has tried and failed each one of these. He testified that if he fails again, the Army will start a packet for discharge. He testified that he is determined to pass the test and remain in the Army. He testified that his hobbies of fishing and hunting have been adversely affected to the point where he cannot stand on the boat and balance himself and cast at the same time. He testified that his hobby of motorcycle riding has also been adversely affected.

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The Medical Records List was entered into evidence at the time of arbitration as Petitioner's Exhibit 2.

The medical records of Quality Healthcare Clinics were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on September 8, 2016, at which time it was noted that he presented with right lower back pain with numbness to the right lower extremity. It was noted that Petitioner reported that he was at work when he picked up an ammunition bag and felt a "pop" in his lower back. It was noted that Petitioner reported that he felt he could complete all job duties at work without any restrictions, that he was in the military reserves and that he had a physical training test on September 10th. The assessment was noted to be that of lower back pain with radiculopathy. It was noted that Petitioner was informed to keep his primary care physician appointment on September 12th. (PX3).

The records of Quality Healthcare Clinics reflect that Petitioner was seen on September 9, 2016, at which time it was noted that on September 7th he bent over to pick up two bags of ammunition, one in each hand, and heard a pop in his back and later felt tightness in the right side of his back. It was noted that Petitioner now had right lower back tightness and right posterior thigh to knee with constant burning pain and sharp pain behind the right knee. It was noted that Petitioner felt like he had to stretch prior to walking after sitting and that his back tightened up at night and after sitting. It was noted that Petitioner's right foot tingled at times. The assessment was noted to be that of right lumbar radiculopathy. It was noted that Petitioner was bringing back Guard papers to complete and that he was able to walk and wear his boots and uniform, but that he was provided with restrictions for the weekend. Petitioner was given medications and given stretches and care for lumbar and SI joint pain. At the time of the September 23, 2016 visit, it was noted that Petitioner stated that the pain had not gotten any better and that sitting made it worse. It was noted that Petitioner had been doing the stretches at home but complained of pain when he did them. It was noted that Petitioner knew he more than likely would be referred to physical therapy. Petitioner was prescribed medications and given an order for physical therapy and an MRI. (PX3).

The records of Quality Healthcare Clinics reflect that Petitioner was seen on October 7, 2016, at which time it was noted that he stated that he seemed to have gotten worse with an occasional pop in the right lumbar region. It was noted that Petitioner stated that he was at work on that date and that at 0300 had a pop on his right side and now more pain down his left leg. It was noted that Petitioner had an appointment with Dr. Raskas on October 14th. It was noted that Petitioner stated that he had radiating pain in the bilateral legs with throbbing and more pain on the right side, and that he had a lot more numbness and tingling when going from sitting to standing positions. It was noted that the MRI showed L5-S1 with severe cord compression. The assessment was noted to be that of (1) L5-S1 compression; (2) radiculopathy. Petitioner was instructed to keep his appointment with Dr. Raskas and to cancel physical therapy. At the time of the November 4, 2016 visit, it was noted that Petitioner was seen to fill out papers for work. It was noted that he had undergone surgery on October 21st and that he stated that he had been out of work since September 7th. It was noted that Petitioner's disability forms were completed. (PX3).

The medical records of Sparta Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner underwent an Initial Evaluation for physical therapy on September 30, 2016. Petitioner was a "no show" for the visits scheduled on October 4, 2016 and October 7, 2016. The Discharge Summary dated November 28, 2016 noted that Petitioner did not return to physical therapy after his Initial Evaluation on September 30, 2016, that he did not show for his last scheduled visit on October 7th and that his current status was unknown. The records also reflect that Petitioner underwent an MRI of the lumbosacral spine on October 3, 2016, which was interpreted as revealing mild focal disc pathology and spondylosis at L4-5 creates low grade impingement of the bilateral L4 and L5 nerve roots; large right L5-S1 right-sided disc extrusion creates severe impingement of the right L5 and S1 nerve roots; expeditious neurosurgical management is indicated. (PX4).

The medical records of Dr. David Raskas were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on October 14, 2016, at which time it was noted that his chief complaint was that of right buttock pain and pain radiating down the right leg that had become progressively worse and progressive weakness in the right lower extremity. It was noted that the injury occurred on September 13, 2016, that Petitioner was moving ammunition and that a little more than 2/3 of the way through the job, he went around a corner and felt a pop in his low back. It was noted that Petitioner's treatment had consisted of medications and physical therapy, and that he went to one session and really could not tolerate it very well at all. It was noted that Petitioner was having severe right buttock pain radiating down his right leg. The assessment was noted to be that of (1) low back pain; (2) lumbar herniated disc. Petitioner was recommended to undergo an L5-S1 microdiscectomy. (PX5).

The records of Dr. Raskas reflect that Petitioner was seen on November 8, 2016, at which time it was noted that he was a little less than three weeks post-op from his microdiscectomy. It was noted that

Petitioner was doing very well clinically, that his leg pain felt a lot better and that he stated after he was up a while he would notice some aching in his back and a little bit down his right leg, but that he felt like his strength was improving. Petitioner was instructed to start physical therapy in two weeks. At the time of the December 20, 2016 visit, it was noted that Petitioner was doing pretty well clinically, that he had missed some physical therapy because the adjustor cancelled his physical therapy appointments and that they had been reinstated. It was noted that Petitioner had had significant relief of his radiculopathy and that he still had some soreness in his back intermittently that he graded at 2/10. Petitioner was instructed to continue physical therapy. At the time of the January 31, 2017 visit, it was noted that Petitioner was doing well, had no issues with pain management and was ambulatory without difficulty. It was noted that Petitioner had improvement in his post-surgical pain compared to pre-surgery, that he denied any radicular symptoms and that he was overall doing very well and was very pleased. Petitioner was cleared to return to all activities. At the time of the March 7, 2017 visit, it was noted that Petitioner was doing very well clinically and was back to working full duties. It was noted that Petitioner occasionally had some sciatic pain in his right leg. Petitioner was to follow-up as needed and was released at maximum medical improvement. (PX5).

The medical records of Frontenac Surgery Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that on October 21, 2016, Petitioner underwent (1) L5-S1 right-sided laminotomy and foraminotomy; (2) microdissection with removal of herniated disk for a pre- and post-operative diagnosis of right-sided L5-S1 herniated disc with S1 radiculopathy. (PX6).

The medical records of Gailcrest Neurological were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner underwent Intraoperative Neurophysiology on October 21, 2016. (PX7).

The medical records of Apex Physical Therapy were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records reflect that Petitioner underwent physical therapy for the timeframe of November 22, 2016 through December 21, 2016. At the time of the December 19, 2016 visit, it was noted that Petitioner complained of continued low back pain with radiation to the right lateral knee and that the lower extremity pain had not changed since before surgery. It was noted that Petitioner also had mid-back pain which started last week and that he was unsure of the cause. (PX8).

The Worker's Compensation Documentation Log was entered into evidence at the time of arbitration as Petitioner's Exhibit 9.

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

The Worker's Compensation Documentation Log was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The records were duplicative of those as contained in Petitioner's Exhibit 9. (RX2; PX9).

CONCLUSIONS OF LAW

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that no AMA rating was offered by either party. The Arbitrator places no weight on this factor when making the permanency determination.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that the record reveals that Petitioner was employed as a Correctional Officer at the time of the accident and that he has returned to this position with Respondent. The Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 28 years old on his date of accident. Given the younger age of Petitioner and the fact that the medical records lack any reference to his having been placed under any restrictions, 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, following his work injury, Petitioner returned to his position as a Correctional Officer with Respondent. As there was no direct evidence of reduced earning capacity contained in the record, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he has continued symptoms of soreness and tightness in the hamstring of his right leg. He described it as being similar to the leg pain/sciatica he experienced after the injury occurred. He testified that he also experiences tightness in his low back. At the time of the March 7, 2017 visit with Dr. Raskas, it was noted that it was noted that Petitioner was doing very well clinically and was back to working full duties. It was noted that Petitioner occasionally had some sciatic pain in his right leg. Petitioner was to follow-up as needed and was released at maximum medical improvement. (PX5). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely his continued complaints and limitations, were somewhat corroborated by his treating records entered into evidence at the time of arbitration. The Arbitrator accordingly places lesser 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 **12.5% loss of use of the person-as-a-whole** as provided in Section 8(d)2 of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mark Komer,

Petitioner,

vs. NO: 13 WC 08232

The Heartland Construction,

Respondent,

17IWCC0833

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 9, 2017, is hereby affirmed and adopted.

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

17IWCC0833

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 Count shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: DEC 27 2017
o121417
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

KOMER, MARK
Employee/Petitioner

Case# **13WC008232**

THE HEARTLAND CONSTRUCTION
Employer/Respondent

17IWCC0833

On 5/9/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.01% 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:

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

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

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Mark Komar
Employee/Petitioner

v.

The Heartland Construction
Employer/Respondent

Case # **13** WC **8232**

Consolidated cases: _____

17IWCC0833

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **February 21, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

Mark Komar
13 WC 8232

17IWCC0833

FINDINGS

On the date of accident, **October 19, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**58,823.11**; the average weekly wage was $**1131.11**.

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

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

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

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

ORDER

Petitioner has not proven, by a preponderance of the evidence that his right shoulder condition is causally related to the work injury therefore, treatment and surgery requested for the right shoulder is hereby denied pursuant to 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.

17IWCC0833

FINDINGS OF FACT

The disputed issues in this matter are: 1) causal connection regarding injury to the right arm: and 2) medical treatment and payment of bills for the right arm. *See,* AX1.

Petitioner's testimony

This claim involves an undisputed accident occurring on October 19, 2012, when Mr. Komar, ("Petitioner"), fell from a ladder while working as a carpenter for The Heartland Construction company, ("Respondent"). Petitioner testified that he fell from the ladder onto the left side of his body, striking his left elbow and forearm, as well as the left side of his torso. Petitioner explained he had severe bruising along the left side of his body and that photos were taken by physicians shortly after the accident, reflecting injuries to the left side of his body. Petitioner explained that as he was falling, he reached to catch the roof with his left arm, however he was unsuccessful.

Petitioner was treated, on an emergency basis, for left forearm and elbow pain. He was diagnosed as suffering a fracture of the left wrist, which was the primary focus of initial care. Petitioner confirmed that there were no complaints of pain regarding the right arm or shoulder at the time of the initial accident and no complaints are reflected in the emergency room records. PX2.

Upon referral, Petitioner treated with Dr. Romano at Hinsdale Orthopedic and was prescribed therapy at Pro Rehab in Palos. Although Petitioner testified that he initially suffered right arm and shoulder pain, initial treatment records do not reflect diagnostic testing or complaints to the emergency room doctors or Dr. Romano. The focus of care was to the left upper extremity and the left side of the body.

Petitioner also presented to Dr. Hytros, his primary care physician. Although Petitioner testified that he complained of symptoms on both the left and right shoulders while treating with Dr. Hytros, the records of Dr. Hytros reflect primary complaints to the left hand and arm which, is where Petitioner apparently suffered the brunt of his impact from the fall. Dr. Hytros records do reference right-sided neck pain however, there is no reference of complaints regarding the right shoulder.

Petitioner was referred to Dr. Karnezis by Dr. Hytros and began treatment in December of 2012. On December 17, 2012, Dr. Hytros' notes have a focus of complaints and treatment to the left hand and shoulder, with left neck strain diagnosed. PX11.

Dr. Karnezis performed a wrist scope in April of 2013 as well as right carpal tunnel release in October of 2013. An additional left wrist surgery was performed on January 20, 2014, with a subsequent surgery involving ulnar shortening in September of 2014. Thereafter, Petitioner underwent a left shoulder surgery involving rotator cuff repair on March 5, 2015, then a procedure to remove hardware in the left wrist on October of 2015. The treatment involving Petitioner's left wrist, shoulder and the right carpal tunnel were accepted by Respondent and all bills have been paid.

Petitioner began complaining to Dr. Karnezis of right shoulder pain on or about November of 2014. Despite Dr. Karnezis' assertion that they were early complaints to the right shoulder, his records do not reflect such complaints until November of 2014, two years after the accident. Petitioner explained that he had been using his right arm more due to the left arm injury and this led to increased pain. Dr. Karnezis has recommended a right shoulder procedure which has been denied by Respondent as unrelated to the work injury.

Petitioner has seen several physicians for independent medical examinations ("IMEs"), throughout the course of his care. The reports of these examinations state that there was never any symptomology or complaints of right shoulder pain, for the first two years of care.

Dr. Jeffery Visotsky examined the petitioner on January 18, 2013 and found the right shoulder exam to be normal with full range of motion and full strength. Similarly, a follow-up examination by Dr. Singh on February 18, 2013, found neck pain and symptomology however the right shoulder demonstrated a full range of motion and there were no specific complaints of right shoulder pain. RXs 1 & 3.

On May 6, 2013, an examination was performed by Dr. Barbara Heller and there was no report of complaints of right shoulder pain and additionally, Petitioner explained that his left shoulder did not manifest symptoms until four months after the injury. This is noteworthy because Petitioner fell on the left side of his body and there had been no complaints of right-sided pain, to date.

Petitioner was re-examined by Dr. Visotsky on September 17, 2013, and again, it was noted that the right shoulder exam was normal with no complaints of pain.

On September 10, 2014, Petitioner was re-examined by Dr. Visotsky and found to have a normal right shoulder exam with full range of motion and no pain or symptomology. It was not until the medical examination on July 12, 2016 with Dr. Visotsky, that this physician first found positive findings to the right shoulder involving a tender AC joint and positive impingement. RXs 4-6.

Upon deposition on February 18, 2014 and October 14, 2016, Dr. Visotsky testified that he found no evidence of complaints of right shoulder pain after the accident for an extended period. He noted no complaints in the emergency room or initial care records. Dr. Visotsky confirmed that the lack of any symptomology in exam findings for almost two years after the work injury, supports his opinion that there is no relation between the work injury and Petitioner's more recent right shoulder complaints. Dr. Visotsky also noted that during physical therapy, Petitioner did not allege any overuse of the right arm, which might otherwise lead to his right shoulder complaints. RXs 8-9.

Dr. Karnezis was deposed and testified as Petitioner's treating physician. It is noteworthy that upon Petitioner's first presentation for treatment, in December 2012, there were no right shoulder complaints reflected in Dr. Karnezis' chart although he testified he believed there had been complaints verbalized. His testimony is inconsistent with his treatment chart.

Dr. Karnezis acknowledged that there was no mention of right shoulder pain contained in his treatment records. Dr. Karnezis speculated that the right arm may have been injured while Petitioner was hanging, in an effort to avoid falling however, Petitioner's testimony at trial stated that he was hanging by his left shoulder, not the right, thereby excluding Dr. Karnezis' speculation that the right arm was injured during the accident.

Dr. Karnezis also testified that he was not privy to the initial treating or emergency room records for initial care; and therefore, was uncertain as to whether Petitioner truly had immediate complaints of pain to the right side after the injury. Dr. Karnezis acknowledged his treatment records do not reflect right shoulder complaints until November, 2014. Dr. Karnezis acknowledged his theory that Petitioner may have overused his right arm due to the left shoulder and hand surgeries was "speculation". PXs 8 & 9.

Dr. Karnezis' treatment records as reflected in Respondent's Exhibits 13–19; for dates of service from through October of 2014, also exhibit an absence of complaints of right-sided shoulder pain, for an extended period after the work injury.

CONCLUSIONS OF LAW

A decision by the Commission cannot be based upon speculation or conjecture. *Deere and Company v. Industrial Commission*, 47 Ill.2d 144, 265 N.E. 2d 129 (1970). A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a causal connection between work and the alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v Industrial Commission*, 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794 (4th Dist. 1989).

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin v. Industrial Commission*, 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v. Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956). It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); *see also*

Hansel & Gretel Day Care Center v. Industrial Commission, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor vs. Industrial Commission*, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal v. Industrial Commission*, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances [emphasis added] support the decision. *See generally, Gallentine v. Industrial Commission*, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), *see also, Seiber v. Industrial Commission*, 82 Ill.2d 87, 411 N.E.2d 249 (1980), *Caterpillar v. Industrial Commission*, 73 Ill.2d 311, 383 N.E.2d 220 (1978). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); *Hosteny v. Workers' Compensation Commission*, 397 Ill. App. 3d 665, 674 (2009).

The narrow issued presented before the Arbitrator in this case involves the requested authorization of Petitioner's right shoulder surgery, as prescribed by Dr. Karnezis. While Petitioner's work injury of October 19, 2012 was undisputed, treatment has initially focused on the left side of Petitioner's body, i.e., the left wrist and left shoulder. It was not until two years after the date of injury that Petitioner's complaints of right shoulder pain manifested in the treatment records and Dr. Karnezis then recommended right shoulder surgery. It is this procedure that is at issue.

Section 8(a) of the Act directs employers to pay for reasonable and necessary medical care "*which is reasonably required to cure or relieve from the effects of the accidental injury . . . .*" Respondent denied authorization of this surgery as unrelated to the work accident. For reasons explained below, the requested surgery to the right shoulder is hereby denied as unrelated to the original accident.

It is noteworthy that all treatment up to this point has been authorized by Respondent; there was also bilateral CTS diagnosed, which Respondent paid. Multiple surgeries to the left wrist and surgery to the left shoulder have also been undertaken.

The initial emergency room records which document a fall from a ladder with a fracture/surgery to the left wrist, severe bruising to the left side of the body, and subsequent surgery to the left shoulder are clear and consistent. Initial emergency room records for Petitioner's early care also reflect a focus of treatment to the left wrist fracture. While the left shoulder complaints did not manifest for several months, the relationship is apparently based on the impact to Petitioner's left side of the body, as explained in Petitioner's testimony.

Regarding Petitioner's right shoulder, there is a notable absence of complaints of pain, during care for the first two (2) years after this work accident. The emergency room records, the records of personal

care physician Dr. Hytros, as well as various IMEs from Drs. Visotsky, Singh and Heller reveal an absence of any right shoulder complaints of pain. Moreover, the reports by these three IME physicians reflect a normal right shoulder examination with full range of motion at full strength.

While Dr. Karnezis offers an opinion that Petitioner may have complained of right shoulder pain initially, Dr. Karnezis also admits that he did not review the emergency room records and did not see the early treatment history for Petitioner. Moreover, Dr. Karnezis acknowledged that his own records do not reflect right shoulder complaints until November of 2014, over two years after the accident. Finally, Dr. Karnezis acknowledges that his opinion on potential "overuse" of the right arm due to left arm disability is "speculation" at best and therefore the theory that Petitioner over-used his right arm during treatment does not rise to the evidentiary standard needed to afford benefits under the Act.

Although Petitioner asserts he made complaints of right shoulder pain to his personal care doctor, Dr. Hytros, these handwritten records do not reflect any such complaints. The handwritten notes reflect consistent complaints on the left side of Petitioner's body and only references right-sided neck pain.

Based on the treatment charts and the examination records of six physicians, the overwhelming evidence suggest Petitioner suffered no injury to the right shoulder on the date of his fall on October 19, 2012. Petitioner's fall was exclusively to the left side of the body with detailed documentation from the emergency room records in addition to subsequent care by Drs. Romano, Hytros, and Karnezis, whose records offered no history or documentation of Petitioner's alleged complaint of right-sided shoulder pain.

The Arbitrator finds Dr. Vosotsky's opinions to be more persuasive that those of Dr. Karnezis. Accordingly, based on the history of accident and fall to the left side of the body; the absence of any initial complaints of right shoulder pain; the variety of treatment and examination records supporting the absence of such right shoulder complaints for two years; the Arbitrator finds that Petitioner has not proven, by a preponderance of the evidence that his need for right shoulder treatment is related to the work accident of October 19, 2012. Therefore, Respondent is not liable for any medical treatment provided to Petitioner for the right extremity and no benefits for treatment on Petitioner's right side are awarded pursuant to the Act.

17IWCC0833

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
13WC8232
SIGNATURE PAGE

Signature of Arbitrator

May 9, 2017
Date of Decision

MAY 9 - 2017

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Eduardo Parra,

Petitioner,

vs.

NO: 14 WC 36335

Aramark Uniform & Career Apparel, LLC.,

Respondent.

17IWCC0834

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

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Petitioner is a 42 year old employee of Respondent (shift lead at time of injury). Petitioner had been working for Respondent 18 years and was currently a maintenance engineer (back and forth with lead). Petitioner had two people on his team at the time of the injury (Arnoldo Cuevas-still his supervisor, was present at hearing). Petitioner now does preventive maintenance on machinery. Respondent is a commercial laundry facility

for uniforms. Petitioner testified to there being about 150 employees at that location of Respondent's. There were two maintenance people on his shift (5:00am to 1:30pm). His job is more tech. Lead was being in charge of the two other guys with you. Petitioner was currently still on light duty (accommodated); he was not on light duty on the date of accident. On the date of accident, October 8, 2014, Petitioner testified that he received a call and he went to see what was going on with the machine. Petitioner stated that as he went to see, he stepped on a cork and fell to the floor. One of the waste water guys and the supervisor came to him, helped him up and took him to the maintenance office and gave him an ice pack. Petitioner agreed he stated that he had stepped on a cork while going to inspect the machine. Petitioner testified that he had stepped on the cork with his right foot and fell to the ground. Petitioner stated that he noticed pain in his right ankle after the fall and he had some pain in his lower back; the right ankle was in a lot of pain. Petitioner testified that he had no prior right ankle or low back problems or injuries before the accident. Petitioner stated that after the fall he was not able to get up by himself; he tried but the ankle pain prevented him getting up. Petitioner stated that co-workers helped him up and helped him to the maintenance office; no one was present in the office. Petitioner testified that he stayed in the maintenance office about two hours icing his ankle before he went home at the end of his shift. There is no nurse at the facility. Petitioner informed Arnoldo Cuevas of the injury but he did not see him there. It was a production supervisor (different department) who helped him to the office and knew what happened. Petitioner testified that he kind of limped, crawled to his car and drove himself home at the end of his shift. Petitioner indicated that he used his left foot to brake and accelerate driving home. Petitioner did not go to the doctor that day; he just stayed home and iced his ankle. Petitioner testified that he was not able to sleep due to the severity of pain.

- Petitioner testified that the next day he went to the emergency room at Little Company of Mary Hospital. Petitioner reported to them that he hurt his right ankle where x-rays were taken and medication and crutches prescribed. Petitioner testified that his ankle was no better when he got home and he went the next day to Dr. Thomas, his primary care doctor. Petitioner reported to Dr. Thomas what was bothering him regarding the ankle and the back and that he had gone to the ER prior. Petitioner stated the doctor gave him like a hard cast for his foot. The cast was on for about 2 weeks before being replaced by a walking boot. He did not return to work as of October 10, 2014, as the doctor then kept him off of work. Petitioner saw the doctor again a few days later but he did not see any improvement so Dr. Thomas wanted Petitioner to see Dr. De Frino, a specialist. Petitioner testified the first month he was not doing much walking or anything and he was on medication but he still had pain in the ankle; not as much in the back. About October 21, 2014 Petitioner stated that he had an x-ray of his low back by order of Dr. Thomas who referred Petitioner to a specialist about November 1, 2014. Petitioner first saw Dr. De Frino (Parkview Orthopedic Group) November 17, 2014 about the right ankle; Petitioner had not at that time returned to work. The doctor examined Petitioner and took x-rays and had Petitioner take off the boot and do some ankle exercises. The

doctor kept Petitioner off work. Petitioner stated that he underwent therapy from November through December 2014. Petitioner indicated when therapy started it did get better but he kind of plateaued and was getting no better; that was when the doctor said that Petitioner needed surgery. An MRI was prescribed and the doctor reviewed it with Petitioner and made the surgical recommendation for the right ankle. Petitioner testified that he wanted to have the surgery and would have it if awarded. At that point, as surgery had not been approved, he had continued in therapy to a point. The doctor had returned Petitioner to light duty work since about December 14, 2014 and Petitioner was still waiting to have the surgery. Petitioner testified to having seen Dr. De Frino a few times since returning to light duty work and waiting for the surgery; they had done further x-rays a few times. Petitioner stated that he had been to IME's with Dr. Holmes a couple times and once with Dr. Wehner. Petitioner stated the pain never goes away; up and down, it depended on his activity level. He gets swelling depending on activity; with a lot of walking or whatever the same day. Petitioner still wears a brace on the right ankle for support as ordered by Dr. De Frino. Regarding his back, Petitioner agreed that he did not have a lot of treatment on it while he was seeing Dr. De Frino. Petitioner stated that his back was bothering him but not as bad as his ankle. Petitioner testified that his ankle bothered him so much that it changed the way he walked, limped; again, depending on activity level.

- Petitioner has been able to accomplish performing the light duty work at Respondent; some days he is on his feet more than other days and that is when he notices his foot/ankle hurts more. Petitioner agreed in 2016 he returned to Dr. Thomas regarding his back after returning from vacation; it got to the point that he could not stand the pain in his back any more. He stated then he had pain to where he could not even move. Petitioner saw Dr. Thomas in April or May 2016 and the doctor gave him two shots and pain medications for his low back which he stated was helpful. Petitioner was not on the job when his back was hurting. He did follow up with the doctor after the injections and his back felt a little better but the doctor recommended Petitioner see a specialist and Dr. Thomas continued Petitioner on light duty at that time (5/16). Petitioner saw Dr. Ghanayem (Loyola) about June 13, 2016. Petitioner informed Dr. Ghanayem of what occurred October 2014 and the doctor examined Petitioner and reviewed the MRI from Little Company of Mary Hospital. Petitioner stated that Dr. Ghanayem recommended therapy for the back and took Petitioner off work from June 9 through August 25, 2016.

The Commission finds that the evidence and testimony established that Petitioner suffered a right ankle and some minor low back injury when he stepped on the cork and twisted his ankle and fell. Petitioner evidenced a clear, unbroken causal connection to his right ankle condition of ill-being and current need for surgery. Petitioner did report a back injury and x-rays were initially taken, but, Petitioner then received no treatment for his back until 2016, and there were no back complaints noted throughout that time. It has been indicated that mechanical back pain can be caused by gait issues. There are differing opinions on that between Petitioner's doctor and

17IWCC0834

Respondent's §12 examiner, Dr. Wehner. Records and testimony clearly evidence Petitioner's ongoing ankle issue and some gait problems and Petitioner having difficulty weight bearing with being on his feet for extended periods. Petitioner also is evidenced to have some degenerative disc disease and that could have potentially been temporarily aggravated then with an altered gait pattern. The fact that Petitioner had no back complaints or treatment until about a year and a half after the accident raises a question as to an ongoing, unbroken causal relationship to his current back condition of ill-being. Petitioner's back complaints and treatment in 2016 appeared after he returned from a vacation in Las Vegas apparently having walked a lot there. His back was not injured/aggravated while treating on the ankle or with work activities. Given the time between the accident and finally seeking treatment for his back almost a year and a half later, the Commission finds that any causal relationship regarding the back had been severed in 2014, and should therefore, reverse and deny any temporary total disability (TTD) or medical expenses/prospective medical care regarding the back in 2016. Petitioner met the burden of proving the current condition of ill-being regarding the ankle is causally related. The Commission finds the decision of the Arbitrator as partially contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to causal connection to the ankle condition of ill-being, but, reverses to find no causal relationship to the current condition of ill-being regarding Petitioner's back.

The Commission, with the above finding of no causal connection regarding the back, modifies/reverses the decision to deny the 2016 period (7-3/7 weeks) of lost time as that was due to the back condition and not causally related to the accident. A finding above of no ongoing causal connection regarding the back finds Petitioner failed to meet the burden of proving entitlement to that TTD period. The Commission finds the decision of the Arbitrator as contrary to the weight of the evidence, and, herein, reverses to deny the TTD period in 2016.

The Commission, with the above finding of no causal connection regarding the back condition of ill-being, modifies/reverses the decision to deny the 2016 bills regarding back treatment. Petitioner met the burden of proving entitlement to the medical expenses regarding the ankle, and the prospective medical regarding the ankle as awarded with the evidence and testimony supporting the award. The Commission finds the decision of the Arbitrator as contrary to the weight of the evidence regarding the back, and, herein, affirms and adopts the Arbitrator's finding as to medical expenses/prospective medical care regarding the ankle, but reverses to deny the medical expenses regarding the back condition of ill-being.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $-0- per week for a period of -0- weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner medical expenses under §8(a) of the Act regarding the ankle condition treatment. Further, the Commission, herein, orders Respondent to authorize and pay for the prospective medical care in the form, of right ankle surgery as recommended by Dr. De Frino. The Commission denies any and all medical bills regarding back treatment in 2016 and forward.

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 $40,000.00. 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: DEC 27 2017
o-11/9/17
DLG/jsf
045

Stephen J. Mathis
Stephen Mathis

Deborah L. Simpson
Deborah Simpson

Dissent

I respectfully dissent from the majority decision and would affirm the Arbitrator's well reasoned decision in its entirety.

David L. Gore

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

PARRA, EDUARDO
Employee/Petitioner

Case# **14WC036335**

ARAMARK UNIFORM & CAREER APPAREL LLC
Employer/Respondent

17IWCC0834

On 2/15/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.64% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0290 KARCHMAR & STONE
GARY P STONE
111 W WASHINGTON ST SUITE 1030
CHICAGO, IL 60602

1739 STONE & JOHNSON CHTD
PATRICK DUFFY
111 W WASHINGTON ST SUITE 1800
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Eduardo Parra
Employee/Petitioner

v.

Aramark Uniform & Career Apparel, LLC
Employer/Respondent

Case # **14** WC **36335**

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

17IWCC0834

An *Application for Adjustment 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 **01/23/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, 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 right ankle and low back conditions of ill-being *are* causally related to the accident.

In the year preceding the injury, Petitioner earned **$64,456.60**; the average weekly wage was **$1,239.55**.

On the date of accident, Petitioner was **40** years of age, ***married*** with **3** dependent children.

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

Respondent shall be given a credit of $6,931.69 for TTD (10/19/14-12/9/14), **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of $6,931.69.

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

ORDER

Respondent shall pay reasonable and necessary medical services as provided in Section 8(a) and 8.2 of the Act as follows: Evergreen Care Center-Dr. George Thomas, Little Company of Mary Hospital, Radiology Imaging Specialists, Ltd. and Athletico Physical Therapy. PX 6-10. For the reasons set forth in the attached decision, the Arbitrator declines to award the bills from Loyola University (Dr. Bajaj) and Loyola University Health System. PX 10-11.

The parties agree Petitioner was temporarily totally disabled from October 9, 2014 through December 9, 2014. Arb Exh 1. For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner was also temporarily totally disabled from June 13, 2016 through August 3, 2016, a period of 7 3/7 weeks, as provided in Section 8(b) of the Act. Based on the stipulated average weekly wage, the Arbitrator finds Petitioner's temporary total disability rate to be $826.37 per week.

For the reasons set forth in the attached decision, the Arbitrator declines to award temporary partial disability benefits.

For the reasons set forth in the attached decision, the Arbitrator awards prospective care in the form of the right ankle surgery recommended by Dr. DeFrino. Petitioner did not request prospective back care at the hearing.

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

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

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

Molly E Mason

Signature of Arbitrator

2/15/17
Date

ICArbDec19(b)

FEB 15 2017

Eduardo Parra v. Aramark
14 WC 36335

Summary of Disputed Issues

The parties agree Petitioner injured his right ankle while working for Respondent on October 8, 2014. They also agree Petitioner was temporarily totally disabled due to this injury from October 9, 2014 through December 9, 2014. The following issues are in dispute: 1) whether Petitioner also injured his low back and required low back care in 2016, with Petitioner seeking an award of various bills; 2) whether Petitioner was temporarily totally disabled due to his back from June 9, 2016 through August 25, 2016; 3) whether Petitioner is entitled to temporary partial disability benefits from August 26, 2016 through the hearing of January 23, 2017; and 4) whether a proposed right ankle surgery is reasonable and necessary. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner testified he has worked for Respondent, a commercial laundry, for approximately 18 years. He has held various job titles during that time. As of the October 8, 2014 accident, he was a "lead," meaning he acted as a shift leader, supervising two maintenance engineers. He now works as a maintenance engineer, maintaining and repairing washers and dryers as directed by his supervisor, Arnoldo Cuevas. He is currently performing light duty. He was not restricted to light duty before the accident.

Petitioner denied having any right ankle or low back problems before his accident of October 8, 2014. On that date, he was walking toward some machines, in order to perform a work assignment when he stepped on a cork with his right foot and fell to the ground. He was unable to get back up on his own due to right ankle pain. He testified he felt a lot of pain in his right ankle and some low back pain after he fell. Two individuals, including a production supervisor, came to his aid and helped him get to a vacant maintenance office, where he applied ice to his right ankle and waited for his shift to end. He then limped to his car and drove home, using his left foot to brake. After he arrived home, he applied more ice to his right ankle. He had difficulty sleeping due to pain.

Petitioner testified he first sought medical treatment the following day, when he went to the Emergency Room at Little Company of Mary Hospital. The Emergency Room records reflect that Petitioner complained of right ankle pain and swelling secondary to "twist[ing] right ankle on wine cork" the previous day. PX 1, p. 12. The records also reflect that Petitioner denied other injuries. PX 1, p. 7. Dr. Damiano ordered right ankle X-rays which showed mild lateral soft tissue swelling and no evidence of acute fracture or dislocation. PX 1, p. 16. Dr. Damiano diagnosed an acute right ankle sprain. He provided Petitioner with an Ace wrap and crutches. He advised Petitioner to take Motrin for pain, stay off work for 48 hours and follow up with a doctor in one or two days. PX 1, pp. 6, 9.

Petitioner testified he went to Evergreen Care Center the next day, October 10, 2014. He testified he went to this facility because it is where his children undergo care. He had not previously been seen there.

The Evergreen Care Center records (PX 2) reflect that Petitioner saw Dr. Malik on October 10, 2014, with the doctor recording the following history and complaints:

> "This is a patient who comes in with complaints of twisting his right ankle at work 2 days prior on 10/8/14. He states he went to Little Company of Mary Hospital yesterday. He had X-rays done that [were] negative for any fractures. He complains of pain, swelling and bruising. **Also complains of right lumbar pain.** The hospital gave him a note to return to work in 2 days but the patient does not think he is able to. He is still in pain and has difficulty ambulating." [emphasis added]

The doctor described Petitioner's past medical history as not significant. On right ankle examination, he noted tenderness, some mild swelling, no bruising or ecchymosis and good reflexes. He diagnosed a right ankle sprain. He advised Petitioner to stay off work for a couple more days and continue taking anti-inflammatories. He also advised Petitioner to return on October 14, 2014. PX 2, p. 22.

Petitioner testified he returned to Evergreen Care Center on October 14, 2014, as directed. On this occasion, he saw Dr. George Thomas. The doctor recorded a consistent history of the work accident. He noted that Petitioner was still experiencing difficulty walking due to right ankle pain and swelling. He also noted that Petitioner complained of a "little bit of right lower back pain" but denied radicular symptoms.

On right ankle examination, Dr. Thomas noted some swelling, bruising and ecchymosis as well as discoloration and hemosiderin staining over the lateral aspect of the ankle and bony tenderness at the lateral malleolus, pain with ankle inversion and pain over the ATFL ligament. He diagnosed a Grade 3 ankle sprain. He indicated that the conservative care to date, i.e., rest and crutch usage, "does not appear to be helping." He applied a U-mold to support the ankle in a "complete 90 degree position" and advised Petitioner to continue using crutches and avoiding weight bearing. He prescribed Tylenol with Codeine, to be taken as needed, and advised Petitioner to continue taking Anaprox. He did not view Petitioner as capable of resuming work, noting that Petitioner's job "consists of ambulation." He directed Petitioner to return to him in one week. PX 2, pp. 19-20.

Petitioner returned to Evergreen Care Center on October 21, 2014 and again saw Dr. Thomas. The doctor's handwritten note of that date reflects that Petitioner was still complaining of right ankle pain and reported being unable to take more than 2-3 steps. Both the handwritten and typed notes reflect that Petitioner again complained of lower back pain.

The doctor noted that Petitioner described this pain as "happen[ing] after injury." He also noted that Petitioner had no previous history of low back pain.

On right ankle re-examination, Dr. Thomas noted decreased swelling and bruising but continued pain with tenderness over the ATFL ligament with inversion and eversion.

Dr. Thomas indicated he also assessed Petitioner's low back. He noted "some mild reproducible lumbar pain, right greater than left." He described straight leg raising as negative and strength and sensation as normal.

Dr. Thomas diagnosed a Grade 3 ankle sprain, lumbar pain and difficulty ambulating. He ordered lumbar spine X-rays and changed Petitioner from the posterior mold to an ambulating CAM boot. He directed Petitioner to stay off work and return in one week. PX 2, pp. 16-18.

Petitioner underwent lumbar spine X-rays at Little Company of Mary Hospital the same day, October 21, 2014. The interpreting physician, Dr. Domiano, noted no fracture, subluxation or significant degenerative disease. He described the films as negative. PX 1, p. 19.

Petitioner saw Dr. Thomas again on October 28, 2014. The doctor noted that Petitioner reported "feeling better with the boot on" and continuing to have difficulty walking when not wearing the boot. The doctor also noted the results of the lumbar spine X-rays.

On re-examination, Dr. Thomas noted decreased swelling and an increased range of motion in the right ankle but "difficulty with ambulating out of the boot." He described Petitioner as "favoring his right ankle" and experiencing increased pain with ankle eversion, especially against resistance. He recommended an orthopedic consultation and directed Petitioner to stay off work and continue wearing the boot "until seen by orthopedics." PX 2, pp. 12-14.

Petitioner returned to Evergreen Care Center on November 8, 2014 and apparently saw a different physician, Dr. Thomas Joseph. The doctor noted ongoing right ankle complaints and a delay in authorization of the previously recommended orthopedic consultation. He discharged Petitioner from care, again recommending that he see an orthopedic surgeon and indicating this individual would need to address work status. PX 2, p. 9.

Petitioner testified that rest and treatment had helped, as of this point, but that he was still experiencing pain.

Petitioner saw Dr. DeFrino, an orthopedic surgeon associated with Parkview Orthopaedic Group, on November 17, 2014. Petitioner testified he was still off work as of this date.

In his initial note, Dr. DeFrino indicated that Petitioner reported "rolling" his right ankle at work after stepping on a cork. The doctor also noted that Petitioner had undergone no formal treatment other than a removable boot.

Dr. DeFrino described Petitioner as a "5' 10" 220-pound male with right ankle pain." On right ankle examination, he noted pain and discomfort over the anterolateral aspect of the ankle as well as some bruising and ecchymosis in the region. He obtained standing right ankle X-rays. He interpreted the films as showing no fracture, dislocation or bony changes. He discontinued the CAM walker boot and prescribed aggressive physical therapy as well as Lodine. He viewed Petitioner's right ankle symptoms as "likely more from the immobilization in the boot rather than the ankle sprain at this point" and indicated that aggressive therapy would help Petitioner "more quickly return to work." He directed Petitioner to stay off work another two weeks to allow therapy to start and then return to light duty with "no heavy lifting, pulling or pushing more than 15 pounds." He indicated it was likely Petitioner would be able to resume full duty after four weeks of therapy. PX 3, pp. 5-6.

Petitioner underwent an initial physical therapy evaluation at Parkview Orthopaedic Group on December 2, 2014. The evaluating therapist, Mary O'Neil, noted a consistent history of the work accident and subsequent care. She indicated Petitioner was "currently off crutches and not using any ankle support." She also noted Petitioner reported "start-up pain" and being able to stand or walk for an hour before becoming symptomatic. She noted reduced gastrocnemius strength and stated that Petitioner's "most significant range of motion loss is in dorsiflexion which is resulting in gait deviations and inability to perform a full squat." PX 3, pp. 10-12.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Holmes, of Midwest Orthopaedics at Rush, on December 3, 2014. The doctor's report of that date sets forth a consistent history of the work accident and subsequent care. The doctor noted that Petitioner had attended one therapy session and was still off work. He also noted that Petitioner complained of pain and swelling in the anterolateral aspects of the right ankle and in the Achilles. He indicated that Petitioner also reported experiencing some ankle instability, stiffness in the ankle on rising and increased pain after an hour on his feet.

Dr. Holmes indicated he reviewed a right ankle X-ray report of October 9, 2014 along with notes from Drs. Malik and Thomas.

On right ankle examination, Dr. Holmes noted a full range of motion, pain with palpation over the anterolateral aspect of the ankle, in the area of the Achilles tendon and direct anterior portion of the ankle and over the anterior tibial fibular ligaments as well as the calcaneus. He described the ankle as stable for anterior drawer testing.

Dr. Holmes obtained right ankle X-rays. He described the films as showing a "relatively well-maintained mortise," a possible slight increase of the lateral clear space and a small cyst in

the area of the lateral distal tibia. He noted no fractures and described overall alignment as excellent.

Dr. Holmes diagnosed a "possible ligament tear in the lateral complex of the ankle" and possibly also an occult lesion "such as an OCD lesion or bruising or mild syndesmotic injury." Given Petitioner's persistent symptoms, he found an ankle MRI to be reasonable and recommended that Petitioner discontinue therapy until the MRI results could be interpreted by the treating physician. He indicated he felt there was a causal relationship between the work accident and Petitioner's symptoms. He did not view the symptoms as a result of natural progression of an underlying disease process. He found Petitioner capable of sedentary or semi-sedentary duty with or without a boot or brace as needed. He did not find Petitioner capable of resuming his usual plant mechanic duties. Holmes Dep Exh 2.

Petitioner testified he began performing light duty at Respondent as of December 10, 2014.

Petitioner returned to Dr. DeFrino on December 15, 2014, with the doctor noting Dr. Holmes' MRI recommendation. He agreed with this recommendation. He provided Petitioner with a Swede O ankle brace and directed him to continue therapy. He found it reasonable for Petitioner to continue therapy as he anticipated the MRI being done within a couple of days. He continued the previous work restrictions. PX 3, p. 13.

The right ankle MRI, performed without contrast on December 22, 2014, demonstrated "intermediate to high-grade but non-retracted partial tearing of the talar insertion of the anterior talofibular ligament," mild peroneal tenosynovitis and no osseous lesions or edema of the ankle or hindfoot. PX 3, pp. 18-19.

A physical therapy note dated December 29, 2014 reflects that Petitioner reported having resumed light duty "which has no physical demands" and was "feeling much better overall." The therapist noted, however, that Petitioner reported increased pain with end range dorsiflexion while exercising during therapy. PX 3, pp. 22-24. A subsequent therapy note, dated January 8, 2015, reflects that Petitioner described himself as fine when walking but experiencing pain when exercising or dorsiflexing the ankle. PX 3, pp. 28-30.

In a note issued on January 9, 2015, therapist O'Neil indicated Petitioner denied pain with walking but complained of 2-7/10 pain with stair climbing, deep squatting or any extreme ankle motion. O'Neil also indicated that Petitioner did not complain of ankle instability. RX 3.

On January 12, 2015, Dr. DeFrino reviewed the MRI results with Petitioner and noted that Petitioner reported having less ankle pain. The doctor noted no instability on anterior drawer testing. He prescribed another four weeks of therapy and continued the work restrictions. He indicated he did not anticipate the need for surgery. PX 3, p. 34.

The following day, January 13, 2015, therapist O'Neil noted that Petitioner reported experiencing a lot of ankle pain and instability if he rotated his trunk while planting his foot. She also noted that Petitioner complained of pain along the Achilles tendon. Two days later, O'Neil noted that Petitioner remained symptomatic with end range motion but reported performing "90% of his work duties now." PX 3, pp. 38-43. On January 22, 2015, O'Neil noted pain with anterior drawer testing. RX 3. On January 29, 2015, O'Neil noted that Petitioner tolerated lifting exercises but consistently complained of pain with deep squatting, end range dorsiflexion and lateral stepping. PX 3, pp. 53-55. In a re-evaluation report issued on February 2, 2015, O'Neil indicated that Petitioner was able to walk "functional distances" but rated his pain at 3/10 "at best" and reported "extreme difficulty with standing for one hour, walking two blocks, running and getting in and out of a car." O'Neil also indicated that Petitioner reported having resumed most of his normal work duties but rated himself at "31% of max functional ability, worse than last re-eval." PX 3, pp. 56-58. On February 5, 2015, O'Neil noted that therapy was being placed on hold due to lack of approval from the insurance carrier. PX 3, pp. 59-61.

Petitioner saw Dr. DeFrino again on February 9, 2015. The doctor noted ongoing complaints of pain around the lateral aspect of the right ankle and instability. On re-examination, he noted "increased instability on the right side compared to the left side." He obtained stress X-rays and interpreted them as showing "fairly marked increased talar tilt consistent with ankle instability right ankle." He viewed the instability as the likely source of Petitioner's continued pain. He also viewed Petitioner as "reaching a plateau with therapy." He recommended that Petitioner attend therapy for two more weeks. He stated Petitioner would require surgery, consisting of a lateral ligament reconstruction, if the additional therapy did not help. He allowed Petitioner to continue light duty. PX 3, pp. 62-63.

There is no documentary evidence indicating Petitioner underwent additional therapy after February 9, 2015. PX 3. RX 3.

Petitioner returned to Dr. DeFrino on February 23, 2015 and voiced ongoing complaints of swelling, soreness and instability in his right ankle. On re-examination, the doctor noted swelling, tenderness over the anterior talofibular ligament region and increased pain with anterior drawer and talar tilt. The doctor viewed Petitioner as having reached a plateau with therapy. He again recommended surgery, noting that Petitioner wished to proceed. He indicated that a "modified Bostrom would be [his] first choice" but that a graft reconstruction might be necessary "if the tissue present at time of surgery [was] inadequate for stable repair." He allowed Petitioner to continue performing light duty. PX 3, pp. 68-69, 81.

At Respondent's request, Dr. Holmes reviewed additional records, along with the right ankle MRI, and issued a report on March 6, 2015. In the report, Dr. Holmes again found causation as to the work accident but stated he was "not fully onboard that there has been a cogent case made for ligament reconstruction at this time." While he viewed the MRI as "consistent with an anterior talofibular ligament injury," he noted that, when he earlier examined Petitioner, he did not detect the instability that Dr. DeFrino documented in his note

of February 9, 2015. He also stated it would be "unusual to have a significant degree of instability with only an injury to the anterior talofibular ligament." He stated that "this is the weakest of the three ligaments on the lateral aspect of the ankle" and that, "in order to get any sort of significant instability, one has to have absence of not only the anterior talofibular ligament but also the calcaneofibular ligament." He noted that Petitioner "has no real tenderness over the calcaneofibular ligament and therefore it would not be suspected that there is any structural injury to the anterior talofibular ligament that would result in any regional instability of the ankle." He found Petitioner's medical condition to be unstable and likely to improve with additional care and the passage of time. He further found Petitioner capable of light duty, semi-sedentary or sedentary work with or without the use of an ankle brace or support. He recommended that these restrictions remain in place for another month to six weeks given Petitioner's subjective complaints. He anticipated that, "hopefully," Petitioner would be able to resume full duty by April 2015, the six-month anniversary of his injury. Holmes Dep Exh 3.

On April 2, 2015, Dr. Holmes issued another report in response to a question from the insurance carrier asking him to specify "the type, length and duration of continued treatment" he was recommending for Petitioner. He recommended that Petitioner use a brace such as an Aircast splint or ASC brace. He indicated Petitioner "should be able" to resume full duty with such a brace but "may need to initially return in a light duty capacity for as long as the next 4 to 6 weeks." He anticipated a return to full duty "no later than April 2015." He indicated Petitioner might need to continue wearing a brace for three or four months. Holmes Dep Exh 4.

Petitioner returned to Dr. DeFrino on April 23, 2015, with the doctor noting Dr. Holmes' recommendation of conservative care. On re-examination, Dr. DeFrino noted "gross instability of the right ankle, positive talar tilt and pain associated with the talar tilt test." The doctor reviewed the X-rays taken on February 9th and interpreted them as showing "talar tilt of 30 degrees on stress, indicating a grossly unstable ankle." He again recommended right ankle surgery. He viewed Petitioner as having "exhausted conservative treatment including bracing." He allowed Petitioner to continue light duty. PX 3, pp. 70-71, 80.

A "work status update" note dated June 1, 2015 reflects that Dr. DeFrino again imposed light duty on that date. There is no accompanying office note. PX 3, pp. 79-80.

Petitioner saw Dr. DeFrino again on June 29, 2015. The doctor noted that Petitioner's right ankle remained unstable and that he was "working light duty awaiting final recommendations for his surgery." In the interim, the doctor recommended that Petitioner resume therapy, ice his ankle and take anti-inflammatories. He again imposed light duty. PX 3, p. 72, 78.

On July 23, 2015, Dr. DeFrino issued a report to Petitioner's counsel, reiterating his surgical recommendation and responding to Dr. Holmes' opinions:

"Dr. Holmes does not address the talar stress test that

> was performed by me on 2/9/15 which clearly shows gross instability of the lateral ligament complex. The degree of instability noted on the patient's stress X-ray, in my opinion, definitively confirms mechanical instability in the ankle.
>
> Review of the MRI scan certainly can be helpful in the diagnosis, however, the MRI scan itself cannot accurately establish mechanical instability alone. This mechanical instability is primarily a clinical diagnosis combined with a stress X-ray.
>
> In summary, if you take the clinical complaints of the patient of chronic pain and instability combined with clear objective evidence of instability from a stress X-ray, the diagnosis is confirmed. Given the long period of conservative management that essentially has failed to address the patient's clinical pain and instability, I recommend a lateral ligament reconstruction."

PX 3, pp. 3-4.

At Respondent's request, Dr. Holmes re-examined Petitioner on October 21, 2015. See below for a summary of the doctor's re-examination findings and conclusions.

On February 8, 2016, Dr. DeFrino issued a "work status update" imposing sedentary duty, with no extended walking or standing, and again recommending right ankle surgery. PX 3, p. 77. No accompanying office note is in evidence.

Dr. Holmes testified by way of evidence deposition on March 14, 2016. RX 1. Dr. Holmes testified he obtained board certification in orthopedic surgery in 1989. Since then, he has been re-certified every ten years. He has focused on foot and ankle surgery since he began his fellowship training in 1986. RX 1, pp. 5-6.

Dr. Holmes testified he examined Petitioner on December 3, 2014, at the request of Respondent or its insurer. He generated a report in connection with this examination. Holmes Dep Exh 2. At the examination, Petitioner provided a history of the work accident and reported "about 70% improvement with the conservative treatment" he had undergone to date. RX 1, p. 7.

Dr. Holmes testified that, when he examined Petitioner, he noted no asymmetry in the lower extremities, a full range of right ankle motion, pain on the anterolatral aspect of the ankle and pain in the area of the Achilles and front of the ankle. RX 1, p. 8. Anterior drawer testing was negative, meaning there was no instability. RX 1, p. 9.

Dr. Holmes testified it is not unusual for a person to have multiple areas of pain following an ankle sprain. This pain can last for months or a year. In Petitioner's case, there

was no specific area of pain that required surgery. RX 1, p. 9. He reached differential diagnoses. Petitioner had a possible ligamentous tear and possibly also an osteochondral defect or lesion and a syndesmotic injury, which is sometimes referred to as a "high ankle sprain.' RX 1, p. 10. He recommended that Petitioner undergo a right ankle MRI and hold off on therapy until the MRI could be interpreted. RX 1, pp. 10-11. He felt Petitioner could be employed "in a wide range," from sedentary work to a semi-sedentary position, possibly without a boot or brace. RX 1, p. 11.

Dr. Holmes identified Holmes Dep Exhibit 3 as a subsequent report he issued on March 6, 2015, after reviewing the MRI images and additional records from Dr. DeFrino and the physical therapist. He interpreted the MRI as showing an anterior talofibular ligament injury, which he felt was "relatively benign." RX 1, pp. 12-13. Although Dr. DeFrino noted a talar tilt on X-rays taken on February 9, 2015, "the presence of a talar tilt is not an indication for ligament reconstruction." Such a tilt is not significant unless both sides are measured. He did not view Dr. DeFrino's surgical recommendation as appropriate at that time. RX 1, pp. 14-15. Based on Petitioner's subjective complaints, he felt that Petitioner was precluded from resuming his previous job duties. RX 1, p. 15.

Dr. Holmes identified Holmes Dep Exhibit 4 as another report he issued on April 2, 2015. In this report, he recommended brace usage and four to six weeks of light duty before a resumption of full duty. RX 1, p. 16.

Dr. Holmes testified he re-examined Petitioner on October 21, 2015. He identified Holmes Dep Exhibit 5 as the report he generated in connection with this re-examination. Petitioner reported pain in the same areas as well as swelling, especially at night, and instability. Petitioner also informed him that he felt there was really no light duty at his job and he was performing heavier tasks. RX 1, pp. 18-19. Petitioner reported taking Tylenol and Advil as needed and using a brace at work. He denied any episodes of his foot giving way. RX 1, pp. 18-19. Dr. Holmes testified he noted no swelling on examination of the calf, ankle and foot. Anterior drawer testing did not reveal any instability. Petitioner did not complain of pain in the area of the anterior talofibular ligament when he performed this testing. RX 1, p. 20. A rating of "3" on such testing would be consistent with a completely dislocated ankle. Petitioner's rating was zero. RX 1, pp. 20-21.

Dr. Holmes testified he reviewed a photograph of an X-ray film supplied by Petitioner's wife. The photograph, taken on February 9, 2015, documented Dr. DeFrino's finding of talar tilt. Dr. Holmes testified the photograph was not significant "as a driver of surgery," for three reasons: 1) there was no photograph of the opposite side, i.e., left side; 2) Petitioner reported no episodes of the ankle "giving way"; and 3) at both of his examinations, anterior drawer testing was negative. RX 1, pp. 21-22. He took X-rays and interpreted them as unremarkable. He believed Petitioner's subjective complaints stemmed from the work accident but he recommended against surgery. He also recommended against Lidoderm patches, therapy and pain management. He recommended topical cream for pain. He also felt it was reasonable to proceed with a functional capacity evaluation. RX 1, pp. 24-25. He did not believe the injury

resulted in any permanent partial disability. He believed Petitioner to be at maximum medical improvement, except for ongoing subjective complaints. RX 1, p. 26.

Under cross-examination, Dr. Holmes testified he would have liked to see bilateral talar tilt measurements. If the tilt on one side is greater than 9 degrees in comparison with the opposite side, that would be a "potential indication for unilateral instability." RX 1, p. 31. Almost no one has zero degrees of talar tilt. Most people have four or five. What matters is the difference between the two measurements, right versus left. RX 1, p. 32. There are no measurements showing what Petitioner's right talar tilt was on February 9, 2015. RX 1, p. 33.

Dr. Holmes testified he devotes about 10 percent of his practice to independent medical examinations. Most of the examinations he performs are for respondents or insurers. RX 1, p. 34. His group charges around $1200 for each examination and $1000 per hour for deposition time. RX 1, pp. 34-35. He does not know how much he billed in Petitioner's case but the figure is likely to be around $3000. RX 1, pp. 35-36.

Dr. Holmes testified he knows Dr. DeFrino very well. He is aware that Dr. DeFrino is a fellowship-trained, board certified orthopedic surgeon. RX 1, p. 37. He believes Dr. DeFrino to be a good foot and ankle surgeon. RX 1, p. 38. He reviewed Dr. DeFrino's report of July 23, 2015. RX 1, p. 40.

Dr. Holmes testified he agrees Petitioner injured his right ankle while working on October 8, 2014. He views the treatment to date as reasonable, necessary and related to the accident. His diagnosis varies from that of Dr. DeFrino and he disagrees with Dr. DeFrino's recommendation of surgery. Petitioner does not need surgery "at this juncture." RX 1, p. 41. Petitioner only requires pain-related modalities. Petitioner injured his anterior talofibular ligament. An injury that is isolated to this ligament does not require surgery. Surgery would only be indicated if Petitioner had persistent ankle swelling, fluid in the ankle due to a joint abnormality, an injury to an additional ligament, a history of repetitive instability or atrophy indicating disuse. RX 1, pp. 44-45. When he saw the photograph of the February 9, 2015 X-ray, he "ballparked" the talar tilt measurement at 15 to 20 degrees. He would need to know the extent of the talar tilt on the left in order to determine whether the right-sided talar tilt is significant. Another factor that could cause him to recommend surgery would be X-ray evidence of a loose body or arthritis. RX 1, p. 46, 49.

Dr. Holmes testified that patients who are in constant pain usually have some non-ligamentous injury such as a nerve or soft tissue injury. RX 1, pp. 49-50. Petitioner has pain but has never complained of tingling or toe numbness, both of which could be indicative of nerve pain. The MRI does not show soft tissue injuries but it was taken in December of 2014. It would be reasonable to have Petitioner undergo a repeat MRI. RX 1, pp. 50, 63-64.

Dr. Holmes acknowledged he does not know how long Petitioner is on his feet at work each day. At this point, it would not be expected that an isolated anterior talofibular ligament injury would be causing pain with bearing weight. RX 1, p. 53.

Dr. Holmes testified that the structural ligaments supporting the ankle are the posterior talofibular ligament and the calcaneofibular ligament. Hypothetically, you could sever the anterior talofibular ligament and this would not affect the ankle's stability. RX 1, p. 54.

Dr. Holmes acknowledged that, based on Dr. DeFrino's examination findings and the February 9, 2015 X-ray, surgery is "potentially" reasonable. RX 1, pp. 55-56. His disagreement with the surgical recommendation is based on his own examination findings, which were different from Dr. DeFrino's, along with Petitioner's denial of episodes of instability. RX 1, pp. 55-56. Scar tissue can develop with repetitive injuries but Petitioner did not report repetitive instability. RX 1, p. 57. Based on his own examination, Petitioner will not likely develop chronic ankle problems without surgery. Petitioner will "absolutely not" develop arthritis without surgery. RX 1, p. 57. If a functional capacity evaluation demonstrated the need for restrictions, those restrictions would not necessarily be permanent. RX 1, p. 58.

Dr. Holmes testified that, from an objective standpoint, his examination findings did not change between 2014 and 2015. RX 1, pp. 60-61. From a subjective standpoint, Petitioner was back to work as of the 2015 examination. RX 1, p. 61. He would like to know what is causing Petitioner's subjective pain before he makes any further treatment recommendations. RX 1, p. 62. If a repeat MRI showed secondary ligamentous damage, a bone contusion, an osteochondral defect or a loose body, that would argue, at least potentially, in favor of Petitioner undergoing a ligament reconstruction. RX 1, p. 64. However, he would then have a question about causation, since the original MRI did not show these things. RX 1, p. 64.

Dr. Holmes acknowledged that Dr. DeFrino's recommendation of surgery is not below the standard of care. His medical judgment simply differs from Dr. DeFrino's. RX 1, p. 65.

On March 28, 2016, Petitioner returned to Dr. DeFrino, with the doctor noting "many months of severe ankle pain and instability" and pending arbitration. On re-examination, the doctor again noted "gross instability of the right ankle with anterior drawer and positive talar tilt." He obtained stress X-rays of both ankles. He indicated the right ankle X-rays showed what appeared to be a 20- to 25-degree intra-articular tilt versus roughly 5 to 7 degrees of talar tilt in the left ankle. [Copies of the comparative X-ray films appear at PX 3, p. 75.] He again recommended right ankle surgery, namely a "lateral ligament reconstruction using allograft tendon." PX 3, pp. 73-75. He again imposed light duty. PX 3, p. 76.

On April 19, 2016, Petitioner saw Dr. Thomas for a check-up. The doctor noted that Petitioner was seeing Dr. DeFrino for ankle pain. He also noted that Petitioner complained of weight gain and fatigue. He ordered various laboratory studies and directed Petitioner to follow up with him. PX 2, p. 8.

Petitioner saw Dr. Thomas again on May 9, 2016. The doctor noted a complaint of "lower back pain on/off for a year." On examination, he noted pain to palpation, positive

straight leg raising and weakness. He administered a Toradol injection and prescribed lumbar spine X-rays. He indicated Petitioner might need an MRI.

Petitioner underwent lumbar spine X-rays at Little Company of Mary Hospital on May 10, 2016. The radiologist interpreted the films as showing no acute fracture or dislocation and moderate facet arthropathy at L5-S1. PX 4, p. 12.

Petitioner saw Michelle Nagel, a certified nurse practitioner [hereafter "Nagel"], in follow-up on May 13, 2016. Nagel noted that Petitioner described his back pain as worsening. She also noted that Petitioner complained of trouble walking and sitting "x 5 days" as well as foot numbness and right ankle pain. She prescribed Norco, to be taken as needed for pain, along with a lumbar spine MRI. PX 4, p. 4.

The lumbar spine MRI, performed without contrast on May 19, 2016, showed no fracture or dislocation, straightening of the normal lumbar lordosis, possibly due to positioning or muscle spasm, and degenerative disc disease involving the L3-S1 levels, "resulting in mild bilateral neural foraminal narrowing at L4-S1." PX 4, p. 8.

Records in PX 2 reflect that Nagel discussed the MRI results with Petitioner and his wife and referred Petitioner to an orthopedic specialist. The records also reflect that Nagel later learned Petitioner would be seeing the specialist on June 13th and would be going on light duty until then. PX 2, p. 3.

On May 24, 2016, Nagel issued a note excusing Petitioner from work on May 23 and 24, 2016 and indicating he could resume light duty on May 25, 2016 with no lifting over 5 pounds, no walking, sitting or standing for long periods , no stairs and no bending. Nagel indicated these restrictions would remain in place until June 14, 2016. PX 2, p. 5.

Petitioner saw Dr. Ghanayem, a spine surgeon, at Loyola University on June 13, 2016. In his note of that date, the doctor indicated Petitioner reported injuring his right ankle at work two years earlier with his back "also hurting" since that injury. He also noted that Petitioner denied any pre-injury back problems. He stated that, to date, Petitioner had undergone an anti-inflammatory injection for his back but no epidural injections or physical therapy.

Dr. Ghanayem described Petitioner as walking with a slight limp and a forward stooped posture. On examination, he noted tenderness to the lumbar base, limited forward flexion and extension, 5/5 strength and negative straight leg raising.

Dr. Ghanayem indicated he reviewed the lumbar spine MRI report. He diagnosed lumbar degenerative disc disease, L3 through S1. He opined that Petitioner's "ankle dysfunction causes his back to be aggravated." He recommended four weeks of physical therapy and a follow-up with Dr. Bajaj, a physical medicine specialist. He took Petitioner off work pending Dr. Bajaj's evaluation. PX 5, pp. 2-5.

There is no documentary evidence indicating Petitioner returned to Dr. Ghanayem after June 13, 2016. On July 7, 2016, the doctor signed a form outlining the treatment he provided on June 13, 2016 and estimating that Petitioner would be disabled due to his back condition for three months. PX 5, pp. 7-8.

An itemized bill in evidence (PX 10) reflects that Petitioner saw Dr. Bajaj on August 3, 12 and 22, 2016. The doctor's records are not in evidence. It appears, based on Dr. Wehner's Section 12 examination report (RX 2, see below), that Dr. Bajaj administered an epidural steroid injection on August 12, 2016. No records concerning this injection are in evidence.

Petitioner testified he underwent the recommended physical therapy at Athletico. The therapy records are not in evidence. An itemized Athletico bill (PX 9) shows that Petitioner attended therapy from June 23, 2016 through July 18, 2016.

Petitioner testified that Dr. Ghanayem kept him off work from June 9, 2016 through August 25, 2016 and that he saw Dr. Bajaj at Dr. Ghanayem's recommendation. Petitioner testified that no physician has recommended he undergo back surgery.

Petitioner testified he resumed working for Respondent, on a light duty basis, on August 26, 2016. Petitioner further testified his hourly pay at this point was $28.35 whereas he had previously earned $31.35 per hour. He indicated that no one at Respondent told him why his pay had been cut. He identified PX 12 as a copy of a paycheck he received on September 8, 2016. This paycheck covers the period ending September 2, 2016. It reflects a regular hourly rate of $28.35.

At Respondent's request, Petitioner saw Dr. Wehner for purposes of a Section 12 examination on August 31, 2016. The doctor's report sets forth a consistent history of the work accident and subsequent care. The doctor noted that Petitioner reported 75% improvement of his back pain following the epidural injection of August 12, 2016. She also noted that Petitioner reported returning to full duty on August 23rd and now experiencing 4/10 lower back pain that worsened with bending forward. She indicated that, specifically, Petitioner complained of pain in his right lower back to his buttock and left thigh anterior numbness and tingling. She described Petitioner as denying any prior auto or work injuries or back problems.

Dr. Wehner described Petitioner's gait as normal until she asked him to walk across the room, at which point he began limping on the right side. She noted no paraspinal spasm or scoliosis, no positive Waddell's, negative straight leg raising, a normal range of hip motion, 5/5 motor strength and intact sensation.

Dr. Wehner indicated she reviewed lumbar spine X-rays taken on October 21, 2014 and May 10, 2016 along with the lumbar spine MRI of May 19, 2016. She described the MRI findings as "mild" and "consistent with the aging process." She saw no pathology consistent with an injury.

Dr. Wehner indicated she reviewed records from the Emergency Room, Evergreen Care Center, Parkview Orthopaedic Group, Dr. Holmes' initial report and Dr. Ghanayem's note of June 13, 2016. She stated she did not review Dr. Bajaj's records.

Based solely on Petitioner's subjective reporting, Dr. Wehner diagnosed low back pain. She did not link this diagnosis to the work accident or the ankle injury, noting that the initial Emergency Room records contain no mention of the back, that there was a gap in back-related complaints after October 2014 and that the altered gait documented by Dr. Ghanayem "far exceeds" what was previously noted by Dr. DeFrino and the therapist. She stated that the type of generalized low back pain Petitioner has "occurs in the normal population at a rate of 80%." She further stated that "there is no medical literature to support that back pain arises out of an altered gait pattern."

Dr. Wehner opined that it was not reasonable or necessary to prescribe Toradol or injections for Petitioner. She stated that Petitioner's back pain should have initially been treated with physical therapy and that it would have been reasonable to order an MRI if the therapy was not helpful. With respect to future care needs, she recommended only self-care via regular exercise, weight management and avoidance of smoking. She indicated a course of six to twelve therapy visits would have been reasonable if the work accident had been the cause of the back pain. She saw no need for Petitioner to have been taken off work due to back pain in 2016, indicating Petitioner could have been placed on light duty. She indicated that, if the accident indeed caused a back injury, Petitioner would have reached maximum medical improvement within six to twelve weeks of the accident. RX 2.

In a report dated November 14, 2016, Dr. Ghanayem responded as follows to the views expressed by Dr. Wehner:

> "I reviewed Dr. Wehner's report dated August 31, 2016. First of all, I would have to comment that her opinion that a gait disturbance cannot cause back pain is simply false and has no scientific basis. The literature is full of reports where gait disturbances can cause mechanical low back symptoms. irrespective to issues of causation, I do believe [Petitioner] has a gait disturbance that is causing his back pain and this is indisputable. I do believe that the back pain and the gait disturbance that I did see, was not excessive and was perfectly consistent with my physical examination findings and [Petitioner's] diagnostic studies."

Dr. Ghanayem stated he did not view Petitioner as a candidate for back surgery. He indicated he would defer to Dr. Bajaj as to when Petitioner would achieve maximum benefit from conservative care. He stated that Petitioner should undergo a functional capacity evaluation once he reached that point. PX 5, p. 6.

Petitioner testified he continues to experience mild pain and throbbing in the front and outside of his right ankle. He is afraid of twisting his ankle. He experiences pain after standing for six hours at work. If he had to walk a long distance, his ankle would hurt. He has tried running but is not able to do this. He is also unable to engage in sports such as basketball.

Under cross-examination, Petitioner testified he twisted his right ankle at the time of the accident. When he went to the Emergency Room, the following day, he complained about his low back as well as his ankle. He is sure he complained about his back but his ankle was bothering him more than his back. He underwent an examination by Dr. Holmes on December 3, 2014 and resumed working on December 10, 2014. He continued attending physical therapy thereafter. On January 15, 2015, he told his physical therapist he had resumed performing about 90% of his regular work duties. The following week he reported no ankle instability. A gap in treatment followed thereafter. He does not recall seeing Dr. Thomas and complaining of fatigue on April 18, 2016. He also cannot recall seeing Dr. Thomas on May 9, 2016, a Monday. He has difficulty remembering exact dates. He worked from December 10, 2014 through May 5, 2016. If May 5, 2016 was a Thursday, that is the day he and his wife left on a trip to Las Vegas. He had been working overtime prior to this date and he told his supervisor, Arnoldo Cuevas, he could not work overtime due to the trip. On Sunday, May 8, 2016, he texted Cuevas and complained of low back pain. When he saw Dr. Ghanayem, on June 13, 2016, he told the doctor he had been experiencing low back pain since the accident.

Petitioner testified he has worked as a "lead" for Respondent on an "on and off" basis. A "lead" earns $3.00 more per hour than a regular team member. A "lead" communicates with Cuevas but also performs the same physical functions as other team members. He has not talked with Cuevas about resuming the "lead" position.

On redirect, Petitioner denied injuring his back when he was in Las Vegas. He walked while he was there but he did not have a specific injury. He told Dr. Ghanayem he had injured his low back two years earlier. He has talked with Cuevas about other jobs he could perform at Respondent but they have not discussed any promotion. He brought up the idea of another position to Cuevas but this discussion "died out."

Under re-cross, Petitioner testified that the position he proposed to Cuevas was a "lead" in charge of all three shifts, with an accompanying $7 per hour raise. Cuevas told him this idea would have to wait until the collective bargaining agreement was discussed and voted on in February [2017].

Paloma Martinez, who identified herself as Petitioner's wife, testified on Petitioner's behalf. Martinez testified she and Petitioner have been married for 18 years and have three children. She and Petitioner do not work together. She works as an assistant realtor. She is aware of Petitioner's work accident but did not witness it. She accompanied Petitioner to doctor visits and independent medical examinations. She conversed with Drs. Holmes and Wehner at the examinations. Neither she nor Petitioner told Dr. Holmes that Petitioner's ankle was stable and did not hurt. Since the accident, she has noticed that Petitioner is "very careful"

with his ankle. She and he engage in fewer activities with their children as a result of this. Petitioner started limping occasionally. When she walks behind Petitioner and observes his gait, it appears to her he is slumped to the right. Petitioner's right ankle looks swollen at times, depending on his activity level. At night, Petitioner complains of throbbing in the ankle. He constantly complains of his ankle and also complains of his low back. He complained of his low back after the accident and that complaint "kept going." Last year, Petitioner's back pain became severe and he underwent a shot. He and she visited Las Vegas before Petitioner had this shot. Nothing unusual occurred when they were in Las Vegas.

Martinez testified she takes care of all of Petitioner's paychecks. In August 2016, she saw a paycheck and noticed Petitioner's hourly rate had dropped by $3.00. She has not visited Respondent and has no independent knowledge as to why Petitioner's pay was reduced.

Under cross-examination, Martinez acknowledged she is not a member of the medical profession. After the accident, Petitioner lost a couple of months of work. Petitioner returned to work on December 10, 2014 and worked thereafter until May 5, 2016. It was after May 5th that they went to Las Vegas. After they returned from Las Vegas, Petitioner did not work for another couple of months.

Arnoldo Cuevas, Petitioner's supervisor, was present throughout the trial, the Arbitrator having overruled Petitioner's motion to exclude. Respondent did not call him to testify.

Arbitrator's Credibility Assessment

Petitioner's lengthy tenure with Respondent weighs in his favor, credibility-wise. None of the physicians who treated or examined Petitioner noted symptom magnification or positive Waddell's signs.

The Arbitrator finds credible Petitioner's testimony that his low back hurt after his undisputed work accident but that he primarily focused on his ankle. The Arbitrator finds it plausible that the mechanism Petitioner described, i.e., stepping on a cork, twisting his ankle and falling, could cause low back pain. While the initial Emergency Room records do not mention any back complaints, Dr. Malik, who saw Petitioner only two days after the accident, recorded a complaint of right-sided lower back pain.

The Arbitrator finds Respondent's ankle examiner, Dr. Holmes, less persuasive than Petitioner's ankle treater, Dr. DeFrino. Dr. Holmes disagreed with the need for surgery but recommended other care based on Petitioner's reported symptoms. Near the end of cross-examination, he conceded that surgery could "potentially" be required, based on Dr. DeFrino's examination findings. He testified he would need to review bilateral X-rays, comparing the talar tilt in both of Petitioner's ankles, in order to rule out any anatomic bilateral talar tilt and fully address the issue of surgery. There is no evidence indicating he ever reviewed the bilateral ankle X-rays Dr. DeFrino obtained on March 28, 2016.

The Arbitrator finds Respondent's back examiner, Dr. Wehner, less persuasive than Dr. Ghanayem, who evaluated Petitioner in June 2016. In his November 2016 report, Dr. Ghanayem not only disagreed with Dr. Wehner. He actually accused her of lying. He indicated there is indeed medical literature supporting the conclusion that back pain can result from a gait disturbance. Dr. Ghanayem's accusation is serious and one the Arbitrator does not take lightly.

Arbitrator's Conclusions of Law

Did Petitioner establish causation as to a low back condition of ill-being?

The Arbitrator finds that the undisputed work accident of October 8, 2014 was a cause of the lower back symptoms first documented on October 10, 2014. The Arbitrator further finds that the work accident contributed to the need for the conservative low back care that Petitioner underwent in 2016, to the extent that care is supported by the existing evidence.

In so finding, the Arbitrator relies on the following: 1) Petitioner's credible denial of any pre-accident low back problems; 2) Petitioner's credible description of the mechanism of injury; 3) the fact that low back complaints were documented within two days of the accident; 4) the 2014 records from Evergreen Care Center, which document that Petitioner was having difficulty walking; 5) Dr. Thomas's note of October 21, 2014, which reflects that Petitioner described his back pain as starting after the accident; 6) Petitioner's and his wife's credible denial of any specific back re-injuries; 7) Petitioner's wife's credible testimony concerning Petitioner's unusual gait; and 8) the causation opinions expressed by Dr. Ghanayem.

The Arbitrator acknowledges that Petitioner resumed working in December 2014 and that a significant period of time passed before low back complaints were again documented. The Arbitrator also recognizes that Petitioner registered these complaints after taking a trip to Las Vegas with his wife in early May 2016. Petitioner credibly denied re-injuring his back during this trip. There is no mention of any such re-injury in the 2016 treatment records.

The Arbitrator notes that Petitioner's back complaints resurfaced during a period when 1) Dr. DeFrino was describing the right ankle as "grossly unstable" and 2) Petitioner was being called upon to work overtime, as he testified under cross-examination. PX 12 reflects that, as of late August 2016, Petitioner had already received $6,267.67 in overtime earnings. That Petitioner's job "consists of ambulation", as one doctor put it, was not contradicted by Arnoldo Cuevas.

The Arbitrator views Petitioner's low back condition as multi-factorial, with the work accident, ankle injury and resultant gait disturbance, underlying degenerative disease, the demands of his occupation and the walking he did while visiting Las Vegas contributing to the condition. Under Sisbro v. Industrial Commission, 207 Ill.2d 193 (2003), an injured worker need prove only that his work accident was a cause of his condition. He need not show that it was

the sole, or even a significant, cause. He is also not obligated to exclude other potential causes. Petitioner clearly established that the work accident was a cause of his low back condition.

Was Petitioner temporarily totally disabled from June 9, 2016 through August 25, 2016?

The parties agree Petitioner was temporarily totally disabled from October 9, 2014 through December 9, 2014. Petitioner also claims he was temporarily totally disabled, due to his back, from June 9, 2016 through August 25, 2016. Petitioner testified that Dr. Ghanayem kept him off work during this period but the existing medical evidence does not support this testimony. It appears to the Arbitrator that Dr. Ghanayem saw Petitioner only once, on June 13, 2016. On that date, the doctor prescribed four weeks of physical therapy and referred Petitioner to Dr. Bajaj, a physical medicine specialist. He directed Petitioner to remain off work until he saw Dr. Bajaj. PX 5, pp. 2-3. Dr. Bajaj's records are not in evidence. His bill reflects he first saw Petitioner on August 3, 2016. The Arbitrator has no way of knowing whether he kept Petitioner off work on that date or thereafter. Petitioner testified he resumed light duty on August 26, 2016 while Dr. Wehner's report states that he reported resuming full duty on August 23, 2016.

The Arbitrator has previously found that Petitioner established causation as to a low back condition of ill-being that required conservative care. The Arbitrator finds it reasonable that Dr. Ghanayem would have taken Petitioner off work pending an assessment by a physiatrist. Based on Dr. Ghanayem's June 13, 2016 treatment note and the chronology set forth above, the Arbitrator finds that Petitioner was temporarily totally disabled from June 13, 2016 through August 3, 2016, a period of 7 3/7 weeks. The Arbitrator acknowledges that, on July 7, 2016, Dr. Ghanayem signed a form indicating Petitioner would likely be disabled due to his back for a period of three months but this was an estimate. As noted earlier, there is no evidence indicating Petitioner returned to Dr. Ghanayem after June 13, 2016. Nor is there evidence indicating Dr. Bajaj kept Petitioner off work. Petitioner offered only Dr. Bajaj's bill.

Is Petitioner entitled to temporary partial disability benefits from August 26, 2016 through the hearing of January 23, 2017?

The Arbitrator declines to award temporary partial disability benefits in this case. While Petitioner testified that, since August 2016, he has been earning $3.00 less per hour than he earned in the past, he admitted under cross-examination that his role at Respondent has varied over time. He was sometimes a "lead" and sometimes not. It was when he worked as a "lead" that he earned an additional $3.00 per hour. He did not claim that his current non-lead work assignment is related to his injury.

Section 8(a) of the Act provides that an employee is entitled to temporary partial disability benefits when he is working light duty on a part- or full-time basis and earns less than he would be earning "if employed in the full capacity of the job or jobs." Petitioner testified he has been performing light duty since resuming work in August 2016 but the available evidence

does not allow the Arbitrator to conclude that the "lead" position constituted the "full capacity" of Petitioner's job.

Is Petitioner entitled to reasonable and necessary medical expenses relating to the back care he underwent in 2016?

The Arbitrator has previously found that Petitioner established causation as to a low back condition of ill-being. The Arbitrator further finds, in reliance on the treatment records and the opinions voiced by Drs. Ghanayem and Wehner, that this condition required a course of conservative care and a lumbar spine MRI. [Dr. Wehner disputed causation but did not take issue with the legitimacy of Petitioner's complaints and recommended a course of physical therapy followed, potentially, by an MRI.]

The Arbitrator awards the following medical expenses, subject to the fee schedule: 1) Dr. Joseph/Park Primary Care, $115.00 (5/13/16, office visit and injection – PX 6); 2) Little Company of Mary Hospital, $902.00 (lumbar spine X-rays, 5/10/16 – PX 7, p. 4) and $2,845.00 (MRIs of orbits and lumbar spine, 5/19/16 – PX 7, p. 5); 3) Radiology Imaging Services, $152.00 (5/10/16, lumbar spine X-rays) and $569.00 (5/19/16, MRIs) – PX 8; and 4) Athletico, various charges with $195.47 balance (physical therapy, 6/23/16 – 7/18/16 – PX 9). The Arbitrator awards the Athletico charges, despite the fact that the Athletico records are not in evidence, based on Dr. Wehner's recommendation of a course of physical therapy. The Arbitrator further finds that Petitioner is entitled to reimbursement of the various $35.00 credit card co-payments reflected on the Athletico bill. PX 9.

The Arbitrator declines to award Dr. Bajaj's bill (PX 10). The Arbitrator finds it reasonable for Dr. Ghanayem to have referred Petitioner to Dr. Bajaj, a physiatrist, since Dr. Ghanayem is a surgeon, but Petitioner did not testify to the type of care Dr. Bajaj provided or offer Dr. Bajaj's records into evidence. There is no evidentiary basis for awarding the doctor's bill. The Arbitrator also declines to award the Loyola University charges of $206.00 associated with the treatment Dr. Bajaj provided on August 3 and 22, 2016, applying the same reasoning.

Is Petitioner entitled to prospective care?

The Arbitrator awards prospective care in the form of the right ankle surgery recommended by Dr. DeFrino. As indicated earlier, the Arbitrator has elected to rely on Dr. DeFrino rather than Dr. Holmes with respect to the issues of diagnosis and treatment needs. Dr. DeFrino saw Petitioner on numerous occasions and had the benefit of reviewing bilateral ankle X-rays. Dr. Holmes rendered his opinions before these X-rays were taken.

Petitioner did not seek prospective back care at the hearing.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Timothy Slone,
Petitioner,

vs.
Viking Mine,
Respondent.

NO: 16 WC 05274

17IWCC0835

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, 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 April 17, 2017, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $37,000.00. 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: DEC 29 2017
o120717
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SLONE, TIMOTHY
Employee/Petitioner

Case# **16WC005274**

VIKING MINE
Employer/Respondent

17IWCC0835

On 4/17/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.95% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

3067 KIRKPATRICK LAW OFFICES PC
ERIC KIRKPATRICK
#3 EXECUTIVE WOODS CT STE 100
BELLEVILLE, IL 62226

1723 LITCHFIELD CAVO
GREG KELTNER
222 S CENTRAL AVE SUITE 200
ST LOUIS, MO 63105

17IWCC0835

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

Timothy Slone
Employee/Petitioner

v.

Viking Mine
Employer/Respondent

Case # **16** WC **5274**

Consolidated cases: **n/a**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **February 10, 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. [ ] 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 **January 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 not** causally related to the accident.

In the year preceding the injury, per the stipulation of the parties, Petitioner's average weekly wage was **$1,255.00.**

On the date of accident, Petitioner was **48** years of age, ***married*** with **2** dependent children.

Respondent shall be given a credit of **$SALARY CONTINUATION** for TTD, **$0** for TPD, **$0** for maintenance, **$0** in non-occupational indemnity disability benefits, and **$0** in other benefits, for which credit may be allowed under Section 8(j) of the Act.

Respondent is entitled to a credit of **$all amounts paid** under Section 8(j) of the Act.

ORDER

Respondent shall reimburse Petitioner for reasonable and necessary medical services of **$130.00** for the Hydrocodone out-of-pocket expenses (*i.e.*, those as identified as $5.00 charges on the exhibit of prescription expenses as contained in Petitioner's Exhibit 6), as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner the sum of **$735.37/week** for a period of **50 weeks**, as provided in **Section 8(d)2** of the Act, because the injuries sustained caused **10% loss of use of the person-as-a-whole.**

Respondent shall be given a credit of **$SALARY CONTINUATION** for TTD, **$0** for TPD, **$0** for maintenance, **$0** in non-occupational indemnity disability benefits, and **$0** in other benefits, for which credit may be allowed under Section 8(j) of the Act.

Respondent is entitled to a credit for **all amounts paid under group health plan** under Section 8(j) of the Act.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Melinda M. Price-Sullivan
Signature of Arbitrator

4/12/17
Date

ICArbDec p. 2

APR 17 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Timothy Slone
Employee/Petitioner

Case # 16 WC 5274

v.

Consolidated cases: N/A

Viking Mine
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On January 20, 2015 Petitioner was 48 years old and employed by Respondent as a Maintenance Foreman. He testified that on that date, a longwall shield struck him in the middle of his back, injuring his rib and back. He testified that prior to the accident he did not have any problems with his back, legs, buttocks or with erectile dysfunction. He testified that since the accident, he experiences constant mid-back pain, numbness in his testicles and tingling into his groin and heels. He testified that his daily pain level averages 6-8 and varies depending upon his activity level. He testified that he first noticed groin symptoms in May or June of 2015. He testified that he stopped using the brace in May or June 2015, and that he first noticed groin symptoms thereafter.

Petitioner testified that he returned to work after the accident in his pre-injury classification as a Maintenance Foreman with no reduction in earnings. He testified that he self-limits his lifting to 20 pounds. He testified that he takes a Hydrocodone tablet every four hours. He testified that he does not have any pain associated with his rib fracture. He testified that he experiences pain if he sits or stands for periods of 5-15 minutes. He testified that his sleep is affected secondary to back pain and that he experiences stiffness when he gets out of bed. He testified that since the accident he has played golf twice in the two years, but that none of his other activities have been limited.

Petitioner testified that he experiences constant groin numbness. He denied that he was sexually active between the accident date and the date he discontinued the back brace. He testified that none of the medications prescribed by Dr. Alexander for erectile dysfunction affect the numbness in his groin. He testified that that he told Dr. Coyle about his groin symptoms, but could not remember exactly what he told Dr. Coyle regarding his symptoms. He testified that he believed that he advised Dr. Coyle of the numbness in his feet and the tingling in his groin after the back brace was discontinued. Petitioner testified that he may have advised Dr. Coyle of his groin issues between June and September 2015.

Petitioner testified that he may have told Dr. Coyle on September 24, 2015 that he was not having any numbness, tingling or weakness in his lower extremities because he was experiencing no symptoms on that particular date. He then testified that he could not recall what he reported to Dr. Coyle. He testified that he could not recall whether he told Dr. Coyle on September 24th that he was having groin symptoms. He admitted that he could not recall whether he ever reported erectile dysfunction issues to Dr. Coyle. He testified that Dr. Coyle told him to limit his lifting to 20 pounds.

Petitioner testified that he was married the weekend before his April 23, 2015 visit with Dr. Alexander, but that he did not mention anything to him about erectile dysfunction issues at the April 23rd

visit. He testified that he did not have any sexual relations with his wife prior to discontinuation of the back brace.

The medical records of Herrin Hospital (related to diagnostic imaging) were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Petitioner underwent a CT of the head on January 20, 2015, which was interpreted as revealing no acute intracranial process. A CT of the cervical spine performed on the same date was interpreted as revealing no fracture; central spinal stenosis and areas of possible radiculopathy. X-rays of the pelvis performed on the same date were interpreted as revealing no acute osseous abnormality. X-rays of the chest performed on the same date were interpreted as revealing (1) no acute cardiopulmonary process; (2) left posterior first rib fracture. A CT of the thoracic spine was interpreted are revealing a non-displaced horizontal fracture through the pedicles and posterior process at T11 which does not extend into the vertebral body; there is no neural foraminal or central narrowing; (2) non-displaced fracture of the right superior facet of T12. (PX1).

The medical records of Harrisburg Medical Center/Dr. Alexander were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. Petitioner was seen on January 23, 2015 for a recheck. It was noted that Petitioner's low back pain was 8/10 due to a fracture at the pedicles and posterior process at T11 and a non-displaced fracture of the right superior facet of T12. It was noted that Petitioner denied chronic low back pain and denied radicular pain on the anterior aspect of the lower extremities as well as down the back of the lower extremities. Petitioner denied numbness in the perianal region. It was noted that Petitioner had a back immobilizer on during the visit. The assessment was noted to be that of fracture of the vertebral column and closed fracture of the thoracic vertebral body. Petitioner was instructed to continue his medications. The records reflect that Petitioner underwent an employment-related physical on September 18, 2014 and that he had no complaints at that time. (PX2).

The records of Dr. Alexander reflect that Petitioner was seen on January 26, 2015 for a recheck. It was noted that Petitioner denied fecal incontinence and urinary loss of control, and that he denied numbness of the limbs and in the perianal region. The assessment was noted to be that of closed fracture of the thoracic vertebral body. Petitioner was referred to an orthopedic surgeon. At the time of the February 2, 2015 visit, Petitioner was seen for a recheck of his back. It was noted that Petitioner denied fecal incontinence and urinary loss of control, and that he denied numbness of the limbs and in the perianal region. The assessment was noted to be that of closed fracture of the thoracic vertebral body. It was noted that Petitioner seemed better and was moving better, and that his back did not cause pain with minimal motion. It was noted that Dr. Alexander feared that Petitioner was going to need a fusion around the fractured pedicles of T11. Petitioner was referred to an orthopedic surgeon and was given a home exercise program. (PX2).

The records of Dr. Alexander reflect that Petitioner was seen on February 19, 2015 for a recheck of his back. It was noted that Petitioner denied fecal incontinence and urinary loss of control, and that he denied numbness of the limbs and in the perianal region. It was noted that Petitioner had seen Dr. Coyle and was told he did not need surgery, and that he was told to stay in the brace. The assessment was noted to be that of closed fracture of the thoracic vertebral body. Petitioner was referred for a consultation with a physical therapist regarding a new brace. At the time of the April 23, 2015 visit, Petitioner was seen so as to discuss his medications. It was noted that Petitioner denied fecal incontinence and urinary loss of control, and that he denied numbness of the limbs and in the perianal region. It was noted that Petitioner was to go back to work on Monday with the brace and that he was still having a lot of pain. It was noted that Petitioner's last x-rays were stable and that he was restricted to wearing the brace. It was noted that Petitioner had a follow-up scheduled with Dr. Coyle, that he was returning to work in a few days and that Dr. Alexander knew "they [were] not going to be gentle with him." It was noted that Petitioner was fit for work and that he had gotten married the past weekend. (PX2).

The records of Dr. Alexander reflect that Petitioner was seen on June 22, 2015 for "personal" reasons. It was noted that Petitioner had had an issue since he broke his back and that he was having erection-related issues. It was noted that Petitioner was still on pain medications. The assessment was noted to be that of closed fracture of thoracic vertebral body and male erectile disorder. Petitioner was prescribed Viagra and Levitra and instructed to return if his condition worsened or new symptoms arose. At the time of the December 2, 2015 visit, Petitioner was seen for a medication recheck. It was noted that Petitioner's medications included Norco and Viagra. The assessment was noted to be that of burst fracture of T11-T12 vertebral body. Petitioner's medications were discussed, and it was noted that Petitioner requested a consultation by neurosurgery. (PX2).

The records of Dr. Alexander reflect that Petitioner was seen on April 11, 2016 for medication refill. It was noted that Petitioner's back pain persisted and was controlled with Norco. The assessment was noted to be that of fracture of thoracic vertebral body. It was noted that Petitioner needed an "FOC" and it would be set up as his work scheduled allowed. At the time of the August 1, 2016 visit, it was noted that Petitioner wished to discuss "male issues" and medications. It was noted that Petitioner reported that since January 20, 2015 when he broke his back, his penis had been numb and was not working like it did. It was noted that Petitioner had "added this to his comp" and that it had affected his physical relationship with his wife. It was noted that Petitioner's back pain was "off and on" and could be severe, and that he had erectile issues more when his back was painful. It was noted that Petitioner had occasional numbness in his groin and that "things [felt] weird." The assessment was noted to be that of erectile dysfunction due to diseases classified elsewhere and late effect of fracture of thoracic vertebra. It was noted that Petitioner would speak to his surgeon and see if he needed a myelogram or if it was felt to be chronic changes and irreversible. It was noted that Petitioner was prescribed Viagra and Cialis. (PX2).

The medical records of Dr. James Coyle were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The Patient Medical History Form completed on January 26, 2015 indicated that Petitioner denied any sexual difficulties. The records reflect that Petitioner's chief complaint at the time of the January 26, 2015 visit was back pain, that he denied any history of similar injuries or symptoms in the past and that he did have a history of a cervical spine fracture secondary to a dirt bike accident in September of 2009. It was noted that Petitioner denied numbness, tingling or weakness in the lower extremities, bowel or bladder symptoms and neck pain. The impression was noted to be that of flexion distraction fracture through T11 and T12. It was noted that this was an osseous fracture as opposed to a ligamentous injury, and that there were extensive degenerative changes in the thoracic spine at this level. It was noted that the appropriate treatment was a TLSO brace, which Petitioner was asked to wear continuously except when he was lying down. It was noted that based on the history given, Petitioner had extensive degenerative changes in his thoracic lumbar spine, but that the work injury was the cause of his acute fracture and need for further treatment. (PX3).

The records of Dr. Coyle reflect that Petitioner was seen on February 3, 2015, at which time it was noted that he had sustained fractures through the pedicles and posterior elements of T11 and a non-displaced fracture of the right superior facet of T12 when a shield hit him in the back on January 20th. It was noted that a repeat CT scan was obtained, which showed T11 pedicle fractures that extended toward the lamina and a fracture of the right superior facet of T12 that were non-displaced on the study. It was noted that Petitioner also had kyphosis over the thoracolumbar junction due to what appeared to be very remote compression fractures of T9, T10, T11 and T12. It was noted that Petitioner had back pain and really had no pain over the first rib where he presumably had a fracture. It was noted that Petitioner was advised that if things stayed the same as they were, he was probably not going to need surgery and bracing would be the definitive treatment. It was noted that Petitioner was unable to work and should wear his brace at all times when he was out of bed. Included within the records was an interpretive report for a CT of the thoracic spine performed on February 3, 2015, which was interpreted as revealing (1)

acute fracture involves the vertebral body and posterior elements of T11; (2) additional fractures involve the inferior endplate of T7, and compression fractures of T9, T10 and T12; suspect T12 is acute, but age of the other changes in uncertain. (PX3).

The records of Dr. Coyle reflect that Petitioner was seen on March 4, 2015, at which time it was noted that he had a non-displaced fracture of the T11 pedicles and the superior right facet of T12. It was noted that Petitioner continued in his brace, and that x-rays obtained on that date showed kyphosis at the thoracolumbar junction and no evidence of further compression. It was noted that Petitioner had intact motor strength in the lower extremities, was not getting tingling in his legs and was still requiring intermittent pain medication. Petitioner was given a prescription for Hydrocodone. It was noted that Petitioner required a total of 12 weeks in the brace, that he could come out of the brace in 6 weeks and that he should avoid any lifting or impact activities in the meantime. At the time of the April 22, 2015 visit, it was noted that x-rays obtained on that date showed no change in his spinal alignment at the thoracolumbar junction and no collapse of the vertebral body. It was noted that Petitioner had no complaints of pain and had no numbness, tingling or weakness in his legs. It was noted that Petitioner wished to return to work and that he should observe normal safety precautions. (PX3).

The records of Dr. Coyle reflect that Petitioner was seen on May 21, 2015, at which time it was noted that he stated he continued to have back pain, worse in the morning, and that it had not gotten any worse than it had been. It was noted that Petitioner took Advil occasionally and was working full time. It was noted that Petitioner was still symptomatic but was no worse than he was when he was last seen and that he was more active. Petitioner was given a prescription for Voltaren. At the time of the July 16, 2015 visit, it was noted that Petitioner stated that the Voltaren did not significantly alter his symptoms and that he took Aleve and Tylenol as needed. It was noted that Petitioner was continuing to work at regular duty. It was noted that Petitioner was really no better and no worse than he previously was and that he was working full time and not experiencing difficulties. It was noted that Petitioner was advised that the options included trigger point injections at the fracture site and continued observation. It was noted that Dr. Coyle did not think Petitioner was symptomatic enough to require surgery. At the time of the September 24, 2015 visit, it was noted that Petitioner was eight months post-injury and noted that his symptoms were affected by the weather. It was noted that Petitioner was working full duty and he was advised that there was really nothing else that needed to be done. It was noted that Petitioner was at maximum medical improvement and that if his symptoms were to flare up in the future, he could return for re-evaluation. (PX3).

The transcript of the deposition of Dr. James Alexander was entered into evidence at the time of arbitration as Petitioner's Exhibit 4. Dr. Alexander testified that he is a board-certified family physician in Harrisburg. (PX4).

Dr. Alexander testified that he was aware that Petitioner had an injury on or about January 20, 2015, and that he suffered a fracture of the thoracic vertebrae at T11 and T12. He testified that he referred Petitioner to Dr. Coyle in St. Louis, an orthopedic spine specialist. He testified that Petitioner was kept off work for approximately 12 weeks and sent back with a brace. (PX4).

Dr. Alexander testified that one of the complaints that Petitioner started to have was erectile dysfunction, and that prior to the accident during the time that he treated Petitioner he did not have any complaints of erectile dysfunction. He testified that he had seen Petitioner going back to 2014, and that there was no mention of erectile issues. He testified that Petitioner brought it up to him after the accident, and that he first mentioned it on June 22nd. He testified that he examined Petitioner's genitalia and found no abnormalities externally that would explain an erectile issue. He testified that he gave Petitioner samples of Viagra and Levitra to try. He testified that he knew that Petitioner had gotten married a couple

of months before he actually asked for the medication, but he did not have any record of whether they helped. (PX4).

Dr. Alexander testified that in June of 2015 Petitioner reported that he his erections did not seem to be as firm as they were before and that he still had that complaint when he last saw him on August 1st, at which time Petitioner mentioned that he was afraid it was affecting his physical relationship with his wife. He testified that Petitioner also was complaining of back pain as well, and that these complaints had continued throughout the time that he saw Petitioner. He testified that as of his last visit with Petitioner, he thought he was as good as he was going to get with regard to his back and that if there was more testing to be done, it would come from a specialist. He testified that with regard to the erectile issues, Petitioner reported at the last visit that he thought his penis was numb and that he stated the Viagra did not do the job he thought it would. He testified that that it was a pretty strong dose of Viagra, and that he was not sure it was going to improve a lot. (PX4).

Dr. Alexander testified that other treatment options for the erectile problems would include a trial of other medications, that Petitioner would have to be referred to a urologist that did sexual therapy and that there were also implants. He testified that he thought Petitioner's erectile dysfunction was related to the effects of Petitioner's work-related injuries. He testified that he realized Petitioner was almost 50 years old, but he did not have any of the symptoms before, had never contacted him for problems before and had never used any of those medications before. When asked if a fracture such as Petitioner's could affect the nerves that run from the spinal cord, Dr. Alexander responded that he was sure it could affect it especially if it was causing numbness of Petitioner's penis. (PX4).

Dr. Alexander testified that he was seeing Petitioner every 3-4 months for reevaluation of his pain medication and control, but there was no appointment scheduled as of the time of the deposition (*i.e.*, August 24, 2016). He testified that Petitioner was cooperating with his treatment. He testified that the prognosis for Petitioner's back and the use of his medications was hard to say, and that he and Petitioner had talked about pain management. (PX4).

On cross examination, Dr. Alexander testified that he knew that they usually tested for bladder and bowel issues after a spinal fracture. He agreed that if one had bowel and bladder function problems, it could go hand in hand with the erectile issues Petitioner had been complaining of since June of 2015. He testified that the scans did not suggest that there was spinal pathology that was causing the erectile dysfunction, but that the scans did not always show what was going on in the sensory or motor nerves for that area. He agreed that his causation opinion was predicated upon the history that he got from Petitioner that the problem began after he had the spinal fractures and continued from the time of the injury up until he first told him on June 22, 2015. He agreed that he took what Petitioner told him at face value. (PX4).

On cross examination, Dr. Alexander agreed that in all of the times that Petitioner saw him from January 23, 2015 up through April 23, 2015, there was no mention at all of any issues involving erectile dysfunction. He agreed that it was at the April 23, 2015 visit that Petitioner told him that he had gotten married the previous weekend. He agreed that at as of April 23rd, Petitioner had not said anything to him about any erectile dysfunction issues. (PX4).

On cross examination, Dr. Alexander testified that he did not review any of the imaging studies that were done in the case and that he was not qualified to read an MRI. He agreed that the radiologist's interpretation of the January 20, 2015 thoracic spine imaging was that at T11 there was no neural foraminal or central narrowing, and he further agreed that he would not dispute the radiologist's reading of the CT film. He testified that the scrotum was innervated by L1, and that he penis was innervated by L2, 3 and 4. He testified that he did not have a lumbar MRI scan, but that he was not aware of any pathology that existed at any of those levels based on imaging studies. (PX4).

On cross examination, Dr. Alexander agreed that erectile dysfunction was a multifactorial disorder. He agreed that age could be an issue. He agreed that smoking over a prolonged period of time could contribute to the development of erectile dysfunction, and that alcohol use could also contribute to erectile dysfunction. He testified that either alcohol use or tobacco use could cause erectile dysfunction without any other factors coming into play. He testified that other causes of erectile dysfunction included hypertension, diabetes, aging, drugs and trauma. He agreed that this list was not exhaustive of all of the risk factors. (PX4).

On cross examination, Dr. Alexander agreed that he had opportunity to review a few of Dr. Coyle's notes, including those from February, March and September of 2015. He testified that he did not see anything in the records that he had from Dr. Coyle that Petitioner reported any erectile dysfunction issues to him. (PX4).

On redirect, Dr. Alexander testified that he was not aware of any quantification of how much smoking or drinking it took to develop erectile problems. He agreed that Petitioner was not considered an alcoholic, an illicit drug user or a diabetic. He testified that Petitioner's blood pressure was "beautiful" and that he thought he was in good shape. (PX4).

Pre-accident medical records from Harrisburg Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen for a variety of issues including left upper arm and left shoulder pain and a pre-employment physical for Viking Mine. (PX5).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 6.

The Group Medical Insurance Payout was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The Workers' Compensation Medical Payout was entered into evidence at the time of arbitration as Respondent's Exhibit 2.

The medical records of Dr. James Coyle were entered into evidence at the time of arbitration as Respondent's Exhibit 3. The records were effectively duplicative of those as contained in Petitioner's Exhibit 3. (RX3; PX3).

The transcript of the deposition of Dr. Frank Petkovich was entered into evidence at the time of arbitration as Respopondent's Exhibit 4. Dr. Petkovich testified that he is an orthopedic surgeon and is board-certified by the American Board of Orthopedic Surgery as well as the American Board of Independent Medical Examiners. (RX4).

Dr. Petkovich testified that he examined Petitioner on October 20, 2016 and that on or about August 10, 2016, he had an opportunity to review some of Petitioner's medical records. After outlining the various medical records that he reviewed, he testified that he also reviewed Dr. Alexander's deposition transcript as well as thoracic spine x-rays taken in his office on October 20th and a new CT thoracolumbar spine taken at St. Luke's CDI on October 20th as well. (RX4).

Dr. Petkovich testified that Petitioner reported to him that he sustained an injury at work on January 20, 2015 when he was working in a coal mine and a wall shield came down on his upper back. He testified that Petitioner reported that he then had some pain in those areas and was taken to Herrin Hospital, where he was evaluated and released. He testified that he reviewed the note of January 26, 2015 of Dr. Coyle, and that Petitioner did not have any complaints of any radicular symptoms throughout either

of his lower extremities and that he did not have any complaints with regard to his perianal area which meant no complaints of bowel or bladder problems or any type of sexual dysfunction. (RX4).

Dr. Petkovich testified that Petitioner continued to follow with Dr. Coyle and was released as of September 24, 2015 to full duty work activities. He testified that Petitioner reported that he was continuing to see his primary care physician, Dr. Alexander, for some complaints of pain in his upper back as well as erectile dysfunction, that he was working at his regular job and that he was continuing to take large doses of narcotic analgesics. He testified that he did not see any notation in Dr. Coyle's records that Petitioner complained of erectile dysfunction or any related issues, nor were there any complaints or symptoms that were documented by Dr. Coyle that would be consistent with erectile dysfunction. (RX4).

Dr. Petkovich testified that there no abnormalities on the lumbar examination performed nor were there any abnormalities on the cervical or thoracic examination, but that there were some subjective complaints of tenderness in the paraspinous thoracic areas consistent with Petitioner's degenerative disc conditions. (RX4).

Dr. Petkovich testified that the nerves that innervated the perianal area came out of the sacral S2, 3 and 4 nerve roots, and that Petitioner had fractures at T11 and T12. He testified that he has had occasion to treat individuals with thoracic vertebral fractures liked those sustained by Petitioner, and that the thoracic vertebrae that were involved in Petitioner's case were in a different area than where the nerve roots exit which innervate the perianal area. He testified that the T11 and T12 nerve roots manifest themselves in the rib cage area, and that they would be the type of pain people have associated with shingles. (RX4).

Dr. Petkovich testified that he obtained x-rays and a CT scan on the date of the IME and that the x-rays showed good structural alignment of the thoracic spine with the T11 and T12 areas completely healed with normal structural alignment, and that there were degenerative changes in the thoracic spine that were chronic conditions that were longstanding and unrelated to the work accident. He testified that there was nothing radiographically on the thoracic spine x-rays to indicate any relationship with any erectile dysfunction. He testified that the CT scan showed the fractures through the T11 pedicles to be completely healed without any displacement and that the fracture to the right T12 superior facet was also healed without any displacement. He testified that the degenerative changes on Petitioner's CT scan were consistent with him having some pain in that area because of degenerative changes, but that the radiographic findings would have nothing to do with any erectile dysfunction Petitioner may have. He testified that the degenerative changes present in Petitioner's spine were obviously chronic conditions which had been there a long time, and that he did not believe that the degenerative changes were in any way aggravated or accelerated as a result of the work injury of January 20, 2015. (RX4).

Dr. Petkovich testified that his diagnoses included non-displaced fracture thoracic T11 pedicles, non-displaced fracture right T12 superior facet, degenerative arthritis and degenerative disc disease thoracic spine and degenerative cervical disc disease. He testified that he did not believe that any of Petitioner's back complaints when he saw him on October 20, 2016 had anything to do with the injury he described as occurring at work on January 20, 2015. He testified that he was sure that Petitioner had back pain after the injury, but that all of that had healed by the time he was released by Dr. Coyle in September of 2015. He testified that he did not believe that there was a causal relationship between the January 20, 2015 accident and Petitioner's erectile dysfunction issues. He testified that anatomically and neurologically, it made no sense. He testified that there were many causes of erectile dysfunction, including psychological, anxiety, excessive alcohol intake, peripheral vascular disease, heavy narcotic usage or use of other medications. He testified that someone could have a spinal cord injury, but that that was not the case here. He testified that a spinal cord injury would be like a paraplegic and would affect

everything distal to that area of the spinal cord, and would not selectively pick out certain areas. He testified that there was a difference between a spinal cord injury as opposed to a nerve root injury. (RX4).

Dr. Petkovich testified that he believed that Petitioner could continue working full duty. He testified that he did not believe that Petitioner needed to be on any medications as a result of the work injury in January of 2015, and that he certainly did not need to be on Norco because the fractures were healed. He testified that typically people with these types of fractures were off the narcotic analgesics within six weeks from the time of the injury. (RX4).

On cross examination, Dr. Petkovich agreed that heavy narcotic usage could influence erectile dysfunction just like the other factors mentioned. He agreed that Petitioner was prescribed the Norco for the thoracic fractures that he suffered in the work accident. He testified that Petitioner told him that he did not recall having any significant pain in his cervical or thoracolumbar spine areas prior to the incident on January 20, 2015. He testified that the x-rays suggested that he had prior issues of back pain. (RX4).

On cross examination, Dr. Petkovich agreed that he primarily did office work, and testified that he had a low-volume, high-intensity type practice where he saw 15-20 patients per week with complex orthopedic conditions. (RX4).

On cross examination, Dr. Petkovich testified that he did not remember whether he asked Petitioner if he had taken any medication before the work accident. He testified that he was not aware of any indication in Petitioner's medical records that he had taken any medication prior to the work accident. He testified that the type of fractures that Petitioner had would not accelerate degenerative changes in the same area. He testified that there could have been injury to the ligaments, tendon and muscle when Petitioner's thoracic spine was fractured. He agreed that radiographs would not show injury to the muscle, tendon or ligament. He testified that there were types of severe ligamentous injuries that could cause some exacerbation or some aggravation of some underlying degenerative bony conditions. (RX4).

On cross examination, Dr. Petkovich agreed that Petitioner had been on Norco and had been able to work as a coal miner, which was a heavy duty job. He testified that he did not ask Petitioner what he experienced if he did not take the Norco as prescribed. He testified that Petitioner was taking a dangerously high dose of Norco which he should not be taking. He testified that he believed that any pain Petitioner had now with regard to his spine was related to the degenerative conditions in his spine that were totally unrelated to the incident and the fractures he sustained at the time of the incident on January 20, 2015. (RX4).

On cross examination, Dr. Petkovich testified that he did not ask for any additional medical records beyond what was supplied to him. (RX4).

On redirect examination, Dr. Petkovich testified that the fractures that Petitioner had were very simple and did not involve any joints or articular surfaces, which was why he did not believe it would accelerate Petitioner's preexisting degenerative changes. He testified that it was possible that Petitioner could have strained or sprained some of the ligaments around the area of the fractures at the time of the trauma, and that he thought it was why Dr. Coyle placed Petitioner in a brace. He testified that it would have been a transitory condition until the fractures healed. (RX4).

The Herrin Hospital Emergency Room records dated January 20, 2015 were entered into evidence at the time of arbitration as Respondent's Exhibit 5. Petitioner was seen on January 20, 2015 for an acute back injury. It was noted that Petitioner stated that he was sitting at work when a shield came down pushing on his back on the ground, and that he heard a pop in his mid back. It was noted that the only pain Petitioner complained of was at the mid back, and that he had no numbness in his private areas nor

any numbness in his legs. The clinical impression was noted to be that of spinous process fracture and rib fracture. Petitioner was discharged home and referred to Dr. Jeffrey Jones. (RX5; PX1).

CONCLUSIONS OF LAW

With respect to disputed issue (F) pertaining to causation, at the outset the Arbitrator notes that Respondent does not dispute that Petitioner's current condition of ill-being with regard to the rib fracture and T11 and T12 fractures are causally related to the work accident, but that Respondent does dispute that Petitioner's erectile dysfunction and groin symptoms are related to the work injury. Having reviewed the evidence submitted by the parties, including the deposition testimony of Dr. Alexander and Dr. Petkovich, the medical records from Herrin Hospital, Dr. Alexander and Dr. Coyle and having considered Petitioner's testimony at the time of arbitration, the Arbitrator finds that Petitioner has failed to meet his burden of proof that his condition of ill-being with regard to his erectile dysfunction and groin issues is related to the work injury of January 20, 2015.

In reaching the foregoing conclusion, the Arbitrator notes that there are inconsistencies between the medical records and Petitioner's testimony as to when his erectile dysfunction and groin issues manifested. The January 20, 2015 records from Herrin Hospital indicate that Petitioner specifically denied any numbness in his private area and legs. (RX5). At the initial meeting with Dr. Coyle on January 26, 2015, Petitioner completed an intake form on which he denied any problems with sexual dysfunction and did not report any symptoms in his groin or legs. (RX3).

The Arbitrator notes that Petitioner saw Dr. Alexander on multiple occasions between the accident date and June 22, 2015, and that at no time prior to June 22nd do Dr. Alexander's records reflect complaints of erectile dysfunction, lower extremity symptoms, testicle numbness or tingling in the groin. (PX2). The Arbitrator notes that erectile dysfunction-related issues are first documented in Dr. Alexander's June 22, 2015 note, which also reflects that Petitioner reported that those symptoms had been in existence since the work injury. (PX2). Dr. Alexander testified that Petitioner reported that his symptoms began after the injury and continued through the visit on June 22, 2015, and further confirmed that Petitioner first reported erectile dysfunction issues on June 22, 2015. (PX3). At the time of hearing, however, Petitioner denied any groin or lower extremity symptoms until he discontinued using the back brace recommended by Dr. Coyle in May or June 2015.

Related thereto, the Arbitrator notes that the medical records of Dr. Coyle reflect that on March 4, 2015, he told Petitioner to discontinue the brace in 6 weeks, and that at the visit on April 22, 2015 (approximately 6 weeks later), Dr. Coyle released Petitioner to full duty work and instructed him to observe normal safety precautions. (PX3; RX3). The April 22nd note of Dr. Coyle does not reflect that Petitioner was still wearing the brace or was to continue doing so, and the records further reflect that at no time after April 22, 2015 did Dr. Coyle comment on Petitioner's use of the brace. (*Id.*). Furthermore, none of Dr. Coyle's records before April 22, 2015 reflect erectile dysfunction complaints or symptoms in the groin, and the medical records reflect that Dr. Coyle's reports of April 22, 2015, May 21, 2015, July 16, 2015 and September 24, 2015 all indicate that on each occasion, Petitioner denied numbness, tingling or weakness in the lower extremities, and that on not a single one of those visit did Dr. Coyle document erectile dysfunction or groin symptoms. (*Id.*). The Arbitrator further notes that she has considered Petitioner's testimony that he may not have mentioned his groin symptoms to Dr. Coyle on September 24, 2015 because he was having no symptoms on that date, but finds that this testimony is inconsistent with Petitioner's testimony that his groin numbness was constant.

The Arbitrator notes that both Dr. Alexander and Dr. Petkovich agreed that erectile dysfunction is a multifactorial disorder which can be caused by a number of different conditions. Dr. Alexander noted

that Petitioner's age alone places him at risk for development of erectile dysfunction, and also noted that smoking and alcohol use can cause erectile dysfunction independent of other factors. (PX4). Furthermore, Dr. Alexander and Dr. Petkovich also agreed that there was no pathology on plain film x-rays or CT scans which would account for Petitioner's groin and lower extremity symptoms and that the nerve roots which exit the spine at T11 and T12 do not innervate the groin. Both physicians testified that the nerve roots which innervate the groin are located in the lumbar spine. (PX4; RX4). The Arbitrator further notes that neither Dr. Alexander's nor Dr. Coyle's records reflect the onset of groin nor lower extremity symptoms after Petitioner discontinued use of the back brace in April of 2015. (PX2; PX3).

Although Dr. Alexander and Dr. Petkovich disagree as to whether there was a causal relationship between Petitioner's erectile dysfunction issues and the work injury, the Arbitrator finds the testimony of Dr. Petkovich, a board-certified orthopedic spine surgeon to be more persuasive than that of Dr. Alexander, particularly in light of the lack of any documentation regarding erectile dysfunction until approximately five months after the accident and approximately two months after Petitioner discontinued the back brace. The Arbitrator finds that there was no medical evidence proffered at the time of arbitration that use of the back brace would mask groin and lower extremity symptoms or that it would take two months after discontinuation of the brace for groin symptoms to manifest. Further, the Arbitrator notes that while there was medical testimony that the use of narcotic pain medications could cause erectile dysfunction, there was no evidence that such medications could cause numbness in the testicles or tingling in the groin and feet. (PX4; RX4).

Having reviewed and considered the entirety of the evidence proffered in the matter, the Arbitrator finds that Petitioner has failed to meet his burden of proof that his condition of ill-being with regard to his erectile dysfunction and groin issues is related to the work injury of January 20, 2015.

With respect to disputed issue (J) pertaining to reasonable and necessary medical expenses, in light of the fact that Respondent does not dispute that Petitioner's current condition of ill-being with regard to the rib fracture and T11 and T12 fractures are causally related to the work accident, the Arbitrator finds that Respondent shall reimburse Petitioner for reasonable and necessary medical services of **$130.00** for the Hydrocodone out-of-pocket expenses incurred (*i.e.*, those as identified as $5.00 charges on the exhibit of prescription expenses as contained in Petitioner's Exhibit 6), as provided in Section 8(a) of the Act. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims 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 injury, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that no AMA rating was offered by either party at the time of arbitration. The Arbitrator places no weight on this factor when making the permanency determination.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that the record reveals that Petitioner was employed as a Maintenance Foreman at the time of the accident and that he has returned to his position on a full duty, unrestricted basis after the completion of his treatment. The Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 48 years old on his date of accident. Given the age of Petitioner and the fact that the medical records lack any reference to Petitioner having been placed under any restrictions, 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, following his work injury, Petitioner returned to his position as a Maintenance Foreman. As there was no direct evidence of reduced earning capacity contained in the record, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he does not have any pain associated with his rib fracture. He testified that he experiences pain if he sits or stands for periods of 5-15 minutes. He testified that his sleep is affected secondary to back pain and that he experiences stiffness when he gets out of bed. He testified that since the accident he has played golf twice in the two years, but that none of his other activities have been limited. At the time of the September 24, 2015 visit with Dr. Coyle, it was noted that Petitioner was eight months post-injury and that his symptoms were affected by the weather. It was noted that Petitioner was working full duty and he was advised that there was really nothing else that needed to be done. It was noted that Petitioner was at maximum medical improvement and that if his symptoms were to flare up in the future, he could return for re-evaluation. (PX3). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely his continued complaints and limitations, were minimally corroborated by his treating records at the conclusion of his treatment with Dr. Coyle. The Arbitrator accordingly places lesser 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 **10% loss of use of the person-as-a-whole (*i.e.*, 0% for the rib fracture, 5% for the T11 fracture and 5% for the T12 fracture)** as provided in Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dennis Clemons,
Petitioner,

vs.

NO: 14 WC 42700

State of Illinois/IDOT,
Respondent.

17IWCC0836

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of nature and extent and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 9, 2017, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DEC 29 2017

DATED:
o120717
DLG/mw
045

David L. Gore

Stephen Mathis

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CLEMONS, DENNIS
Employee/Petitioner

Case# **14WC042700**

STATE OF ILLINOIS/IDOT
Employer/Respondent

17IWCC0836

On 5/9/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.01% 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:

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WORKERS' COMPENSATION MANGER
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SPRINGFIELD, IL 62794-9208

CERTIFIED as a true and correct copy pursuant to 820 ILCS 305/14

MAY 9 = 2017

Ronald A. Peria, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
x None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Dennis Clemons
Employee/Petitioner

v.

State of Illinois / IDOT
Employer/Respondent

Case # 14 WC 42700

Consolidated cases: _____

17IWCC0836

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Douglas **McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on **April 18, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **June 3, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$66,192.00**; the average weekly wage was **$1,272.92**.

On the date of accident, Petitioner was **56** years of age, ***married*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

Respondent is entitled to a credit of **$11,793.54** under Section 8(j) of the Act.

ORDER

Respondent shall be given credit for $11,793.54 for medical benefits paid under Section 8(j) of the Act.

Respondent shall pay reasonable and necessary medical services of $39,402.60, as provided in Section 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $721.66 for 25 weeks as 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.

5/4/2017
Signature of Arbitrator Date

MAY 9 - 2017

Statement of Facts

It is undisputed that the Petitioner was lifting a heavy desk on June 3, 2014 with a co-worker. As he lifted, his back popped and he felt pain down his legs. The Petitioner testified that he told his co-worker about the pain he was having in his back and that he then sought evaluation by a medical professional the next morning. The Petitioner first sought care at Abraham Lincoln Memorial hospital where he provided a history of being injured while lifting desks. His symptoms were of lower back pain on both sides that "comes around to his upper thighs." (PX 2) His examination revealed moderate muscle spasm of the right and left posterior back. He was diagnosed as having sustained an acute lumbar strain. He was referred to see his family doctor.

The Petitioner then followed up with his family doctor, Dr. Zwilling, who placed him on light duty and referred him to an orthopedic facility. The Petitioner then was evaluated by Dr. Paul Smucker, a pain management physician, on July 25, 2014. He provided a consistent history of onset. His symptoms were in the lower back radiating to the anterior groin along with numbness and tingling in the anterior bilateral thighs. (PX 4) He went through an epidural injection and had an MRI. The MRI, performed on August 22, 2014, showed bulging disc and facet arthropathy at the level of L2-3 contributing to moderate to severe canal and bilateral foraminal stenosis. (Id) The Petitioner testified that the epidural injection was not successful in alleviating his complaints and was ordered for another epidural injection.

The Petitioner testified that Dr. Smucker placed him on light duty and the Petitioner was able to continue working for the Respondent on light duty. The Petitioner testified that he was recommended for a 2nd epidural injection but that was denied by workers' compensation so he sought an orthopedic surgeon's opinion through his family doctor and was referred to Dr. Stephen Pineda, a spine surgeon. The Petitioner first saw Dr. Pineda on December 3, 2014 and provided Dr. Pineda a history of low back pain since June of 2014 after lifting desks. Dr. Pineda's diagnosis was probable aggravation of degenerative disc disease and/or stenosis. Dr. Pineda indicated that the Petitioner needed to undergo therapy and then follow up with Dr. Pineda. The records reflect the Petitioner underwent physical therapy from December 9, 2014 until he followed up with Dr. Pineda on January 7, 2015. Upon being re-evaluated by Dr. Pineda on January 7, 2015, Dr. Pineda made a recommendation for decompression surgery in order to alleviate the Petitioner's complaints of pain in his back and legs.

The Petitioner underwent decompression surgery on January 30, 2015 with Dr. Pineda at Memorial Medical Center in Springfield in the form of a laminectomy, foraminotomies and decompression at L2-L3. The operative note also indicated that there was significant thickening of the ligamentum flavum. (PX 7) The Petitioner followed up on February 10, 2015 with Dr. Pineda and was doing well. Dr. Pineda continued him on with a 20 lb. lifting restriction. He then followed up with Dr. Pineda on

March 10, 2015 and April 1, 2015. During both of those visits times the pain in his back and legs had been alleviated and he was released to return as needed.

Dr. Pineda testified by ay of an evidence deposition. He was asked whether there was a causal relationship between the event lifting desks and his condition of ill being in the lumbar spine. He said that there was a relationship, assuming the Petitioner had provided an accurate history. He explained that the Petitioner had some pre-existing stenosis or degeneration, but that his symptoms "really took off..." following the lifting episode. (PX 6 at 13-14) Dr. Pineda also acknowledged that the Petitioner did have evidence of significant stenosis at the same spinal level, L2-3, based upon an MRI performed presumably in 2001. He was shown records from Dr. Narla during cross examination indicating that he was having symptoms in June 2001for which he received treatment. (Id at 30)

Dr. Lawrence Li, an orthopedic surgeon, performed a Section 12 examination for the Respondent on October 2, 2014. Dr. Li also testified by evidence deposition. His exam findings were consistent with stenosis at L2-3. He noted the Petitioner had no sensation at the L3 distribution on the right. He diagnosed the Petitioner as having sustained a lumbar strain in the lifting incident superimposed over chronic preexisting spinal stenosis. (RX 1 at 15) He further said that the sensation loss was due to stenosis, osteophytes and a disc protrusion. He then opined that lifting the desk would not aggravate the stenosis nor the disc because he had the disc prior. (Id at 25) He did however, acknowledge that the accident did aggravate the Petitioner's symptoms. (Id at 26)

Dr. Pineda further testified that the physiology of the Petitioner's lumbar spine had been permanently altered by the surgery he performed in January of 2015.

17IWCC0836

In support of the Arbitrator's decision relating to:

(F) Is Petitioner's current condition of ill-being causally related to the injury?

The Arbitrator finds the opinions of Dr. Stephen Pineda, the Petitioner's treating surgeon, are more credible than those of the Respondent's examining physician, Dr. Lawrence Li in this matter and finds that there is a causal relationship between the Petitioner's injury lifting desks on June 3, 2014 and the conditions of ill-being in his lumbar spine as found by Dr. Pineda. The arbitrator make this finding based upon Dr. Pineda's testimony that the accident in question caused an aggravation of his underlying degenerative disc disease. (See PX 5 pg. 6 and PX 6 pg. 8)

The Arbitrator further bases this upon the Petitioner's unrebutted testimony that he was working full duty with no restrictions at the time of the accident in June of 2014 and was not under active medical care for his low back at that time.

The Arbitrator notes that the Respondent presented no contrary testimony or evidence to refute the Petitioner's assertions that this event caused the chain of events that led to his need for back surgery. The Arbitrator also bases his decision upon the medical records submitted into evidence as Petitioner's Exhibits 2, 3, 4, 5 and 7. The Arbitrator finds that all of these medical records submitted into evidence provide a consistent history of the Petitioner's symptoms beginning on June 3, 2014 after lifting desks. Specifically the Arbitrator notes that the Petitioner's initial history to Abraham Lincoln Memorial hospital emergency room indicated that he had pain in the low back with radiating symptoms into both thighs after helping his boss move desks.

The Arbitrator notes that Petitioner did admit to having prior back problems but that the Respondent presented no evidence that the Petitioner was under any medical care for his lumbar spine from January of 2007 until his accident in June of 2014.

The Arbitrator further notes that there was no evidence of any treatment by the Petitioner involving an injury at the level of L2-3 between 2001 with Dr.Narla and June 4, 2014, the day after his accident.

The Arbitrator finds that the Respondent's own examining doctor, Dr. Lawrence Li, indicated that the accident in question aggravated the Petitioner's symptoms because he had a lumbar strain super-imposed on his conditions of spinal stenosis. (See RX 1, pgs. 25-26) The Arbitrator further notes that Dr. Li testified that he was not aware of any documentation of the Petitioner having any ongoing lumbar complaints between early 2007 and his reports of back pain associated with this accident in June of 2014. (See RX 1 pg. 27)

The issue on causation really boils down to what is and has been black letter law in Illinois for quite some time. A Petitioner is entitled to compensation if he or she sustains an injury which aggravates a pre existing condition, so long as the accident is a cause of the current injury. The evidence shows the Petitioner with a preexisting condition at L2-3. It further shows that with said condition he performed his regular job with the State which involved some lifting for a period of thirteen years without any record of treatment or symptoms in the injured areas. He then had a traumatic event, followed by documented findings consistent with an acute injury. He continued with consistent symptoms from then until his surgery some seven months later.

Dr. Li's testimony is not persuasive. While he agrees with Dr. Pineda that the Petitioner's stenosis had been present for a long time, he gives no plausible explanation as to why the accident did not aggravate the disc and other soft tissue bringing about the new ongoing symptoms. While he suggests that the aggravation should have been temporary, he ignores the fact that the documented symptoms remained from the accident date up to the date of surgery.

Based upon the Petitioner's testimony and the testimony of the medical experts in this case, the Arbitrator finds the Petitioner's testimony credible and that there is a causal relationship between the Petitioner's accident and the conditions of ill-being about his lumbar spine for which he sought treatment.

In support of the Arbitrator's decision relating to:

(J) Were the medical services that were provided to the Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

As to the issue of medical bills, having found that there is medical causation in this matter, the Arbitrator awards the medical bills to the Petitioner as found in Petitioner's Exhibit # 9, subject to the Fee Schedule. Respondent is entitled to Section 8 (j) credit for bills already paid.

In support of the Arbitrator's decision relating to:

(L) What is the nature and extent of the injury?

Applying the factors set forth in Section 8.1b of the Act, the Arbitrator first notes that the parties have not submitted an AMA report, so consideration of that factor is waived.

The Petitioner works as an engineering technician for the Department of Transportation. Very little evidence was introduced concerning his physical job requirements. Obviously he had to do some lifting as he was injured while lifting a heavy desk so as to avoid

scratching the floor. The Arbitrator gives some weight to this factor, acknowledging that Petitioner has some residuals from a lower back injury and has a job which requires some lifting.

The Petitioner was 56 years old when he was injured. The Arbitrator gives some weight to this finding as the Petitioner will have to deal with his injury for some years, but certainly the factor is less critical than it would be to a younger individual.

There is no showing of diminished future earnings, so the Arbitrator gives no weight to that factor.

With respect to evidence of disability corroborated by treatment records, the Arbitrator notes that this is an unusual case. The Petitioner had surgery consisting of a decompression at L2-3 with foraminotomies. Despite the nature of the surgery, when he was released from care by Dr. Pineda less than three months later his had no complaints. He showed normal strength and sensation to light touch. He testified that he was having no symptoms at arbitration. On cross-exam, he said that his back felt better than before his accident. The only evidence from the treating doctor to support a permanency award is contained in Dr. Pineda's deposition, referenced above. He said that the spine was permanently altered as a result of his surgery and suggested that he may develop spurring and arthritis in the future. (PX 6 at 26-27)

Based upon this, the Arbitrator finds that the injury in question caused a permanent partial disability in the amount of 5% disability to the whole person or 25 weeks of permanent partial disability at a maximum PPD rate of $721.66.

STATE OF ILLINOIS)
) SS.
COUNTY OF ADAMS)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Monty Logan,
Petitioner,
vs.

NO: 17 WC 05378

Chuck Miller, individually, and d/b/a/ Miller Construction Co.,
Respondent.

17IWCC0837

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, medical expenses, prospective medical, average weekly wage, penalties, fees and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 6, 2017, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $41,000.00. 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: DEC 29 2017
o120717
DLG/mw
045

David L. Gore

Stephen Mathis

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

LOGAN, MONTY
Employee/Petitioner

Case# **17WC005378**

CHUCK MILLER INDIVIDUALLY AND D/B/A MILLER CONSTRUCTION CO
Employer/Respondent

17IWCC0837

On 6/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.07% 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:

0393 THOMAS R LICHTEN LTD
53 W JACKSON BLVD
SUITE 224
CHICAGO, IL 60604

2904 HENNESSY & ROACH PC
MICHAEL HOLT
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

17IWCC0837

STATE OF ILLINOIS)
)SS.
COUNTY OF ADAMS)

☐ 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)

Monty Logan
Employee/Petitioner

v.

Chuck Miller, individually, and d/b/a Miller Construction Co.,
Employer/Respondent

Case # **17** WC **005378**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Quincy**, on **April 5, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **01-11-2017**, 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 **$16,380.00**; the average weekly wage was **$315.00**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **0** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Petitioner *was* temporarily totally disabled from **January 12, 2017** through **April 5, 2017**, a period of **12 weeks.**

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-** for any medical bills paid by a group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$253.00/week** for **12 weeks**, commencing **January 12, 2017** through **April 5, 2017**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of **$37,850.38**, as provided in Section 8(a) and 8.2 of the Act.

Petitioner's request for prospective medical care is denied.

Petitioner's Petition for Penalties and Attorney's Fees is denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

May 31, 2017
Date

JUN 6 – 2017

FINDINGS OF FACT and CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner presented to the Blessing Hospital ER on January 11, 2017 at approximately 3:32 p.m. He arrived by private vehicle. He reported doing house demolition when some stairs collapsed and he fell 8 feet. He tried to catch himself with his left hand and sustained deep lacerations to it. He also reported that his left knee "popped" out of place. Petitioner's pain was noted to be severe. Petitioner's head and neck showed no sign of trauma or injury. A c-spine x-ray was ordered due to the mechanism of injury. Petitioner's femur x-rays showed a questionable subluxation of the proximal fibia in relation to the distal femur and an ACL tear. A large joint effusion was present. Degenerative changes were also noted within the knee and degenerative joint changes within the knee and, to a lesser degree, the left hip. Cervical spine x-rays showed advanced degenerative disc disease at multiple levels with slight bilateral osseous neural foraminal narrowing and facet arhtropathy. Petitioner denied any use of alcohol. Petitioner was given morphine and fentanyl, and a knee immobilizer. Medications were prescribed and he was told to follow up with Dr. Stewart or Dr. Fu in orthopedics and to see Dr. Fynn-Thompson regarding his lacerations. Petitioner was taken off work through January 13, 2017. (PX34)

On January 13, 2017 Petitioner presented to Quincy Medical Group where he was examined by N.P. Bruns. Petitioner complained of left knee pain following an injury on January 11, 2017 in which he was demolishing a house, fell through some stairs approximately six feet and landed "awkwardly" on his left leg. He felt significant pain soon afterwards with swelling and trouble bearing weight. He went to the emergency room and underwent x-rays that revealed significant osteoarthritic changes and large effusion. He had been placed in a knee immobilizer and advised he might have a ligamentous injury. Hydrocodone was not providing any relief. Petitioner had been partially weight bearing since then but still in moderate discomfort. Petitioner's history included a prior knee arthroscopy in 1968 (which knee wasn't stated). On exam, significant swelling and effusion was present along with an obvious defect in the quadriceps proximal to the patella. Petitioner was unable to perform a straight leg raise. Petitioner's x-rays were reviewed and Mr. Bruns noted his discussion with Petitioner regarding the moderate osteoarthritic changes shown by the x-ray. Petitioner was diagnosed with a complete rupture of the quadriceps tendon and an MRI was ordered along with a referral to a trauma surgeon as Mr. Bruns felt it imperative that the quad be fixed as Petitioner would ultimately need a joint replacement. Petitioner was referred to Dr. Harmer for surgical consideration. Medications were also ordered. (PX 2, pp. 1 - 5)

Petitioner underwent a left knee MRI on January 13, 2017. According to the radiologist's impression, Petitioner had a quadriceps tendon tear. A few thin anterior fibers appeared to remain intact representing the contribution from the rectus femoris muscle. The more posterior fibers were retracted approximately 1.5 cm. from their expected insertion. He also had a Grade 1 strain of his quadriceps musculature and hematoma anteriorly, complex fluid within the prepatellar bursa which might represent hemorrhagic bursitis, large knee joint effusion, a moderately large Baker's cyst, moderate to severe chondromalacia within the medial central weight bearing compartment, a partial thickness tear of the PCL, mucoid degeneration of the ACL, a root tear of the posterior horn of the lateral meniscus; and a superior and inferior articular surface tearing of the posterior horn of the medial meniscus with undersurface tearing extending into the body. (PX 2, pp. 60 – 61)

Dr. Harmer examined Petitioner on January 17, 2017. Petitioner advised the doctor that he was a laborer and that on January 11th he was walking down a set of stairs "and stair stairs way causing him to

fall." He fell with a concentrated load on his left knee with immediate pain about his patella. Petitioner acknowledged prior bilateral arthritic knee pain which was moderately bothersome for him. He denied any head injury. Petitioner's treatment since then was noted. Dr. Harmer noted that Petitioner was a contract laborer and was at work when he was injured. "He states that his employer though does not carry Worker's Compensation insurance." (PX 2, p. 7) Petitioner's examination was consistent with a quadriceps tendon injury as noted on the MRI, he was to be scheduled for surgery the next day, and the doctor noted Petitioner would require a knee extension brace thereafter. (PX 2, pp. 6 - 10)

Petitioner underwent a left quadriceps tendon rupture repair on January 19, 2017. He was kept overnight at the hospital. (PX4, PX 5)

Petitioner was examined by Dr. Frazier at Quincy Medical Group Family Practice on January 31, 2017 regarding his hypertension and high cholesterol. His knee injury was not addressed. Petitioner's chart indicates that in May of 2012 Petitioner had been diagnosed with osteoarthritis of the knee. (PX 2, p. 13) (PX 2, pp. 11 – 15)

That same day (1/31/17) Petitioner presented to Dr. Fynn-Thompson at Quincy Medical Group Plastic Surgery for evaluation of lacerations to his left middle and small fingers sustained when he was working on January 10th demolishing a house. Petitioner reported walking down some steps that were unsecured and he fell through the steps and into the basement, injuring his left lower extremity and sustaining lacerations to his fingers while trying to catch himself. The lacerations had been sutured by the ER doctor and he was not presenting for follow up care. Petitioner reported some ongoing discomfort with gripping secondary to the presence of the open wounds. He was also using crutches to get around due to his left knee injury and surgery. Petitioner's small finger wound had not fully dried up and Petitioner was instructed to work on range of motion as tolerated. No further surgery was felt necessary. He was to return in 2 weeks. (PX 2, pp. 16 – 19)

Dr. Harmer re-examined Petitioner on February 2, 2017. He was two weeks post-op and doing well with no concerns. His knee mobilizer was locked in full extension. Therapy was to be initiated, three times a week. (PX 2, pp. 20 – 22)

Petitioner presented to physical therapy on February 3, 2017. His history of a knee injury sustained when falling down stairs while working at tearing down houses was noted. Petitioner was having trouble with prolonged standing, walking, bending and sitting. He was going down stairs backwards using a hand rail and was not using a hand rail going up the stairs. Petitioner also reported having stopped excessive, daily alcohol consumption cold turkey since having his surgery and had dropped 30 lbs. in the last two weeks. He also reported having increased sweating and shakiness during that time frame. Petitioner's employer was listed as a "private company that performs gutting/deconstruction of buildings for Blessing." (PX 2, p. 24) Therapy was to continue for twelve weeks. (PX 2, pp. 23 – 30)

Petitioner attended physical therapy on February 7, 2017. (PX 2, pp. 31 – 35)

Petitioner signed his Application for Adjustment of Claim herein on February 14, 2017. Petitioner's Application alleges that he injured "his left leg, left hand, neck, back, both arms, and body" on January 11, 2017. The accident was described as "The injury arose from and is related to the employment." (AX 2)

On March 14, 2017 Petitioner filed a motion to set a 19(b) Petition and Penalties and Attorney's Fees Petition for hearing on April 5, 2017 in Quincy. (PX 1)

By letter dated March 15, 2017 Petitioner's attorney forwarded to Respondent's workers' compensation carrier, a copy of the Application for Adjustment of Claim and requested payment of TTD benefits and medical bills incurred to date. (PX 6)

Petitioner returned to Quincy Medical Orthopedics on March 16, 2017 where he was examined by Dr. Harmer who described him as "doing well." Petitioner had no concerns and was ambulating with his knee immobilizer on and in a locked position. Petitioner wasn't taking any pain medication. His physical examination was good and Dr. Harmer instructed Petitioner to begin ambulating without the knee immobilizer. He was allowed to return to work with up to one hour of standing but no lifting, pushing, or pulling. (PX 2, pp. 36 – 39)

By letter dated March 20, 2017 Petitioner's attorney forwarded to Respondent's workers' compensation carrier, a copy of the Application for Adjustment of Claim and requested payment of TTD benefits and medical bills incurred to date. (PX 6)

According to the March 23, 2017 physical therapy note Petitioner had no complaints involving his neck, head, shoulders, or upper extremities. He did have lower extremity complaints evidenced by ongoing decreased knee range of motion and strength. (PX 2, pp. 40 – 47)

By fax dated March 28, 2017 Petitioner's attorney forwarded to Respondent's workers' compensation carrier, a copy of the Application for Adjustment of Claim and requested payment of TTD benefits and medical bills incurred to date. (PX 6)

Petitioner also attended therapy on March 29, 2017. Petitioner had no complaints involving his neck, head, shoulders, or upper extremities. He did have lower extremity complaints evidenced by ongoing decreased knee range of motion and strength. (PX 2, pp. 48 – 55)

On March 31, 2017 Respondent filed its response to Petitioner's 19(b) Petition and its Response to Petitioner's Penalty Petition. (RX 1, RX 2)

The Arbitration Hearing

Petitioner's case proceeded to arbitration on April 5, 2017 on a 19(b) basis. The disputed issues included accident, causal connection, medical bills, TTD, prospective medical care, and penalties and attorney's fees. Two witnesses testified at the hearing – Petitioner and Respondent, Chuck Miller.

Petitioner testified he has worked for Respondent for approximately 10 years as a full-time laborer. His hours varied between 35-39 hours a week on average. He was paid $9.00/hour cash. Petitioner testified that when he began working for Respondent he asked about being paid by check but Mr. Miller indicated that he paid employees using cash. Petitioner has never received a W-2 or 1099 from Respondent in all his years of employment.

Petitioner testified that the kind of work he did for Respondent included doing labor work to operator's work. When asked if he was involved in the demolition of various structures, he indicated that he was not as he was "more or less" there to clean up what the track hoe couldn't get close to other buildings.

Petitioner also testified that Mr. Miller owns a farm. When asked if he did work for Mr. Miller at the farm, Petitioner replied just "for the construction." He also testified that Mr. Miller had firewood at his farm and that Mr. Miller asked him to deliver firewood that he sold to people in Quincy.

Petitioner testified that Mr. Miller has a coal burning furnace at his home and that he has done work for Mr. Miller in order to keep it fueled. Petitioner testified to going out to Mr. Miller's farm, picking up 55 gallon drums, putting them in the back of a truck, getting them filled and taking them back to Mr. Miller's house and removing them from the truck. He also filled buckets of corn and cleared weeds from Mr. Miller's property.

Petitioner testified that within the past year he has been involved in the demolition of a building referred to as the "Quincy Auto Museum" which was owned by the Quincy Park District. He thought that the demolition began in November/December of 2016. He did not know if the demolition job was a prevailing wage job. He believed that he was paid $9.00 an hour while working on that job. Petitioner also testified to working in the past year on tearing down houses that Mr. Miller had contracted with the City to tear down. When asked if any of those jobs were prevailing wage jobs, he replied that he was "only there to be a laborer."

Petitioner also testified that Blessing Hospital had been buying up houses to tear down for expansion of the hospital buildings. Petitioner testified that he did some work for Mr. Miller on those jobs and one of the houses was located at 824 College in Quincy. Petitioner identified PX 9 as a photograph of the house at 824 College which is where he was injured.

Petitioner testified that he began working at 824 College in the latter part of December of 2016. Initially, and at Mr. Miller's direction, they obtained entry and went down to see if the water meter was still in the house. Petitioner testified that he used a crow bar to break into the house because they didn't have keys. When they got down in the basement the water meter had already been removed. Petitioner further testified that after January 5, 2017 they proceeded to remove the fencing around the house. After that they would go to the other jobs and "do stuff" and then return to this job and "do stuff." It was never an ongoing thing; rather, they skipped around a lot.

Petitioner testified that on January 11, 2017 he put aluminum siding taken from the house into a truck, drove across the bridge, sold the aluminum and brought the money back to Mr. Miller. Petitioner further testified that he then went out and got two loads of firewood and took it to other residencies. Petitioner then dropped Mr. Miller's truck off and he went home in his truck.

Petitioner's attorney then asked Petitioner if he spoke to Mr. Miller before heading home about going back to the 824 College address and he replied that he did. He testified that, as he had before on previous occasions, he told Mr. Miller that the building didn't have any orange fencing around it as they usually put around buildings they were demolishing, and he had seen children playing around the house and looking inside the building and he felt that for the safety of the children they needed to close any open windows. Petitioner testified that he returned to 824 College to do that. Petitioner also testified that he was referring to the basement windows because those were the ones the children were looking into. Petitioner testified that he had had numerous conversations with Mr. Miller about the fencing and windows.

Petitioner testified that when he returned to the house, he went to go downstairs to the basement and the stairs collapsed on him causing him to fall about eight feet. He cut his left middle and little fingers on nails trying to stop his fall but once he hit the bottom his leg was twisted and his left knee injured. Petitioner testified that his right shoulder and low back hurt. He crawled over to a window, pull himself up and out of the basement. When asked if he also injured his neck, he replied "Yes."

Petitioner testified that the hospital was located about two blocks from the house. A man he was working with, Paul Woodworth, helped him to his truck and Petitioner drove himself to the hospital. Petitioner further testified that by leaning up against the wall and allowing emergency room staff to assist

him, he got into the emergency room. Petitioner testified that Mr. Woodworth is another person who does work for Mr. Miller.

Petitioner testified that the hospital personnel treated him and referred him to Dr. Harmer, an orthopedic surgeon. Dr. Harmer explained to him that he had torn muscles away from his kneecap and had to undergo surgery which took place on January 19, 2017. After the surgery Petitioner required crutches to ambulate. He was told to undergo physical therapy but was only able to do so for two visits because he couldn't make it into town due to his physical ability and so he had in-home care and therapy for three weeks. Petitioner is continuing to undergo physical therapy two times per week. He now goes to Quincy Medical Group for his therapy.

Petitioner testified that Dr. Harmer imposed work restrictions of no standing for more than one hour, no bending, kneeling, or lifting and no standing or walking "a lot." He continues to wear a fairly large brace on his left knee. Petitioner testified that Mr. Miller doesn't have any work available within those restrictions.

Petitioner testified that he did not know if Mr. Miller had workers' compensation insurance or not. Mr. Miller never said anything to him about it. When asked if Mr. Miller ever said anything to him about what he needed to do if he got hurt on the job, Petitioner replied "He said that we had to take care of it ourselves."

Petitioner testified that he sustained an injury while working for Mr. Miller on May 6, 2015 in Astoria while building a Dollar General building. He was helping put in a drainage system and he sustained a 3" by ½" deep cut in his left knee. Petitioner testified that Mr. Miller was present when it occurred but didn't offer to take him to the hospital; rather, he told him to be careful. Petitioner further testified that he took himself to Culbertson Memorial Hospital for treatment. He did not think that bill had ever been paid and it was turned over to collection.

Petitioner testified that his left knee currently hurts, rating it at a "4" on a scale of "1 to 10." He also testified to having no feeling in the end of his middle finger or on the side of his little finger. He sustained a fractured middle finger and there is a deformity at the distal joint. His other wounds have healed. Petitioner testified that when he sleeps at night he sleeps on his back or his arms go numb within five minutes. His right shoulder still hurts with a pain, like the pain in his lower back. Petitioner also testified that before he started working for Mr. Miller he had back pain for which he had to take medication as he has three bad discs.

Petitioner testified that some of his bills have been paid by his wife's insurance and he has made some payments out of his own pocket.

On cross-examination Petitioner acknowledged that he was shaking a little bit at the hearing while testifying due to "a hereditary problem" and the fact that he was also nervous. He agreed that the shaking was a problem prior to the work accident. He also acknowledged having issues with his low back before he fell down the stairs. He denied ever undergoing surgery for his back but has been regularly taking prescription medication. He takes three Gabapentin per day and if he doesn't take it for two days he will be in traction. Dr. Frazier prescribes it. Petitioner denied any other health problems.

Petitioner testified that he began working for Mr. Miller on January 11th at 7:30 a.m., his regular start time. He usually stopped working at 3:00 p.m. When he would wake up in the morning Petitioner would drive his truck from his home in Camp Point to Mr. Miller's house at 28th and Broadway. Once there he did "numerous things" but he couldn't exactly recall. They didn't stay at Mr. Miller's house very long. When asked where he went, Petitioner couldn't remember but he indicated that he had a log book he

kept that would show where he went. Petitioner relied on the log book to help him remember things. He thought they went back over to the "824 house on Elm." There was a vacant house on Elm Street that was also being worked on. When asked to clarify whether he left Mr. Miller's house and went to the College Avenue house or a different location, Petitioner replied that he would have to look at his log book to know what he did that day; however, he didn't bring his log book with him to the hearing.

When asked if he worked at 1021 Elm Street on January 11th, Petitioner testified that they might have taken off some siding. He explained that there were many times that they didn't stay on one site during the day. When asked if he went to Elm Street and ripped up pavers off the ground, he replied "No" and explained that happened on another day. He then testified that they did pick up pavers but he didn't know if it was that day or not. When asked if he remembered where he went after he left Mr. Miller's house on January 11th, Petitioner replied, "No, I do not."

Petitioner testified that they usually took lunch between 11:30 and 12:00. He did not remember what he did on the 11th before lunch. Petitioner was asked if he had any problems with his memory and he replied that he did. When asked about the nature of his memory problem, he explained that, "like everybody else, you can't remember what you did for the day and the hours that you worked because we jump around a lot." When asked if he had a medical condition that affected his memory, Petitioner replied "No." He denied being under any treatment or needing medication for a memory problems.

Petitioner testified that after lunch that day he went to Mr. Miller's farm located outside of town and picked up a load of firewood and took it to a home on the south side of Quincy. They used Mr. Miller's vehicle to deliver the firewood. They then returned to the farm and picked up another load and delivered it. He then returned to Mr. Miller's house in Quincy. He got back there about 2:30 or 2:45 p.m. He then dropped the truck off, got in his truck and went over to 824 and proceeded to go downstairs to the basement to secure/seal up the window.

Petitioner testified that Paul Woodworth does scrapping which involves going in and cleaning out the house of anything valuable. Petitioner acknowledged occasionally doing some scrapping on his own but he explained that in this instance Mr. Woodworth had taken everything out of the house worth anything so there was no scrapping to be done at 824 College. When asked if he went there to do scrapping on his own that afternoon, he replied "No, I did not." He also denied having a conversation with Mr. Woodworth that alerted him that no further materials were to be scrapped in the house.

Petitioner acknowledged that when he arrived at 824 it was after his shift had ended (3:00 p.m.) When asked if Mr. Miller directed him to go to 824 College after 3 p.m. Petitioner testified that they had a conversation prior to that time regarding putting up an orange fence and he told him the fence wasn't up and it needed to be up and that they needed to seal up any windows and he agreed. Petitioner felt it was his obligation to go to the house to do that. When asked if he was asked or directed by Mr. Miller to go to the house on College Avenue to do some further work in terms of securing the property with the orange fence, Petitioner replied, "The orange fence was not there, so I went there to close up the window downstairs."

Petitioner agreed that it was after his normal quitting time but "we did that a lot, but on other occasions when I was working for Mr. Miller he would tell me to go to other sites, put up fence that was – I was off my time at that time, and it was just an ongoing thing that we would do such a procedure that after you get done working that you would go over and do extra things."

Petitioner agreed that he was paid $9.00 per hour and would be paid in cash on a weekly basis.

Petitioner agreed that the house at 824 College Avenue was owned by Blessing Hospital and was being torn down. Petitioner did not know if Mr. Miller had an agreement with Blessing Hospital to tear the house down. Petitioner denied falling down the stairs; rather, they collapsed on him. He also testified that Bob, Paul Woodworth's man, was there and he helped him out of the window in the basement. Petitioner, again, denied going to the property to "scrap" as Mr. Woodworth had already taken everything.

Mr. Chuck Miller testified on his own behalf. Mr. Miller has a business called Miller Construction and he performs general contracting, dirt, demolition and gravel work. It is a sole proprietorship. He has been in the construction business in and around Quincy since 1970.

Mr. Miller testified that he has a residence/home located on Broadway Street and that he has a farm located outside of town. He agreed that Petitioner was working for him on January 11, 2017 as a laborer and that Petitioner generally worked 25 to 25 hours per week for him. He was paid $9.00 per hour and paid weekly in cash.

Mr. Miller testified that on January 11, 2017 they were working on Elm Street taking up some pavers. The address was 1021 Elm Street, just a few blocks away from the hospital. The property was owned by Blessing Hospital. Mr. Miller testified that H & D Development (run by Mike Hastings) had an agreement with Blessing Hospital to tear down and demolish the Elm Street house. Mr. Miller is not a partner with H & D Development.

Mr. Miller further testified that before a property is smashed/demolished, Paul Woodworth would go into the building and remove any metals ("scrapping." With regard to the 1021 Elm Street property, he thought Mike Hastings had done the "scrapping." Mr. Miller recalled arriving at the Elm Street property at 7:30 a.m. on the day of the accident. They took pavers up that morning and delivered them to his farm. Petitioner and one other person ("Jeff") were helping him. Mr. Miller testified that the job at 1021 Elm Street was a two day job so Petitioner and "Jeff" worked there all day on the day of the accident except for half an hour for lunch. Mr. Miller didn't know "Jeff's" full name. They continued picking up/removing pavers until 3 o'clock that afternoon and then they left. Three o'clock in the afternoon was the usual quitting time for the day.

Mr. Miller testified that Petitioner kept his personal vehicle at Mr. Miller's residence on Broadway. Petitioner left Elm Street in the work truck and went to Mr. Miller's residence to get his vehicle. Mr. Miller had his own truck and he drove himself to another job or out to the farm. At three o'clock the work day was over. Petitioner was not paid after 3:00 p.m.

Mr. Miller denied that there was any work to be done on a house on College Avenue. He denied directing Petitioner to go over to the house on College Avenue to do anything on January 11, 2017.

Mr. Miller denied that Petitioner delivered fire wood on January 11, 2017 as he believed that had been down a couple of days before. When asked about any discussion with Petitioner about a fence being put up to protect the premises, Petitioner explained that they never had any fence there. They went in and smashed the house and never put any fencing up.

According to Mr. Miller, Mr. Hastings also had an agreement with Blessing Hospital regarding tearing down the College Avenue property.

Mr. Miller testified that Petitioner would have had his own personal truck if he went to the College Avenue house.

Mr. Miller also testified that some time on the 11th of January he got a call from Petitioner regarding an accident and Mr. Miller told him he had hurt his knee. He received no other details at that time. Mr. Miller denied that there was any fencing to be put up or windows to be boarded up. When asked if he directed Petitioner to do anything over at the College Avenue property, Mr. Miller testified that there was no fence over there and he didn't direct him to do anything at the College Avenue property.

Mr. Miller testified that he had an agreement with Petitioner to sell Petitioner a half ton GMC truck.

On cross-examination Mr. Miller denied that Petitioner ever talked to him about an unsecured window and potential problems with children getting into the house. When asked if he never put orange fencing up on these houses, Mr. Miller replied "very seldom" as when they are going to leave it for a week. However, he agreed that they started working on the College Avenue property in December of 2016. When asked if he recalled Petitioner testifying that Mr. Miller had told him to break into the house with a crow bar, Mr. Miller replied that as far as he knew the door was open and there was no reason to get in there as the City had already taken the meter out.

Mr. Miller acknowledged that he and Paul Woodworth have been friends for forty years and he would let Mr. Woodworth enter homes and take out anything of value. Mr. Woodworth kept all the money from such endeavors. Mr. Miller also recalled that Mr. Woodworth had a helper named "Bob." He agreed that Mr. Woodworth and Mr. Miller were in the 824 College house on January 11, 2017 "doing whatever they needed to do that he told them they could do."

Mr. Miller also testified that Petitioner and "Jeff" were working on Elm Street. He acknowledged having another laborer named "Waukeen" working for him and that it is possible it could have been "Waukeen" working that day and not "Jeff." When asked if he really could remember who it was, he replied, "No."

Mr. Miller testified that he would have Petitioner pick up firewood at his farm only three or four times all winter for sale to people in Quincy.

Mr. Miller also testified that he never found out what caused the stairs to collapse on Petitioner nor did he speak to Mr. Woodworth about it. Mr. Miller also acknowledged that Petitioner hardly did anything at 824 College but what he did do there was minimal. He thought they took some aluminum from the property to the scrap yard and he agreed that was done at his direction.

Mr. Miller agreed that he paid everyone working for him in cash and he has never reported anything to the IRS. Mr. Miller testified that Petitioner wanted cash so he paid him in ash. He didn't pay anyone by check.

Mr. Miller also agreed that shortly before the 824 College job there was tear down of the Quincy Auto Museum and while it was considered a prevailing wage job Petitioner was not paid prevailing wage because his work there was very minimal and he tried to keep him off the job. He also acknowledged having other jobs with the City of Quincy which were prevailing wage but he wouldn't pay Petitioner prevailing wage because they would take a track hoe in, knock down the building in a day and be done. Mr. Miller couldn't recall whether he demolished a house at 915 Lind in Quincy. When asked if he paid prevailing wage on that job Mr. Miller explained that all Petitioner did was put fuel in the machine and throw a little straw out when done. All in all, he wasn't there more than half an hour.

Mr. Miller was also asked about the truck he sold to Petitioner. According to Mr. Miller, Petitioner hasn't paid for the truck yet. Mr. Miller explained that he had originally sold the truck to

another employee of his but that didn't work out so Petitioner agreed to take over the payments. When asked if Petitioner had been making weekly payments of $60.00 since November of 2014 Mr. Miller didn't know. He didn't think Petitioner had made any payments since January. About a week before the hearing Mr. Miller had tried to get the truck back but Petitioner drove off in it.

Mr. Miller also testified that he may have spoken with an insurance adjuster through his agent. Mr. Miller denied that he had Petitioner do anything after 3:00 in the afternoon.

On redirect examination Mr. Miller was asked about the removal of aluminum from 824 College but he didn't think that happened the same day as the removal of the pavers on Elm Street; rather, he thought it was about a week before.

Petitioner was called to testify on rebuttal. Petitioner was adamant that they delivered firewood on January 11th because on the last load they got stuck in the back yard and Mr. Miller had to come and pull them out. He recalled it because they got yelled at for getting stuck. He also testified that Blessing Hospital always had them put up orange fencing around all the houses being torn down and in all the time he had worked for Mr. Miller, Mr. Miller would have orange fencing put up.

Petitioner agreed that his work day ended at 3 o'clock every day. He added, however, that "we" would do other jobs (such as fencing) while going out of town and whatever time it took would be added to the next day's pay. They did it all the time. He further testified that the window he was going to secure was a very small one and wouldn't have taken him much time at all. He also testified that Paul Woodworth had gone into the basement to extract the metal and took out the window but didn't bother boarding it back up.

Petitioner denied that he was the one asking to be paid in cash.

Petitioner was also asked about the truck he was purchasing from Mr. Miller. He agreed that he had been having $60.00 taken out of his pay every week to pay for the truck. Petitioner further testified that he had paid for the truck in full.

On further cross-examination Petitioner testified regarding the log book he keeps. He records what he does during the day, including the hours he works, and at the end of the week he summarizes how much he has paid, deducts sixty dollars, and then Mr. Miller pays him the rest. Petitioner did not bring the log book with him to show what he did on January 11, 2017.

Petitioner's medical bills and the Blue Cross/Blue Shield lien information is found in PX 7 and PX 8.

The Arbitrator concludes:

The Credibility of the Witnesses.

Resolution of the issues in this case boils down to the credibility of the witnesses. The Arbitrator is cognizant of the fact Petitioner had some issues with his memory while testifying as to the timeline of events on January 11, 2017. She also recognizes that Petitioner maintained a log book that could have greatly helped corroborate or explain events but the absence of the log book doesn't not undermine his testimony as to why he was at 824 College shortly after 3:00 p.m. on January 11th. Petitioner testified, and Mr. Miller largely agreed, that Petitioner was hired as a general laborer and ran around a great deal performing a variety of tasks for Mr. Miller. That he could not remember exactly what he did the morning of the 11th or that he mixed up street addresses and street names at one point (824 Elm) doesn't negate

that he fell down the stairs at the College Avenue property as he claimed. Overall, the Arbitrator found Petitioner to be a more credible witness than Mr. Miller, who also had a great deal of problems with recollection and inconsistencies.

Medical records have Petitioner presenting to the emergency room around 3:30 p.m. on January 11, 2017 and providing a history consistent with his arbitration testimony. The Arbitrator has difficulty believing that what happened to Petitioner didn't happen as it appears Petitioner was under the impression, initially, that Mr. Miller had no workers' compensation insurance. If such was the case, why would Petitioner have made up the accident? Indeed, no one really challenged whether Petitioner had a stairway collapse from underneath him while at 824 College. Respondent's focus appears to be on whether Petitioner was "in the course of" his employment as the accident occurred after Petitioner had technically clocked out for the day. For reasons to be set forth herein, the Arbitrator concludes that Petitioner was in the course of his employment.

Petitioner testified that when he arrived at 824 College to go to the basement to secure the window, Paul Woodworth (or his employee "Bob") was there. He further testified that Mr. Woodworth (or "Bob") helped him out of the basement. Mr. Miller testified that he and Mr. Woodworth are good friends. Mr. Miller could have subpoenaed Mr. Woodworth to testify on his behalf. He didn't. While Petitioner arguably could have also subpoenaed Mr. Woodworth to testify, it is also understandable why he might not have, given Mr. Miller's and Mr. Woodworth's personal relationship with one another. Furthermore, if it was Mr. Miller's position that Petitioner was over at 824 College on January 11th to engage in "scrapping" with Mr. Woodworth's employee "Bob," Mr. Miller should have subpoenaed "Bob" or Mr. Woodworth to testify and give corroboration to Mr. Miller's, otherwise, uncorroborated claim. Petitioner's explanation for why he went to 824 College on the afternoon of January 11, 2017 was reasonable and consistent with the practice and requirement of Blessing Hospital. Mr. Miller's testimony that he hardly ever put up fencing was not believable. He testified that he never put up fencing and then back peddled to some degree noting that he only did so on jobs taking longer than one week. Such was the job on College Avenue as it began on December 16th. Petitioner's accident happened approximately three weeks later.

While Mr. Miller denied any prior discussions with Petitioner regarding a basement window or need for fences, his testimony on this issue was not altogether clear or credible. Petitioner's attorney asked him if he recalled Petitioner telling him that there was an unsecured window posing a risk with children and no orange fencing and Mr. Miller replied "no" and then added that they "smash them in one day and haul them. So, there's no reason to put a fence up." As noted above, there were times when fencing was needed so Petitioner's insistence that there was no need for fencing is not entirely credible. Additionally, Mr. Miller never denied that Petitioner spoke to him about the window. He only denied the fencing.

It also appears to this Arbitrator that Mr. Miller runs a fast and loose business. He pays his employees in cash and does not provide a W-2, 1099, or other forms as required by the government. Petitioner testified, without rebuttal from Mr. Miller, that Mr. Miller had previously told him that if he got hurt on a job he had to take care of himself. Petitioner illustrated how that practice had previously rung true for him when he described a prior left knee injury he sustained on a job in Astoria. Again, Mr. Miller didn't rebut this.

Mr. Miller's recollection was often vague and uncertain. He could not be sure if Petitioner was working with "Jeff" or "Waukeen" on January 11th. At the same time Mr. Miller made some concessions that completely undermined his credibility. Most significant was the fact that he agreed with Petitioner's attorney that Petitioner and Mr. Woodworth were in the 824 house on January 11, 2017 "doing whatever they needed to do." He also agreed that Petitioner would occasionally work at the property located on

College Avenue. If Mr. Miller could not be sure who was working with Petitioner on January 11th, one can reasonably infer that his memory might be wrong on what tasks were being performed and where they were being performed.

Lastly, the Arbitrator had an opportunity to watch both gentlemen as they testified. While Petitioner had some problems with shakiness and steadiness, he appeared steadfast in his testimony and, while slow, was very deliberate. He came across as a simple, honest, and hardworking man. Mr. Miller, in contrast, was evasive and appeared to care very little about having to be at the hearing. The Arbitrator further sensed a spirit of ill-will between Mr. Miller and Petitioner stemming from the sale of a truck to Petitioner. It is apparent they have a difference of opinion as to whether the truck has been paid for and who should be in possession of it. As such, Mr. Miller's memory and testimony in this matter may be somewhat reflective of that underlying dispute.

Issue (C) Did Petitioner sustain an accident on January 11, 2017 that arose out of and in the course of his employment by Respondent?
Issue (D) What was the date of the accident?

Petitioner sustained an accident on January 11, 2017 that arose out of and in the course of his employment with Respondent. Petitioner was both in the course of his employment and his injury arose out of his employment. In so concluding the Arbitrator relies upon the more credible testimony of Petitioner over that of Mr. Miller. While Petitioner may have technically clocked out prior to the accident, Petitioner was at the 824 College property for the benefit of Mr. Miller. Petitioner was deriving no personal benefit from his presence at the house on College Avenue. He was there to seal up/secure a basement window as a service to his employer. Petitioner credibly testified, without rebuttal, as to the common practice of doing extra work activities for Mr. Miller after 3:00 p.m. with the wages to be counted on the next day's earnings.

Issue (F) Is Petitioner's current condition of ill-being causally related to the injury?

Petitioner's current conditions of ill-being in his left knee, left leg, left middle and pinky fingers, and right shoulder are causally related to his work accident of January 11, 2017. While Petitioner initially reported other aches and pains, including neck pain and low back pain, those complaints, other than the low back, appear to have resolved with no ongoing problems or complaints noted by Petitioner. While Petitioner also testified to some ongoing low back pain, the Arbitrator is unable to find Petitioner's current low back complaints are causally related to the accident as Petitioner clearly acknowledged prior back problems for which he was taking medication at the time of the accident and no records or expert opinions were submitted showing any ongoing low back problems were causally related to the accident.

While Petitioner did have a left knee laceration in May of 2015 and there's a distant reference in the medical to some osteoarthritis of the knee and bilateral knee problems, no records were submitted showing any active or recent treatment to Petitioner's left knee prior to the accident. Furthermore, Petitioner was working full duty before the accident. Accordingly, the Arbitrator bases her causation determination upon a chain of events, noting Petitioner's good heath before the accident, the histories contained in the medical treatment records, the records themselves, and Petitioner's credible testimony.

The Arbitrator also notes the absence of any Section 12 examinations or reports from Respondent.

Issue (J) Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

Petitioner is awarded medical bills in the amount of $37,850.38 for reasonable and necessary medical expenses, including out-of-pocket payments in the amount of $27.07 and payments by Petitioner's spouse's health insurance carrier, Blue Cross/Blue Shield, in the amount of $37,823.31. Said bills are set forth in PX 7 and 8.

Issue (K) Is Petitioner entitled to any prospective medical care?

Prospective medical care is denied. Petitioner did not request that any specific medical care be awarded.

Issue (L) What temporary benefits are in dispute? (TTD)

Petitioner is awarded temporary total disability benefits from January 12, 2017 through April 5, 2017, a period of 12 weeks. Respondent did not dispute the dates of temporary total disability, only liability for the benefits. Benefits shall be paid at the rate of $253.00 per week.

Issue (M) Should penalties or fees be imposed upon Respondent?

Petitioner's Petition for Penalties and Attorney's Fees is denied. Liability for the accident was disputed with a good faith issue being raised as to whether Petitioner was in the course of his employment. The resolution of the issue required a hearing, focusing on the credibility of the witnesses. As such, Petitioner's Petition for Penalties and Attorney's Fees is denied.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Faustina Lazcares,

Petitioner,

vs.

NO: 16WC029584

University of Illinois,

Respondent.

17IWCC0838

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of accident and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 April 4, 2017 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

No bond is required for the removal of this cause to the Circuit Court. 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: DEC 29 2017

SJM/sj
o-12/7/17
44

Stephen J. Mathis

David L. Gore

Deborah L. SImpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

LAZCARES, FAUSTINA
Employee/Petitioner

Case# **16WC029584**

UNIVERSITY OF ILLINOIS
Employer/Respondent

17IWCC0838

On 4/4/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.91% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

2333 WOODRUFF JOHNSON & PALERMO
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4234 MERIDIAN PKWY SUITE 134
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0522 THOMAS MAMER & HAUGHEY
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0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLP ST 13TH FL
CHICAGO, IL 60601-3227

CERTIFIED as a true and correct copy pursuant to 820 ILCS 305/14

APR 4 - 2017

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

17IWCC0838

STATE OF ILLINOIS)
)SS.
COUNTY OF Champaign)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Faustina Lazcares
Employee/Petitioner

v.

University of Illinois
Employer/Respondent

Case # 16 WC 29584

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Urbana**, on **January 26, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **8/09/16**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$41,153.73**; the average weekly wage was **$760.00**.

On the date of accident, Petitioner was **44** years of age, ***married*** with **2** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

Respondent is entitled to a credit under Section 8(j) of the Act.

ORDER

- Respondent shall pay reasonable and necessary medical services of $6,220.00 to Carle Foundation Hospital, $1,825.00 to Carle Physician Group, and $20.00 to Petitioner, pursuant to the medical fee schedule, as provided in Sections 8(a) and 8.2 of the Act.
- Respondent shall authorize and pay for the reasonable, necessary, and related treatment that Dr. Gurtler has recommended for Petitioner's left leg condition of ill-being, pursuant to Section 8(a) and subject to Section 8.2 of the Act.
- Respondent shall be giving a credit for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Edward Lee
Signature of Arbitrator

3/28/17
Date

ICArbDec19(b)

APR 4 - 2017

FINDINGS OF FACT

The Petitioner testified that on August 9, 2016 she was employed by the Respondent as a building service worker. She performed janitorial services at the Grainger Library. She testified that this was the only building that she worked in for Respondent.

On August 9, 2016, she was required to attend a mandatory meeting at approximately 10:00 a.m. This meeting was at Noyes Lab. To attend this meeting, she was required to walk from Grainger Library to Noyes Lab. The walk was approximately four blocks and she had to pass several public streets including Green Street. She testified that the meeting took place in an auditorium-like room. There were approximately 100 other employees of the Respondent in attendance at this meeting.

The Petitioner testified that at the conclusion of the meeting she was walking down the auditorium stairs when she encountered an unusual step which caused her left foot to go further down than she expected. She further testified that this caused her to twist her ankle and her left knee popped at that time. She had an immediate onset of pain in her left ankle and left knee. She testified that the height differential of this step was much bigger than the other steps she had previously encountered while walking down the steps. She further testified that while walking down the stairs there were people who were also walking down the stairs that were in front of her and behind her.

Following this incident, the Petitioner filled out a First Report of Injury with her supervisor. On the report, Petitioner indicated that the date of injury as on August 9, 2016 at 11:00 a.m. at Noyes Lab, Room 100. In describing the incident, Petitioner stated "I stepped down a stair and when I put my foot on the next feel was so far." (RX 1). In the supervisor's report, Romana Burns indicated that Petitioner misjudged the depth of her next step after a series of shallow steps when one step was very deep causing Petitioner to come down hard on her left leg and heard a pop in her leg. Ms. Burns indicated that a contributing condition to the accident was "unrecognizable hazard." (RX 2).

On August 9, 2016, Petitioner was evaluated by Kelly Jane Harding, NP at Carle Convenient Care. By history, Petitioner reported that she was walking down stairs this morning and twisted her left leg while going from stair to stair. The assessment was acute pain of left knee and acute left ankle pain. Petitioner was instructed to use an Ace wrap on the left knee, was taken off of work for three days, and instructed to follow up with her primary care provider as needed. On August 12, 2016, Petitioner was reevaluated at Carle Convenient Care. At that time, Petitioner stated that her foot rolled out from underneath her due to the uneven steps which caused a twisting of her knee. She reported a pulling sensation in her knee with standing. The assessment was sprain of left knee. Petitioner was cleared to return to work but was encouraged to take breaks at work to allow her to ice her knee. She was further instructed to follow up if her symptoms worsened. (PX 1).

On September 16, 2016, Petitioner was evaluated by Dr. John Hoffman at Carle Family Medicine. At that time, Petitioner reported that she sustained an injury at work on August 9 while she was going down stairs and the last step was uneven and significantly larger causing the left ankle to become inverted and her left knee popped. She further reported that her left knee pain and swelling had persisted. On examination, she had effusion in the left knee and a mildly positive McMurray test. Dr. Hoffman diagnosed a left knee injury and recommended Petitioner to undergo an MRI to her left knee. (PX 1).

On October 3, 2016, Petitioner underwent an MRI to her left knee at Carle. Dr. Dean Hoffmeister's impression was prominent radial tear posterior horn medial meniscus, probable reactive bone marrow edema medial tibial plateau, medial and patellofemoral cartilage thinning, and joint effusion. (PX 2).

Petitioner was evaluated by Dr. Robert Gurtler at Carle Department of Orthopedics on October 13, 2016. By history, Petitioner reported that on August 9 she was at a meeting and coming down stairs that were uneven. She reported swelling and pain since this incident. Dr. Gurtler's diagnosis was a left knee medial meniscus tear. Dr. Gurtler opined that the meniscal injury was caused by her tumbling on the uneven stairs when she was at a meeting on August 9, 2016. Dr. Gurtler recommended a left knee arthroscopic medial meniscectomy. (PX 2).

Petitioner testified that she wants to proceed with the surgery that Dr. Gurtler recommended. She further testified that she continues to have ongoing pain in her left knee. She further testified that she was not having any left knee pain prior to the August 9, 2016 accident. She further testified that she has not sustained any new traumas to her left knee since the August 9, 2016 incident.

CONCLUSIONS OF LAW

With regard to whether an accident occurred that arose out of and in the course of Petitioner's employment by the Respondent, the Arbitrator makes the following conclusions of law:

The Arbitrator finds that the Petitioner sustained an accident on August 9, 2016 which arose out of and in the course of her employment by the Respondent while descending the stairs following the mandatory meeting at Noyes lab.

In support of this conclusion, the Arbitrator notes the following:

The Petitioner has the burden to prove that her injuries arose out of and in the course of her employment. *820 ILCS 305/2.* There is no dispute that Petitioner's injury occurred "in the course of her employment." Petitioner was on Respondent's premises, attending a mandatory meeting, at the time of the August 9, 2016 accident. However, Petitioner must prove that her injuries "arose out of her employment" with Respondent.

If a claimant can show that an injury takes place in an area with a special risk or hazard, the hazard becomes part of the employment, satisfying the "arising out of" requirement of the Act. *Litchfield Healthcare Ctr. v. Indus. Comm'n*, 349 Ill. App. 3d 486 (2004). In *Litchfield Healthcare Ctr. v. Indus. Comm'n*, the claimant tripped over an uneven sidewalk on her employer's premises. Although traversing a sidewalk is typically a risk that the general public is exposed to, the Appellate Court found that since the Petitioner was able to show a special hazard associated with the sidewalk, was enough to establish an increased risk. *Id* at 491.

Similar to the claimant in *Litchfield*, the Petitioner was traversing a risk that is typically associated with a neutral risk, a set of stairs. However, the record is clear that the set of stairs Petitioner was descending on August 9, 2016, had a special risk which created a hazard that increased Petitioner's risk of injury. It was Petitioner's unrebutted testimony that the stair that caused her to twist her ankle and injure her knee, was unusual. She further testified that there were people in front of her going down the stairs at the time of her injury. She further testified that the steps she had already encountered while descending down the stairs were even, until she got to the step that caused her injuries. The photographs submitted by both Petitioner and Respondent support Petitioner's testimony that the stair height was not consistent. Respondent

admits that this was an "unrecognized hazard." (RX 2). As such, this created a special risk which becomes part of the employment and increased Petitioner's risk of injury.

With regard to whether Petitioner's current condition of ill being is causally related to the injury, the Arbitrator makes the following conclusions of law:

The Arbitrator finds that Petitioner's left knee condition of ill being is causally related to the August 9, 2016 work accident.

In support of this conclusion, the Arbitrator notes the following:

All of the evidence submitted is consistent with an immediate onset of pain in Petitioner's left knee following the traumatic accident that occurred on August 9, 2016. It was Petitioner's unrebutted testimony that she was not having any left knee pain prior to this accident. She further testified that she an immediate onset of pain in her left knee following this accident. The injury report Petitioner filled out on the date of the accident indicates that she injured her left leg while going down stairs earlier that day. (RX 1). The supervisor's report of injury confirms that Petitioner injured her left leg at the time of the August 9, 2016 accident.

The medical records support Petitioner's testimony of an immediate onset of pain in her left knee following the August 9, 2016 work accident. Petitioner was seen at Carle that same day and reported left knee pain after twisting her left leg at work while going down stairs. (PX 1). This history is consistent throughout all of the medical records from Carle. (PX1, PX2).

Finally, Dr. Robert Gurtler specifically opined that Petitioner's left knee meniscal injury was caused by her tumbling on the uneven stairs while she was at the meeting on August 9, 2016. (PX 2). The Respondent failed to provide any evidence to rebut the opinion of Dr. Gurtler.

With regard to the issue of whether the medical services provided to Petitioner reasonable and necessary, the Arbitrator makes the following conclusions of law:

The Arbitrator finds that the medical expenses offered into evidence on behalf of Petitioner, which total $8,045.00, are reasonable and necessary and orders Respondent to pay for these expenses, pursuant to the fee schedule.

With regard to whether Petitioner is entitled to any prospective medical care, the Arbitrator makes the following conclusions of law:

The Arbitrator finds that Petitioner is entitled to ongoing treatment for her left knee condition of ill-being, including the surgical procedure that was recommended by Dr. Gurtler. **In support of this conclusion, the Arbitrator notes the following:**

The Petitioner has continued to complain of pain and swelling in her left knee following the August 9, 2016 work accident. She has been diagnosed with a medial meniscus tear in her left knee. Based on Petitioner's objective findings and subjective complaints, Dr. Gurtler recommended a left knee arthroscopic medial meniscectomy. Petitioner testified that she is interested in proceeding with this treatment.

STATE OF ILLINOIS)
) SS.
COUNTY OF MCLEAN)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Chad Ewing,

Petitioner,

vs. NO: 15WC027253

Crestwicke Country Club,

17IWCC0839

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, benefit rates, medical expenses, causal connection, notice, permanent disability, temporary disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 2, 2017 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

No bond 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: DEC 29 2017
SJM/sj
o-12/7/17
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

EWING, CHAD
Employee/Petitioner

Case# **15WC027253**

CRESTWICKE COUNTRY CLUB
Employer/Respondent

17IWCC0837

On 2/2/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0564 WILLIAMS & SWEE LTD
STEVE WILLIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 61701-9531

1680 CASSANO & ASSOCIATES
MICHAEL J MANSEAU
1240 IROQUOIS AVE SUITE 210
NAPERVILLE, IL 60563

17IWCC0839

STATE OF ILLINOIS)
)SS.
COUNTY OF MC LEAN)

☐ 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

Chad Ewing
Employee/Petitioner

v.

Crestwicke Country Club
Employer/Respondent

Case # 15 WC 27253

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Bloomington, on December 28, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On July 3, 2015, Respondent was operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship did exist between Petitioner and Respondent.

On this date, Petitioner did not sustain an accident that arose out of and in the course of employment.

Timely notice of this accident was not given to Respondent.

Petitioner's current condition of ill-being is not causally related to the accident.

In the year preceding the injury, Petitioner earned $n/a; the average weekly wage was $n/a.

On the date of accident, Petitioner was 44 years of age, single with 1 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

Respondent has not paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00.

Respondent is entitled to a credit of $0.00 under Section 8(j) of the Act.

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

William R. Gallagher, Arbitrator
ICArbDec p. 2

January 23, 2017
Date

FEB 2 - 2017

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on July 3, 2015. According to the Application, Petitioner was "raking" and sustained an injury to the "back, legs and other parts of the body" (Arbitrator's Exhibit 2). Respondent disputed liability on the basis of accident, notice and causal relationship. There was also a dispute regarding the computation of the average weekly wage (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a groundskeeper and testified that he sustained a low back injury while raking a sand trap. At the time of the accident, Petitioner had worked for Respondent for slightly less than one month. Petitioner stated that he did not own a vehicle and he would walk from home to the house of a friend named "Ray" who would give him a ride to work. Ray was also Petitioner's immediate supervisor.

Petitioner testified that on the morning of July 3, 2015, he walked to Ray's house and, as usual, he drove him to work. Later that day, Petitioner was working in a sand trap pushing/pulling a rake and felt a "pop" in his low back.

Following the accident, Petitioner stated that he was assisted to the office by two other employees. Petitioner then informed Ray that he had injured himself at work and they had what Petitioner described as a "dilemma." The two employees who assisted Petitioner did not testify when this case was tried.

Petitioner initially sought medical treatment on July 21, 2015, when he was seen by Dr. Roberto Cipolla. According to Dr. Cipolla's record of that date, Petitioner had a history of "...recurrent low back pain with sciatica for many years." The record also noted that Petitioner experienced a recent flare of his back symptoms two weeks ago; however, there was no specific reference to Petitioner having sustained a work-related accident (Petitioner's Exhibit 1).

Dr. Cipolla noted that there was a decreased range of motion of the back and diagnosed Petitioner with right sided low back pain with sciatica. Dr. Cipolla ordered an injection, prescribed some medications and recommended Petitioner undergo an MRI (Petitioner's Exhibit 1).

Petitioner was subsequently seen by Carey Harris, a Nurse Practitioner, on July 31, 2015. At that time, Petitioner informed NP Harris that he had injured his back at work while raking a sand trap. NP Harris opined that Petitioner had chronic back pain and prescribed medications (Petitioner's Exhibit 1).

NP Harris again saw Petitioner on September 9, 2015, and Petitioner still had complaints of low back pain. The record of that date noted that Petitioner had not undergone the MRI because of "insurance issues." (Petitioner's Exhibit 1).

Petitioner testified that, because of the severe back symptoms he had experienced immediately after the accident, he engaged in little or no physical activity for several days thereafter.

However, Respondent introduced into evidence copies of Petitioner's Facebook page which revealed that Petitioner went to a swimming pool and made a road trip sometime around July 4, and July 5, 2015 (Respondent's Exhibit 5).

Further, Respondent also tendered into evidence copies of text messages sent by Petitioner to Ray Actis (Petitioner's supervisor) between July 4, and July 8, 2015. In those text messages, Petitioner informed Actis that he was ill because of some respiratory problems and was unable to work. There was no mention of Petitioner having sustained a work-related accident in any of the text messages (Respondent's Exhibit 4).

Respondent also tendered into evidence a certified copy of Petitioner's felony conviction. Petitioner pled guilty to forgery on June 7, 2007 (Respondent's Exhibit 1).

Raymond Actis testified on behalf of Respondent when this case was tried. Actis was the golf course superintendent and Petitioner's immediate supervisor. Actis stated that Petitioner never informed him that he had sustained a work-related injury while raking sand. He also stated that Petitioner did not come to his office being assisted by two other employees.

Actis testified that Petitioner did not have any complaints of back pain until July 10, 2015. At that time, Petitioner informed Actis that he had a "coughing fit" while walking to his house and hurt his back at that time. Actis reviewed the text messages sent by Petitioner to him and confirmed their authenticity. When Actis saw Petitioner's Facebook page and realized that Petitioner was going to a swimming pool and taking a road trip during the same period of time Petitioner was claiming to be ill, Actis determined that he was going to terminate Petitioner's employment with Respondent and did so shortly thereafter.

Conclusions of Law

In regard to disputed issue (C) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner did not sustain an accidental injury arising out of and in the course of his employment for Respondent on July 3, 2015.

In support of this conclusion the Arbitrator notes the following:

Petitioner did not seek any medical treatment for his back injury until July 21, 2015. According to Dr. Cipolla's record of that date, Petitioner had low back pain with sciatica for many years. While the record noted that Petitioner had sustained a recent flare of his back symptoms, there was no reference to Petitioner having sustained a work-related injury.

The first reference to Petitioner's work-related injury in any medical record was in the record of NP Harris dated July 31, 2015, which was four weeks post accident.

Petitioner claimed that after the accident he was assisted by two other employees; however, neither testified when this case was tried.

Petitioner's testimony that he had significant low back symptoms which limited his activities shortly after the accident was contradicted by Petitioner's Facebook page which clearly showed him engaging in activities on July 4, and July 5, 2015.

Petitioner's text messages to Ray Actis wherein he claim to be sick referred to Petitioner having respiratory symptoms and made no reference to Petitioner having sustained a work-related injury or having low back symptoms.

Petitioner was a convicted felon as he pled guilty to forgery in 2007.

Raymond Actis credibly testified that Petitioner did not report any work-related injury to him and that Petitioner, in fact, injured his back as a result of a "coughing fit."

Based upon the preceding, the Arbitrator finds the credibility of Petitioner to be suspect.

In regard to disputed issues (E), (F), (G), (J), (K) and (L), the Arbitrator makes no conclusions of law because these issues are rendered moot as a result of the Arbitrator's conclusion of law in disputed issue (C).

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tracy McCallister,

Petitioner,

vs. NO: 14WC035180

Taylorville Community School District #3,

17IWCC0840

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, causal connection, permanent disability, temporary disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 22, 2016 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

17IWCC0840

No bond is required for the 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: DEC 29 2017

Stephen J. Mathis

SJM/sj
12/7/2017
44

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McCALLISTER, TRACY
Employee/Petitioner

Case# **14WC035180**

TAYLORVILLE COMMUNITY SCHOOL DIST #3
Employer/Respondent

17IWCC0840

On 8/22/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.44% 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:

4535 ATTEBERRY PC
RACHAEL N HARRIS
220 W MAIN CROSS
TAYLORVILLE, IL 62568

2593 GANAN & SHAPIRO PC
TIMOTHY C STEIL
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

17IWCC0840

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

Tracy L. McCallister
Employee/Petitioner

v.

Taylorville Community School Dist. #3
Employer/Respondent

Case # 14WC 035180 _____

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on **July 26, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **10/18/2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**22,880.00**; the average weekly wage was $**440.00**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **0** dependent children.

Respondent is entitled to a credit of $0 under Section 8(j) of the Act.

ORDER

As the Arbitrator finds Petitioner has failed to prove she suffered an accident that arose out of an in the course of her employment and furthermore failed to prove her condition is causally related to an injury, Petitioner's request for workers' compensation benefits are hereby denied.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

D. Dylan McCarty

Signature of Arbitrator

8/16/2016

Date

AUG 22 2016

FACTS OF THE CASE

Petitioner's Testimony

Petitioner has been employed with Respondent since 2011. Petitioner began her employment at South School Elementary as a cleaning aide. (T.9)

Each evening, Petitioner would sweep every classroom, vacuum all the rugs and once to twice a week wipe desks down. Petitioner cleaned bathrooms located inside some of the classrooms. (T.9-10). Petitioner cleaned the kitchen wherein she would mop it, bring stuff out of it and sweep it. At times, Petitioner had to clean the lunchroom wherein the tables would come out of the walls and she had to fold them up and put them in the walls.

Petitioner emptied trash and cleaned chalkboards in the classrooms. (T.10). When Petitioner buffed the floor, she utilized a machine that had a handle on it. Petitioner testified the machine vibrated against her hands when she held onto it.

Petitioner worked at South School Elementary for 3 years. (T.11). Petitioner worked at South School Elementary through June 30, 2013. Petitioner was then laid off for about a month. Petitioner then got called to work at the Taylorville High School.

Petitioner was hired as a custodian for the high school. (T.12). Petitioner was hired full time, she would work from 3 to 11:30. Petitioner testified there were other custodians who worked with her at the high school. Petitioner testified her job duties at the high school included sweeping the rooms, hallways, wipe chalkboards unless there was a "save" on it, empty trashcans, clean bathrooms and mop the bathrooms.

Petitioner would dust mop the rooms. (T.13). Petitioner estimated the dust mop weighed approximately three to five pounds. Petitioner testified she would dust mop between the aisles of the desks. Petitioner testified she flexed and extended her wrist when she dust mopped.

Petitioner would shut the windows if there were any open windows in the classrooms. (T.14). Petitioner testified the windows were heavy. Petitioner would close at least one window per day. Petitioner testified she occasionally buffed floors at the high school.

Petitioner testified most of her job duties required her to extend and flex her wrist. (T.15). Petitioner testified approximately 90% of her activities involved flexing her wrist. Petitioner testified at South School she would buff once or twice a week. One time, Petitioner worked overtime and she buffed the halls. She would also buff during the holiday or for summary work. Petitioner testified she started noticing issues with her wrists at the South Elementary School.

Petitioner noticed her hands started tingling, felt numb and she was dropping things. (T.115-16). Petitioner testified she sought treatment for her hands in September 2013.

After Petitioner was released from care on January 16, 2014, she went back to work at the high school and performed the same job duties. (T.19). Petitioner testified that there was some relief after the surgery.

Petitioner testified she eventually had issues again with her hands. (T.20). Petitioner testified her hands started hurting and waking her up in the middle of the night with numbness and tingling. Petitioner testified she was currently not working at the high school due to budget cuts.

Petitioner testified she then became employed at Gowin Park in Taylorville which is an assisted living facility. (T.21). Petitioner testified she would help assist residents with showers, eating and trying to pick them up. Petitioner testified she was not able to do that job as it hurt and she did not have the strength. Petitioner testified she quit playing softball as it was too much for her with holding the bat and gripping and squeezing. Petitioner testified that prior to the injury, she played softball one to two nights a week. Petitioner testified she had difficulties with vacuuming and wiping windows down in her house. Petitioner testified those activities made her feel numb and she has to quit for a while.

Petitioner testified her sleep pattern is occasionally interrupted. (T.23). Petitioner testified she takes ibuprofen approximately once a week. Petitioner testified that during the month layoff between the elementary and high school, her symptoms were not bothering her. Petitioner also noticed the symptoms were not as bad when she was on vacation.

On cross-examination, Petitioner testified she alleges she noticed her symptoms when she was working at the elementary school. (T.25).

On Petitioner's alleged accident date, Petitioner agreed she was working at Taylorville High School. (T.26).

Petitioner testified South School Elementary included grade levels kindergarten through fifth grade. (T.27). South School Elementary had one floor. (T.28). Petitioner testified there was a head custodian who would work with her. Petitioner testified that at first, she cleaned all her classrooms and swept the floors. Sometimes Petitioner would pick up the playground. Petitioner would clean the kitchen first and then clean the classrooms.

Petitioner testified she cleaned approximately 14 classrooms at South School. (T.29). When Petitioner cleaned the classroom, she would sweep with a dust mop. Petitioner would then sweep the debris and throw it into a trashcan. Petitioner would then take out the trash which was filled with mainly papers. Petitioner would empty the classroom trashcans into a bigger trashcan on rollers. Petitioner would then wipe boards down.

Most of the classrooms were whiteboards and one classroom that had a chalkboard. (T.31). After wiping down the whiteboards, Petitioner would vacuum area rugs located in the classrooms. Once or twice a week Petitioner would wipe desks down.

Petitioner testified she would also clean the little bathrooms located in the bathrooms for the lower grades. (T.32). Cleaning the bathrooms involved wiping down the toilets and sinks as well as sweeping and mopping. There are also bathrooms in the main hall that she would clean. (T.33). If a classroom had a sink, she would also wipe the sink out. Petitioner testified there were six bathrooms in the classrooms and four in the main hall.

Petitioner testified she did all of the described job activities until the next principal divided it up. (T.34). The new principal divided up Petitioner's responsibilities in 2011 or 2012. After the restrooms were divided up, Petitioner cleaned the little kid's restrooms and two restrooms in the hall. (T.35). She also had a restroom in the nurse's lounge.

Petitioner also cleaned the teacher's lounge. (T.36). Cleaning the teacher's lounge involved similar tasks as she would in cleaning the classrooms.

Petitioner buffed the hallway approximately once a week in front of the kitchen and the hallway going down past the first and second grade. (T.38). Petitioner testified during the summer there would be a summer crew who would be responsible for buffing the floor.

Petitioner testified Taylorville High School is approximately three stories high along with an east wing. (T.39). Petitioner testified there are three other custodians that worked with her at the high school. Petitioner testified each floor had a custodial room where supplies were kept. Each custodian was assigned to a different area of the high school to clean.

When Petitioner first started at the high school, she was responsible for the east wing and then a half floor along with stairways and then the second floor all the way to the library. (T.40). Petitioner testified she performed essentially the same job cleaning functions at the high school as she did at the elementary school. Petitioner testified there are no bathrooms in any of the classrooms at the high school. Petitioner did not recall how may classrooms she was responsible for cleaning.

Petitioner testified bathrooms had approximately five to six toilets or urinals for men and the women's had more. (T.41). Petitioner testified she vacuumed the entryway rugs at the high school. Petitioner could not recall if she was originally assigned to vacuum the entry rugs.

Petitioner testified she did not buff any of the floors at the high school prior to her surgery. (T.42).

Petitioner testified she did not wash any of the windows in the classrooms during the school year but she did in the summer time before the kids came back. (T.43).

Petitioner testified she cleaned the windows at the main doors approximately once a week. Petitioner testified she would clean windows if she was told to do it. (T.44).

Petitioner testified she was released to go back to work in January 2014. (T.45). Petitioner testified she has not seen her treating physician since January 2014.

Petitioner testified she has not sought any treatment for her continued symptoms. (T.46) Petitioner testified she now works at Angelo's Express as a manager in the parlor. Petitioner testified Angelo's Express is for food pick up or delivery.

Petitioner testified her job duties involved sitting at a desk, answering phones, taking orders or helping customers out. (T.47). Petitioner testified she did not make any of the food. Petitioner testified there is a ladies room on the second and third floors. Petitioner testified she was not certain if the woman's restrooms had four stalls or a couple of more than that.

Petitioner testified the men's room would have two stalls and three urinals. (T.48). Petitioner testified the floor buffer is a machine she would plug in and she would put a little bit of stuff on the pad for the shine and press a button and hold onto it and press the lever. Petitioner testified the lever was located on the right side.

Petitioner testified the buffer did not hold any water. (T.49). Petitioner testified the buffer was heavy as she had to be able to handle it or it would get away from her. Petitioner testified she did not do any of the waxing of the floors.

On re-direct, Petitioner testified she noticed a lot of her symptoms from gripping while dust mopping and cleaning classrooms was when she noticed a lot of her symptoms (T.52).

Petitioner's Exhibits

On September 19, 2013, Petitioner presented to Dr. Gill of Springfield Clinic with complaints of numbness and tingling in her hands, particularly in her left hand as she was left hand dominant. (Px-1) Petitioner reported she wakes up at night and she drops things with her left hand noticed a loss of strength in her hands. An EMG was ordered.

On September 23, 2013, Petitioner underwent an EMG/NCV at clinic. (Px-5). The study revealed findings consistent with bilateral median neuropathy at the wrists which was moderate on the left and mild on the right.

On September 30, 2013, Petitioner presented to Dr. Wayne Manson of Springfield Clinic at the referral of Dr. Gill. (Px-2). Dr. Manson reviewed Petitioner's EMG findings which were positive for modest carpal tunnel disease on the left side. Carpal tunnel release was recommended.

On October 18, 2013, Petitioner underwent a left carpal tunnel release. (Px-2). After a couple post-operative follow-ups, on November 15, 2013, Dr. Manson noted Petitioner continued to improve on the left side. On November 26, 2013, Dr. Manson noted Petitioner was doing well with left carpal tunnel release and wanted to proceed with the right side.

On November 26, 2013, Dr. Manson prepared a letter stating Petitioner did manual labor with her hands and therefore he believed her occupation has contributed to her acquiring carpal tunnel syndrome. (Px-4). Dr. Manson indicated he had never seen a case of carpal tunnel syndrome in a legal secretary, an attorney, or anybody in an occupation who does not perform manual labor with their hands.

On December 6, 2013, Petitioner underwent a right carpal tunnel release. On December 13, 2013, Dr. Manson reported Petitioner's numbness and tingling was getting quite a bit better in the right side. Petitioner provided with lifting restrictions. On December 20, 2013, Dr. Manson reported Petitioner noted more bruising and had local symptoms. Petitioner was able to move all of her digits well. No numbness or tingling. Dr. Manson believed everything was going to be alright. Petitioner was to follow-up in four weeks.

Although Petitioner testified she presented to Dr. Manson in January 2014, Petitioner did not present Dr. Manson's chart note for that visit.

On June 2, 2015, Dr. Manson was deposed. (Px-3). Dr. Manson testified he was a general surgeon. (Px-3, T.3-4). Dr. Manson did not specialize in orthopedics. (Px-3, T.20). Dr. Manson testified as to the letter he prepared on November 26, 2013 wherein he opined carpal tunnel syndrome is associated with people who do manual labor. (Px-3, T.9). Dr. Manson testified he had never seen carpal tunnel syndrome in somebody who doesn't do manual labor. (Px-3, T.9). Dr. Manson testified his opinion as to causal connection would not change assuming a patient has been a janitor for over five years, buffs a floor with a buffing floor machine at least three to four times a week totaling approximately four hours a week; a patient who sweeps and mops floors five days a week totaling approximately 20 hours a week, in addition to gripping and picking up papers, taking out trash, wash widows and other janitorial like job activities. (Px-3, T.10). Dr. Manson testified that manual labor and the cause of carpal tunnel are two in the same. (Px-3, T.12).

Dr. Manson testified that he saw Petitioner on December 20, 2013 and that her paresthesia seemed to have resolved. (Px-3, T.16). Dr. Manson testified she was doing well that day. (Px-3, T.16)

Dr. Manson testified he was not provided a history of how many hours Petitioner worked during any given day or week. (Px-3, T.17). Dr. Manson testified that this information might have an effect on his causation opinion. (Px-3, T.18). Dr. Manson testified he was not provided with any specific job description other than information

that Petitioner worked as a janitor. (Px-3, T.18). Dr. Manson testified Petitioner did not describe to him the amount of time she spent each day performing specific work activities. (Px-3, T.18). Dr. Manson testified Petitioner also did not provide a history of the frequency with which she performed any of her work activities. (Px-3, T.19). Dr. Manson testified it would be fair to say the extent of his understanding of Petitioner's job duties was she had performed manual labor with her hands as referenced in his November 26, 2013 letter. Dr. Manson testified that it is not very often a case of non-work related issues or medical conditions are associated with carpal tunnel syndrome. (Px-3, T.19). Dr. Manson testified he was aware of other conditions such as increased BMI, diabetes and hypothyroidism being associated with carpal tunnel syndrome. (Px-3, T.19). Dr. Manson agreed carpal tunnel syndrome could be idiopathic in nature meaning there is no known cause. (Px-3, T.19).

Dr. Manson did not recall seeing Petitioner after January 13, 2014. (Px-3, T.20). Dr. Manson testified he did not provide Petitioner with any permanent work restrictions for either hand. (Px-3, T.20). Dr. Manson did not have an independent recollection of discussing any of the specific types of activities at work as described in the hypothetical provided by Petitioner's counsel. (Px-3, T.20).

Respondent's Exhibits

On October 4, 2013, Respondent prepared accident reporting forms after Petitioner notified it of her carpal tunnel syndrome in the left wrist. (Rx-1). Petitioner reported noticing carpal tunnel syndrome while closing windows in the girl's locker room.

Petitioner's job description document Petitioner's job duties as a custodian. (Rx-2) The job description documents that all windows on the inside and those that can be reached on the outside are to be cleaned at least once each year and more frequently if necessary. Windows where the public entered should be cleaned weekly if there is a need. Petitioner's job description also describes dust mopping, vacuuming of rugs, emptying trash, dusting furniture, cleaning of bathrooms and cleaning chalkboards as testified to by Petitioner.

Dr. Nash Naam testified on September 29, 2015 as to the IME he had performed on Petitioner on January 14, 2014. (Rx-4). Dr. Naam testified he is board certified in orthopedic surgery and had a fellowship in hand surgery. (Rx-4, T.5). Dr. Naam testified he has a subspecialty in hand surgery. (Rx-4, T.5). Dr. Naam performed an IME of Petitioner on January 14, 2014. (Rx-4, T.6). Dr. Naam reviewed Petitioner's medical records prior to his examination. (Rx-4, T.6). Dr. Naam reviewed the EMG that was performed on September 23, 2013 which confirmed presence of carpal tunnel syndrome and reviewed the carpal tunnel releases performed on October 18, 2013 and December 6, 2013. (Rx-4, T.7).

Dr. Naam testified Petitioner provided a history of numbness and tingling in both hands that started around September 2013 and noticed her symptoms secondary to what she described as closing heaving windows and repetitive custodial work. (Rx-4, T.8). Petitioner reported her symptoms improved following the surgery and noticed there was some soreness over the scar but in general her symptoms has improved. (Rx-T.9). On exam, Petitioner had negative Tinel's which indicated Petitioner's carpal tunnel had resolved. (Rx-T.9).

In addressing the causal relationship of Petitioner's carpal tunnel syndrome, Dr. Naam testified he listened to Petitioner's work activities own statements concerning the job activities she had started on August 17, 2013, the EMG/NCV which was on September 23, 2013 and further review of Petitioner's job description. (Rx-T.10-11). Dr. Naam also noted Petitioner had a BMI of 36.7. (Rx-T.11). In putting these factors together, Dr. Naam testified there was no causal relationship between Petitioner's work activities and the carpal tunnel syndrome. Dr. Naam testified the short amount of time between Petitioner starting her job in August 2013 to the day of the EMG, five weeks, was a very short period of time for which any specific activity could produce carpal tunnel

syndrome. (Rx-T.13). Dr. Naam reviewed Petitioner's job description which listed 33 different job activities. Dr. Naam stated that the variability of her job duties was a reason he did not feel they were a causative factor in the development of her condition. (Rx-T.13-14). Dr. Naam testified that with doing variable activities, different groups of muscles are being utilized as well as joints and ligaments which do not allow one joint or one part to be used repeatedly over and over in the same fashion. (Rx-T.14). Dr. Naam testified he did not see anything in the records to suggest Petitioner developed an acute onset of carpal tunnel syndrome. (Rx-T.15). Dr. Naam testified Petitioner's description of her job duties were consistent with the written job description. (Rx-T.16).

Dr. Naam discussed non-occupational factors for carpal tunnel syndrome. (Rx-T.16) Dr. Naam testified carpal tunnel syndrome is common in females compared to males and is believed that the size of the carpal tunnel is smaller. (Rx-T.16). Carpal tunnel syndrome was also more common in females in the middle age group from 40 to 60 and is also more common in patients who have a high BMI or obesity or increase of their weight. (Rx-T.16). Dr. Naam testified Petitioner exhibited three factors for carpal tunnel syndrome which was her sex, age, and BMI. (Rx-T.17).

Dr. Naam reviewed Dr. Manson's letter of November 26, 2013 and stated the letter was totally inaccurate and almost like a joke as carpal tunnel syndrome has been seen in legal secretaries, attorneys as well as physicians and nurses. (Rx-T.18). Dr. Naam testified he has seen carpal tunnel syndrome in people who perform manual labor jobs and also office function type jobs. (Rx-T.19).

On cross-examination, Dr. Naam testified his opinions would not change if he was informed Petitioner held the same job with the same employer and performed the same job tasks prior to August 2013. (Rx-T.20). Dr. Naam testified that grasping has to be frequent, repetitive, forceful and with vibration wherein a person has a prolonged exposure to coarse vibration and not just fine vibration to cause or aggravate carpal tunnel syndrome. (Rx-T.21). Dr. Naam agreed that carpal tunnel is not based necessarily on the job tasks but how often an individual is exerting the wrist, flexing and gripping and using vibratory tools. (Rx-T.22). Dr. Naam testified the association of symptoms with certain activities does not necessarily indicate that the activities caused the condition. (Rx-T.25). Dr. Naam testified that an aggravation does not change the physiology or the pathophysiology of the condition. (Rx-T.26). Dr. Naam opined that after review of Petitioner's job description as well as Petitioner's description of her work activities, it was his opinion there was no causal relationship between Petitioner's work activities and the bilateral carpal tunnel syndrome as Petitioner's work activities were variable and included several types of activities and therefore there was not a specific activity that was done repeatedly to be considered a cause or contributing factor for the carpal tunnel syndrome. (Rx-4, Ex.2)

CONCLUSIONS OF LAW

With respect to (C.) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; and (F.) Is Petitioner's current condition of ill-being causally related to the injury?, the Arbitrator finds as follows:

In a repetitive trauma claim, the issues of accident and causation are intertwined. In order to prevail, the Petitioner must prove that her work activities were causally related to the development of her condition. They need not be the sole or even predominant cause so long as they are deemed a cause. The Arbitrator relies on the medical evidence in such a case. The Arbitrator finds the opinions of Dr. Naam are more persuasive than Dr. Manson. Dr. Manson's initial causation opinion based on a generic understanding that Petitioner worked as a janitor is not persuasive. Additionally, Dr. Manson's testimony as to causation based on a hypothetical presented by Petitioner's counsel was not the job duties as described by Petitioner at trial. Dr. Manson was presented with the hypothetical that Petitioner had buffed floors with a buffing floor machine at least three to four times a week totaling approximately four hours a week was not consistent nor supported by Petitioner's

own testimony. On the other hand, Dr. Naam's opinions were based after he thoroughly reviewed Petitioner's job description and discussed Petitioner's job duties with Petitioner. Dr. Naam credibly testified non-occupational risk factors of Petitioner's age, sex and BMI were the cause of her carpal tunnel syndrome. He also explained persuasively that the variety of duties performed by the Petitioner on a regular basis weighed against a finding of causation. He said that she used different muscle groups to perform each task, as opposed to using one muscle group over and over in a repetitive fashion. (RX 4 at 14) Dr. Manson, on the other hand, provided no explanation or basis for his opinion other than the anecdotal belief that manual labor caused carpal tunnel. As such, the Arbitrator finds Dr. Naam had a better understanding as to Petitioner's job duties and therefore assigns greater weight to Dr. Naam's opinions.

In reliance of Dr. Naam's opinions, job description and Petitioner's testimony as to her job duties, the Arbitrator finds Petitioner failed to prove she suffered an accident that arose out of and in the course of employment with Respondent and furthermore failed to prove her bilateral carpal tunnel condition is causally related to an accident at work.

With respect to (J.) Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services? (K.) TTD benefits are in dispute (L.) What is the nature and extent of the injury? The Arbitrator finds as follows:

As the Arbitrator finds Petitioner has failed to prove both accident and causation, the Arbitrator finds Petitioner is not entitled to workers' compensation benefits and therefore these issue are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Frank Star,

Petitioner,

vs. NO: 10WC013308

Illinois Department of Transportation,

Respondent.

17IWCC0841

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of prospective medical care, credit due to Respondent and maintenance, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 26, 2017 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

DATED: DEC 29 2017
SJM/sj
12/14/17
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

STAR, FRANK
Employee/Petitioner

Case# **10WC013308**

IDOT
Employer/Respondent

17IWCC0841

On 6/26/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

2194 STROM & ASSOCIATES LTD
LINDSEY S STROM
180 N LASALLE ST SUITE 2510
CHICAGO, IL 60601

5705 ASSISTANT ATTORNEY GENERAL
CAITLIN PAPADOPOLOUS
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

JUN 26 2017

RUTH A. HASKIN, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS) 17IWCC0841
)SS.
COUNTY OF Cook)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☐ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Frank Star
Employee/Petitioner

v.

IDOT
Employer/Respondent

Case # 10 WC 13308

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 **Frank Soto**, Arbitrator of the Commission, in the city of **Chicago**, on **5/11/2017**. 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. ☒ 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? **Dr. Sergey Neckrysh**
L. ☐ What temporary benefits are in dispute?
☐ TPD ☒ Maintenance ☐ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Prospective/ongoing medical pursuant to Sec. 8 (a) and Credit for maintenance Respondent paid after 4/28/2015**

FINDINGS

On the date of accident, **3/24/2010**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$43,122.50**; the average weekly wage was **$829.28**.

On the date of accident, Petitioner was **65** years of age, ***married*** with **0** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

ORDER:

Petitioner's current condition of ill-being **is related** to the injury sustained on March 24, 2010.

Respondent is **not liable** for unpaid medical bills from Dr. Sergey Neckrysh.

Respondent is **not** entitled to a **credit for maintenance** paid from July 5, 2016 through the date of the hearing, May 11, 2017.

Respondent **is** entitled to a **credit for maintenance** paid from April 28, 2015 through July 5, 2016.

Respondent is ordered to approve and pay for prospective medical treatment, including surgery, recommended by Dr. Neckrysh as it relates to the lumbar back.

Respondent shall pay Petitioner compensation that has accrued from March 24, 2010 through May 11, 2017 and shall pay the remainder of the award, if any, in weekly payments.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

6/23/2017
Date

ICArbDec19(b)

JUN 26 2017

17IWCC0841

PROCEDURAL HISTORY

On March 28, 2017, Petitioner, Frank Star, filed his Notice Of Motion And Order seeking an immediate hearing pursuant to Section 19(b) and Section 8(a) of the Act. The matter was set for hearing on May 11, 2017. At the hearing, Respondent made an oral motion to continue this hearing. In support of the oral motion to continue the trial, Respondent said on May 8, 2017, they had confirmed a time for a Section 12 examination and had just processed the doctor's payment. The date Respondent secured for the Section 12 examination was June 29,2016. Respondent acknowledged not delivering notice of the examination to Petitioner prior to the hearing. Respondent also acknowledged receiving Petitioner's request for surgery and medical records in January of 2017. Regarding said the IME was not previously scheduled because Respondent was waiting for radiology films which had been subpoenaed. On March 6, 2016, Respondent subpoenaed Petitioner's medical records including the radiology films. The records had been received on April 10, 2017. Respondent did not want to schedule the Section 12 examination until the records and radiology films had been received. As of the date of the hearing, Respondent had not received the radiology films. Despite not receiving the radiology films, on May 8, 2017, Respondent contacted the doctor and scheduled the examination for June 29, 2017 and processed the doctor's payment.

The Arbitrator denied the oral motion to continue providing two explanations for the denial. The First, Respondent had not provided Petitioner notification of the Section 12 examination or complied with the requirements notice required under the Act. Petitioner was verbally told Respondent was requesting a Section 12 examination at the hearing. At that time, Respondent still had not delivered notice of the time and place of the examination and sufficient money to defray the travel expenses as required under the Act. All that had occurred, prior to the hearing, was a communication between Respondent and a doctor and the internal processing of the doctor's payment. Second, the Arbitrator found the Respondent's actions insufficient to provide a reasonable basis to continue the hearing. Respondent did not show sufficient due diligence requesting the examination. The Arbitrator finds Respondent could have scheduled the examination after receiving Petitioner's demand for medical treatment in January of 2017 or after receiving Petitioner's Request for Hearing. If the examination was scheduled and Petitioner provided notice, under the Act, of the examination, Respondent's actions may have been sufficiently diligent to continue the trial. The Arbitrator also notes Respondent did not make a motion to continue the trial after Petitioner rested. Respondent could have made a motion to continue or bifurcate the hearing to secure the Section 12 examination and testimony of the doctor. That was not done so the Arbitrator did not have the opportunity to decide the issue at the completion of Petitioner case-in-chief.

FINDINGS OF FACT

The parties stipulate that Respondent, Illinois Department of Transportation, was operating under the Illinois Workers' Compensation Act on March 24, 2010 and on that date Petitioner, Frank Star, sustained an accidental injury that arose out of and in the course of employment by Respondent. Respondent disputes Petitioner's current condition of ill-being is causally connected to his injury and liability for medical treatment rendered by Dr. Sergery Neckrysh as being not reasonably related or medically necessary. Respondent also disputes Petitioner is entitled to maintenance on and after April 28, 2015. Petitioner disputes Respondent paid $127,633.39 in TTD and $78,111.22 in maintenance for which Respondent claims entitlement to a credit pursuant to Section 8(j) of the Act. Petitioner is seeking prospective medical care. Petitioner filed a petition for penalties but withdrew petition for penalties at the onset of the hearing. (Arb. Ex. 1)

Petitioner testified on March 24, 2010, he was working for Respondent (IDOT) as a seasonal employee (Tr p. 21-24). Petitioner had worked for Respondent for three years. On March 24, 2010, Petitioner was picking up trash on the side of the highway. He used a stick with a nail on it to pick up the garbage and put it in a bag (Tr. p. 23). Petitioner testified, on March 24, 2010, he was picking up trash on an embankment when he slipped and fell (Tr. p. 24). Petitioner immediately felt sharp pain in his back and left leg. His coworkers helped him up and into an IDOT truck (Tr. p. 24-25). Petitioner was brought back to the station at Hillside, where he reported the accident to his supervisor, Johnny Jones, as well as to a technician named Frank (Tr. p. 25-26). Petitioner was taken to WorkRight Occupational Health (Tr. p. 26).

Petitioner treated with Dr. Michael of Illinois Neurospine Institute. Petitioner has physical therapy without benefit and three epidural steroid injections with only a few months of relief. (RX 2) On March 23, 2011, Petitioner underwent spinal fusion surgery. After surgery, Petitioner continued to treat with Dr. Michael until April 28, 2015. Petitioner showed slow progress and he continued to complain of back and leg pain. On July 9, 2012, Petitioner was examined by Dr. Michael. Petitioner continued complaining of left low back pain down the left lower extremity. Dr. Michael ordered a CT scan. (PX 1) Petitioner returned to Dr. Michael to review the CT scan on September 10, 2012. Dr. Michael found the scan showed insufficient mass at L3-4 and L5-SI. At that time, Dr. Michael advised Petitioner he could have exploratory surgery of the fusion with the possibility of repeating the fusion or he could try to live with the pain. (PX 1) On October 1,

2012, after a follow up visit with Petitioner, Dr. Michael renewed his recommendation to repeat the fusion.

On November 27, 2013, Petitioner returned to Dr. Michael. Petitioner was complaining of sever low back pain especially with changes in the weather. Petitioner also complained of numbness and tingling. Petitioner returned to Dr. Michael on April 1, 2014. At that time, Dr. Michael thought the source of Petitioner's pain could be pseudarthrosis. One of Dr. Michael's recommendations included removing the hardware and exploring the fusion. Petitioner declined surgery, at that time, so Dr. Michael proscribed lumbar epidural steroid injections. (PX 1) Petitioner returned to Dr. Michael on April 28, 2015. At that time, Petitioner continued complaining of left lower pain, numbness and tingling. Dr. Michael determined Petitioner was at maximum medical improvement and released Petitioner from care and to return as needed. (PX 1)

On June 3, 2014, Petitioner attended a Section 12 examination with Dr. Srdian Mirkovic of Northshore Orthopaedics. In his report, Dr. Mirkovic said Petitioner's low back pain is more likely than not partially related to the Petitioner's injury on March 4, 2010. Dr. Mirkovic addresses the issue of whether Petitioner's work injury is causally related to his current condition or need for medical treatment. Dr. Mirkovic wrote: *"Mr. Star's current condition is complicated by the unsuccessful surgery, which is more likely than not contributing to his persistent symptoms. The injury on March 4, 2010, however, is causally related to Mr. Star's history of low back pain following the events on 3/4/10, the treatment that Mr. Star underwent prior to the surgery on 3/23/11 was reasonable and related to the events on 3/4/2010."* (RX 2) It appears, Dr. Mirkovic incorrectly stated the date of injury as March 4, 2010 rather than march 24, 2010. In his report, Dr. Mirkovic describes that Petitioner had a fall at work while picking up paper on the side of a highway which matched the Petitioner's testimony.

On November 3, 2016, Petitioner elected to have an independent medical examination which was performed by Dr. Sergey Neckrysh, assistant professor of the department of neurosurgery at University of Illinois-Chicago. In his report, Dr. Neckrysh states he reviewed all medical records including but not limited to West Suburban Hospital, Dr. Ronald Michael and Illinois Neurospine Institute, North Michigan Surgical Center, Oak Park Medical Center, Dr. Sean Salehi, physical therapy notes, Herron Medical Center records, MRI results from October 26, 2010 and the Independent Medical Exam from Dr. Mirkovic. During the examination, Dr. Neckrysh

noted Petitioner had positive SLR in the left leg at approximately 35 to 40 degrees, which was alleviated by knee flection. Petitioner had severe tenderness to touch and palpation in the lumbosacral area. Dr. Nexkrysh ordered a CT myelogram of the lumbar to assess the condition of the bone, instrumentation and the interference of bony anatomy with the neurological structures and a standing scoliosis x-ray of the anterior-posterior and lateral projections. (PX 2)

After the having the CT myelogram and x-rays, Petitioner returned to Dr. Neckrysh. The CT myelogram demonstrated an unconventional construct with the left-side screw in L3, no posterior lateral or interbody fusion across the L3-4 level. At L4-5 there is no left-sided pedicel screw and there appeared to be a piece of bone or spineology bag inside the disc space and some degree of bone formation within the interbody space. At L5-S1 the pedicle screws appeared to be small in diameter and very under size compared to the pedicle size and a very patent disc space, 12 mm in height, without much bone formation within the disk space or posterolaterally across the construct. (PX 2)

Dr. Neckrysh diagnosed Petitioner with pseudoarthrosis specifically at L3-4 and L5-S1 levels. Dr. Neckrysh recommended removal of the instrumentation and replace it with brand new instrumentation from L3-S1 with bilateral pedicle fixation at L3, L4 through S1 and perform an interbody fusion between L3-4 and L5-S1 levels with posterolateral fusion from L3 to S1. Dr. Neckrysh also recommended an EMG of the left lower extremity to assess the extent of the radiculopathy. Dr. Neckrysh did not change Petitioner's restrictions. (PX 2)

The parties stipulated Petitioner has permanent restrictions which Respondent could not accommodate. The Respondent did not provide Petitioner a vocational rehabilitation plan. Petitioner performed a self-directed job search. (Tr. p. 28-29, 40). Petitioner testified he searched for jobs, applied for jobs and documented his search on a search logs which were sent to Respondent. (Tr. p. 29, 40-42). Petitioner created a resume and attended job fairs. (Tr. p. 46). Petitioner continues to perform weekly job searches which are submitted to Respondent and Petitioner continues to receive maintenance benefits. Petitioner testified he was unable to find employment. (Tr. p. 30, 31).

Petitioner is a 72-year-old man with no computer skills (Tr. p. 66-67). His highest level of education is the 9th grade. (Tr. p. 69). Petitioner began working at nine years old. He grew up in the South driving a tractor and performing work in the fields (Tr. p. 70). Petitioner testified that he worked for the Chicago Transit Authority ("CTA") driving a bus for 25 years and 7 months (Tr.

p. 43). Petitioner explained that many of the jobs that he has applied to include some sort of driving, because that is what he is used to (Tr. p. 72). Petitioner testified he has not received any professional assistance for obtaining a job from Respondent nor has Respondent offered Petitioner employment. (Tr. p. 67).

Petitioner testified he would like to undergo the surgery recommended by Dr. Neckrysh because he is constantly in pain, despite taking medication. He testified he never had any back issues prior to the work-related injury with Respondent (Tr. p. 32). Petitioner testified he is unable to bend his back and is in constant pain. Petitioner explained that his back pain shoots down to his left leg into his feet, which sometimes goes numb (Tr. p. 32). Petitioner further testified the pain is an aching pain which travels to his groin and sometimes into the testicles. (Tr. p. 32-33). Petitioner can only walk for approximately 10 minutes before he starts to have pain. (Tr. p. 33). He had never needed to use a cane prior to the work injury. Petitioner testified never needed to use a cane prior to his work injury and he needs the assistance of his wife to perform activities of daily living, including household chores, washing him and making meals for him (Tr. p. 34).

CONCLUSIONS OF LAW

The employee bears the burden of proving by a preponderance of the evidence all of the elements of his claim. *R & D Thiel v. Workers' Compensation Comm'n*, 398 Ill. App. 3d 858, 867 (2010). Among the elements that the employee must establish is that his condition of ill-being is causally connected to his employment. *Elgin Board of Education U-46 v. Workers' Compensation Comm'n*, 409 Ill. App. 3d 943, 948 (2011). Thus, if a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Sisbro supra.* "[*A*] Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury." *Fierke v. Industrial Commission*, 723 N.E.2d 846 (3rd dist. 2000). Proof of an employee's state of good health prior to the time of injury, and the change immediately following the injury, is competent as tending to establish that the impaired condition was due to the injury. *Westinghouse Electric Co. v. Industrial Commission*, 64 Ill. 2d 244,356 N.E. 2d 28 (1976). It is well established that an accident need not be the sole or primary cause as long as employment is a cause of a claimants' condition. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill.2d 193, 205 (2003). An employer takes its employees as it finds them. *St. Elizabeth's Hospital v. Illinois Workers' Compensation Comm'n*, 371 Ill. App. 3d 882, 888 (2007). A claimant with a

preexisting condition may recover where the employment aggravates or accelerates that condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d 30, 36 (1982). The Arbitrator found the testimony of Petitioner to be credible.

WITH RESPECT TO ISSUE (F) IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CASUALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes Petitioner has proven by a preponderance of the credible evidence Petitioner's current condition of ill-being is related to the injury sustained on March 24, 2010. Dr. Neckrysh's and Dr. Michael diagnosed pseudoarthrosis. On September 10, 2012, after reviewing a CT scan, Dr. Michael found an insufficient mass at L3-4 and L5-SI and, at that time, he recommended exploratory surgery of the fusion with the possibility of repeating the fusion. (PX 1) On April 1, 2014, Dr. Michael believed the origin of Petitioner's pain could be pseudarthrosis and recommended hardware removal and fusion exploration. At that time, Petitioner wanted to try to live with pain. After trying to live with the pain, Petitioner wants to proceed with the surgery.

The Arbitrator notes the opinions of Dr. Mirkovic of Northshore Orthopaedics, who performed the Section 12 examination. Dr. Mirkovic found Petitioner's work injury was causally related to Petitioner's history of low back pain following his work injury. Dr. Mirkovic said "*The patient's history of chronic low back pain is more likely than not partially related to the patient's injury on March 4, 2010. The Patient's subsequent improvement following surgery and the presence of pseudoarthrois is more likely than not a significant contributing factor to the patient's persistent symptoms, unrelated to the events on March 4, 2010...Mr. Star was more likely than not predisposed to persistent low back pain.*" (RX 2) Dr. Mirkovic attributed Petitioner's current condition to an unsuccessful surgery. (RX 2)

Respondent does not dispute Petitioner's condition of ill-being and original fusion surgery were causally related to Petitioner's work injury of March 24, 2010. Respondent approved the original fusion surgery. Dr. Mirkovic contributes Petitioner's current condition to an unsuccessful surgery. When one has surgery, there are no guarantees. Bad results are an associated risk to surgery and does not break the causal chain. Petitioner testified he did not have any low back pain

or problems prior to his work accident of March 24, 2010. "[*A*] Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury." *Fierke v. Industrial Commission*, 723 N.E.2d 846 (3rd dist. 2000), proof of an employee's state of good health prior to the time of injury, and the change immediately following the injury, is competent as tending to establish that the impaired condition was due to the injury. *Westinghouse Electric Co. v. Industrial Commission*, 64 Ill. 2d 244,356 N.E. 2d 28 (1976). It is well established that an accident need not be the sole or primary cause as long as employment is a cause of a claimants' condition. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill.2d 193, 205 (2003), An employer takes its employees as it finds them. *St. Elizabeth's Hospital v. Illinois Workers' Compensation Comm'n*, 371 Ill. App. 3d 882, 888 (2007). The Arbitrator finds Petitioner's work accident was a cause of his current condition.

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 Petitioner claims Respondent is liable for unpaid medical bills from Dr. Neckrysh which Respondent denies. Petitioner submitted Dr. Neckrysh's report of November 4, 2016 and office notes of January 31, 2017 into evidence but Petitioner failed to submit Dr. Neckrysh's medical bills into evidence. The Petitioner's claim is denied because Petitioner failed to prove the charges were related, reasonably required to diagnose, treat, cure and relieve Petitioner from the effects of his injury.

WITH RESPECT TO ISSUE (K) WHETHER PETITIONER IS ENTITLED TO MAINTENANCE BEYOND APRIL 28, 2015 AND ISSUE (N) WHETHER RESPONDENT IS ENTITLED TO A CREDIT FOR MAINTENANCE PAID AFTER APRILE 28, 2015, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner is seeking maintenance from September 1, 2014 through the date of hearing, May 11, 2017, representing 140 4/7 weeks. Respondent claims Petitioner is not entitled to maintenance as of April 28, 2015, the date Dr. Michael found Petitioner to be at maximum medical improvement. Petitioner's job restrictions are not in dispute and Petitioner testified Respondent did not offer Petitioner a job within his restrictions. (Tr. p. 67-68) Respondent paid Petitioner

maintenance from September 1, 2014 through May 31, 2017. (RX 3) Petitioner testified Respondent did not proved him any professional assistance obtaining a job. (Tr. p. 67). Petitioner testified he conducted his own job search and he documented the search in a weekly log. Petitioner's weekly job search log shows he applied for approximately five jobs per week from July 5, 2016 through April 28, 2017. (PX 3) Petitioner job search logs were being forwarded to Respondent and Petitioner continued to receive workers' compensation benefits throughout the time he was submitting the job search logs. (Tr. p. 31) Petitioner testified he created a resume and also attended job fairs. (Tr. p.46-48)

Petitioner is a 72-year-old man with no computer skills (Tr. p. 66-67). His highest level of education is the 9th grade. (Tr. p. 69). Petitioner began working at nine years old. He grew up in the South driving a tractor and performing work in the fields (Tr. p. 70). Petitioner testified that he worked for the Chicago Transit Authority ("CTA") driving a bus for 25 years and 7 months (Tr. p. 43).

Based upon the testimony and the documents submitted into evidence Petitioner reached maximum medical improvement when Dr. Michael released Petitioner from care on April 28, 2015. Once an injured Petitioner reached maximum medical improvement, he was no longer temporarily and totally disabled. Maintenance and TTD are separate and distinct benefits. *Freeman United Coal Mining Co. v. Industrial Commission*, 318 Ill.App.3d 170, 741 N.E.2d 1144, Ill.Dec. 966 (5th Dist. 2000). A claimant is entitled to maintenance when the employee's condition has stabilized but he is engaged in a prescribed vocational rehabilitation program. *Archer Daniels Midland Co. v. Industrial Commission*, 138 Ill.2d. 107, 561 N.E.2d 623, 149 Ill.Dec. 253 (1990)

In this case, Petitioner's condition stabilized on April 28, 2015. Petitioner testified he would receive maintenance benefits as long as he continued to forward his job search logs to Respondent. (Tr. p. 31) Petitioner started his job search on July 5, 2016. (Rx. 3) Respondent did not offer evidence indicating that Respondent had objected to the sufficiency of the Petitioner's job search or weekly job logs. Since July 5, 2016 through the date of the hearing, Respondent continued to receive Petitioner's weekly job logs and Respondent continued to pay maintenance benefits. The Arbitrator finds that had Respondent disapproved of the scope of Petitioner's job search or the sufficiency of the job logs Respondent would have done so prior to the hearing. If Respondent objected to Petitioner's job search or job logs than Petitioner could have corrected his job search or logs to satisfy Respondent's objections. Additionally, Respondent could have

prepared a written assessment for rehabilitation required to return Petitioner to employment as provided under the Rules Governing Practice, Section 9110.10 (formally 7110.10). Respondent did not do this. Based upon the testimony and the evidence presented, the Arbitrator finds Respondent voluntarily accepted Petitioner's job search and job jobs as being an acceptable vocational program and maintenance based upon this fact from the date Petitioner began his job search, on July 5, 2016, through the date of the hearing. Therefore, the Arbitrator finds Respondent is not entitled to a credit for maintenance paid from July 5, 2016 through the date of the hearing, May 11, 2017.

Petitioner did not begin his job search until July 5, 2016 but Respondent paid maintenance from September 1, 2014 through May 31, 2017. (Rx 3) In good faith, Respondent may have voluntarily agreed to pay maintenance beginning on September 1, 2014. However, Petitioner did not present evidence of a job search prior to July 5, 2016. A Respondent who, in good faith, pays maintenance would anticipate a credit for amounts Respondent may have overpaid. Therefore, the Arbitrator finds Respondent is entitled to a credit for maintenance paid from April 28, 2015 through July 5, 2016.

WITH RESPECT TO ISSUE (0) RECOMMENDED OR PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator found the Petitioner's back condition was causally related to his work accident. On April 28, 2015, Dr. Michael recommended removing the hardware and exploring the fusion and Petitioner declined surgery. Because Petitioner did not wish to proceed with the surgery, at that time, Dr. Michael determined Petitioner had reached maximum medical improvement. In November of 2016, Petitioner resumed treatment with Dr. Keckrysh who recommended removing the instrumentation and replace it with new instrumentation from L3-S1 with bilateral pedicle fixation at L3, L4 through S1 and perform an interbody fusion between L3-4 and L5-S1 levels with posterolateral fusion from L3 to S1. Dr. Neckrysh also recommended an EMG of the left lower extremity to assess the presence of the radiculopathy. The surgery being recommend was is similar surgery that Dr. Michael recommended in 2014 and 2014. Petitioner new wishes to proceed with the surgery. The Arbitrator finds Petitioner is entitled to prospective medical care as recommended by Dr. Neckrysh. Respondent is ordered to approve and pay for ongoing treatment recommendations, including surgery, by Dr. Neckrysh as they relate to the lumbar back.

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

David Jones,

Petitioner,

vs. NO: 14WC024175

17IWCC0842

Voith Industrial,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, causal connection, prospective medical care, worker's compensation fraud, permanent disability, statute of limitations, and temporary disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 2, 2017 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: DEC 29 2017
SJM/sj
o-12/14/17
44

Stephen J. Mathis

David L. Gore

DISSENT

I respectfully dissent from the Decision of the majority. I would have found that Petitioner did not sustain his burden of proving a compensable accident or causation to a current condition of ill-being of his lumbar spine, reversed the Decision of the Arbitrator, and denied compensation.

Petitioner testified that on June 27, 2014, he injured his lower back and coccyx while driving a flatbed truck after his truck hit a large pothole. He testified he felt immediate pain in his lower back and legs. However, Petitioner never made that allegation in his contemporaneous, handwritten incident report. In that statement, Petitioner indicated that he was "just driving and my tailbone started paining (*sic*) real bad." There was some other indication in this report that the injury might be associated with bad equipment, because part of the seat cushion was missing. He also executed a refusal of medical treatment form at that time, even though Petitioner denied signing the form in his testimony. In addition, Respondent's safety manager, Brian Fryer, testified that when he made a schematic of the accident, Petitioner never mentioned driving over a pot hole and that Petitioner did not mention anything about a defective seat at that time. Finally, Petitioner did not report driving over a pot hole to medical providers at Ingalls Occupational Health or Ingalls Hospital. He again simply noted that he had discomfort after "just driving" over the course of several days. In my opinion, Petitioner failed to prove he sustained a traumatic accident or injury.

On the issue of causation, despite Petitioner's testimony to the contrary, the medical records indicate that Petitioner sustained a slip and fall injury in March of 2015 after which he developed right leg pain. It was only after that incident that Petitioner began reporting right-sided pain and pain radiating down his right leg. However, he did not report that incident to his doctors treating his claimed workers' compensation-related back/coccyx injury, but rather related his increased pain back to the initial alleged June 27, 2014 accident. In my opinion, Petitioner has failed to prove the alleged accident caused his current condition of ill-being.

Petitioner's testimony was contradicted by his previous, contemporaneous statements as well as the medical records. In my opinion, Petitioner was not credible. Therefore, I would have found that Petitioner did not sustain his burden of proving a compensable accident or causation to a current condition of ill-being of his lumbar spine, reversed the Decision of the Arbitrator and denied compensation. For these reasons, I respectfully dissent from the majority.

Deborah L. Simpson

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

JONES, DAVID
Employee/Petitioner

Case# **14WC024175**

VOITH INDUSTRIAL
Employer/Respondent

17IWCC0842

On 6/2/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

2356 FOHRMAN, DONALD W & ASSOCS
ADAM J SCHOLL
101 W GRAND AVE SUITE 500
CHICAGO, IL 60654

2965 KEEFE CAMPBELL & ASSOC LLC
LILIA PICAZO
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

17IWCC0842

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)

David Jones
Employee/Petitioner

v.

Voith Industrial
Employer/Respondent

Case # 14 WC 24175

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian T. Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **January 25, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **June 27, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* 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 $**28,443.29**; the average weekly wage was $**546.99**.

On the date of accident, Petitioner was **56** years of age, ***single*** with **0** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent is entitled to a credit of $**1,640.97** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

The parties agree that Respondent claims they paid $**76,831.04** in other benefits for which credit may be allowed under Section 8(j) of the Act. (AX 1) However, PX 6 indicates Respondent paid a total of $**52,575.83** in disability benefits and AX 1 indicates the parties agree that Respondent paid $**0** in medical bills for which credit may be allowed under Section 8(j) of the Act.

ORDER

Prospective Medical Care

Respondent shall authorize and pay for the discogram, and, if necessary, the transforaminal lumbar interbody fusion that Dr. Wingate has recommended, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Medical benefits

Respondent shall pay Petitioner $**82,854.94**, which is the total of the submitted medical bills listed in PX 1 for the reasonable, necessary and related treatment rendered to Petitioner, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $**364.66**/week for **132-1/7** weeks, commencing **7/16/14** through **1/25/17**, as provided in Section 8(b) of the Act.

Credit

Respondent shall be given a credit in the amount of $**1,640.97** for TTD benefits that they have paid.

Respondent shall be given an 8(j) credit in an amount equal to the total disability, medical and other benefits rendered to Petitioner through their group plan.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

June 1, 2017
Date

ICArbDec19(b)

JUN 2 - 2017

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

17IWCC0842

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Jones

v. Case No. 14 WC 24175

Voith Industrial

Attachment to Arbitration Decision

FINDINGS OF FACT

As of June 27, 2014, Petitioner had been employed by Respondent for 4 years. Respondent's business involves industrial cleaning of factories and plants. Petitioner testified that his duties included waxing floors, cleaning machinery, cleaning the cafeteria area, changing air filters, disposing of buckets of slag and taking out garbage. The physical aspects of the job required him to bend, stoop, twist, turn from side to side, and to lift up to 120 lbs.

Prior to June 27, 2014, Petitioner testified, he never had any medical issues with his lower back. No testimony or medical records were introduced by either party that contradicted his statement. On June 27, 2014, Petitioner testified, he was operating a flatbed vehicle to pick up garbage around the assembly plant. The vehicle was all metal and the chassis was roughly 6 inches off the ground. Petitioner confirmed that a picture of a flatbed presented at hearing (PX 7) was the same type of vehicle he operated on June 27, 2014. Petitioner pointed out that the vehicle shown in the picture was not the flatbed that he operated that day. The vehicle he drove that day was missing half of the driver's seat cushion, which caused him to have one buttock on the seat cushion and the other buttock on the metal of the seat. Additionally, he testified that the flatbed truck had poor suspension.

After picking up the garbage from the assembly plant, Petitioner drove the flatbed outside towards the rubbish shed, which was the building in which the garbage was processed. Petitioner testified that the rubbish shed was approximately ½ a block away. In order to get there, he had to make several turns and then drive up the ramp of the rubbish shed to dispose of the garbage on the truck. On his way to the building, Petitioner testified, the back tire of the flatbed hit a pothole of approximately 12 inches in diameter and 6 inches deep. Petitioner testified that he did not see the pothole. The flatbed bottomed out and he felt a jolt from the impact into his spine. Thereafter, he felt an instant pain in his tailbone area. Immediately afterward he was approached by his team lead, Ken Mason, who was following Petitioner in another vehicle. Petitioner further testified that Mason must have seen the expression on his face because he asked Petitioner the following question: "Man, are you alright?" Petitioner indicated that he did not feel alright. Mason then called up to the office to notify others of the occurrence. Petitioner testified that the Safety Manager, Brian Fryer, and Fryer's supervisor, Joseph Thurman, soon arrived on the scene. They then accompanied Petitioner back to the office and filled out paperwork with him.

Petitioner testified that he wanted to seek medical treatment at an urgent care facility but that no one had time to take him there. Petitioner testified that he worked in the office the rest of the day, and that Christopher Walden, the big boss, sent someone to Walgreens to pick up a cold pack for Petitioner's back.

On June 27, 2014, Petitioner signed a document in which he voluntarily refused medical treatment for the work-related injury and acknowledged that Respondent maintains workers' compensation insurance and has offered to provide medical treatment. However, he did not waive his right to future medical treatment if his condition worsens. (RX 3)

The following day, June 28, 2014, Petitioner's wife drove him to Ingalls Hospital Calumet City. (PX 6) The Emergency Room Triage Notes indicate the following:

"Pt. states that he drives a truck and the last couple of days the seat has been bothering his tailbone. Pt. states that it hurts to drive and sit down. pt. has not taken anything for pain."

The Nursing Assessment of the Back is as follows:

"Patient arrives ambulatory, Gait steady *** Back assessment findings include tenderness to tailbone, no paresthesias to extremities, no weakness to extremities, no incontinence of bowel or bladder. Left dorsalis pedis pulse +3 (easily palpated, considered normal). Right dorsalis pedis pulse +3 (easily palpated, considered normal)." (PX 6)

Petitioner's Past Medical History was positive for Type II diabetes, hypertension, pulmonary disease and pneumonia and negative for surgery and psychiatric care. (PX 6)

Thierry Dubois, M.D., wrote, in pertinent part, the following:

"**HPI QUICK ORTHOPEDIC** – *History of Present Illness:* L buttock pain after driving a flatbed at work. Patient states the flatbed only has half a seat. The 1 half of the cushion is missing. *HISTORIAN:* History provided by patient. *MECHANISM OF INJURY*: Mechanism of injury: Blunt trauma, by direct blow, Repetitive. *LOCATION:* Symptoms are localized, most severe to left buttocks. *QUALITY:* Pain is dull in nature, described as aching. *TIME COURSE:* Gradual onset of symptoms. Date and time of onset was 1 week, Symptoms are worsening. *ASSOCIATED WITH:* No associated symptoms. *EXACERBATED BY:* Patient's condition is exacerbated by Sitting. *RELIEVED BY:* Patient's condition relieved by nothing because patient has not tried anything for relief *** **ROS** – *NEUROLOGIC:* Negative neuro-

logic review of symptoms. **PHYSICAL EXAM** – *** *BACK:* Back exam included findings of normal inspection, range of motion normal, no tenderness, no costovertebral angle tenderness. *LOWER EXTREMITY:* Left pelvis exam normal, Right pelvis exam normal, Left hip exam normal, Right hip exam normal, Left thigh exam normal, Right thigh exam normal, Left knee exam normal, Right knee exam normal, Left lower leg exam normal, Right lower leg exam normal, Left ankle exam normal, Right ankle exam normal, Left foot exam normal, Right foot exam normal, L buttocks with point tenderness noted at sciatic notch. *NEURO:* *** Gait normal. *** **MEDICATION ADMINISTRATION SUMMARY** – Ibuprofen 600 mg. PO. *** **DISPOSITION** – *PATIENT:* Disposition type: Discharge, Disposition: Home / Occ Med Referral, Condition: Good." (PX 6)

Petitioner went to Ingalls Occupational Health on July 2, 2014. Petitioner stated that the date of accident was June 27, 2014. The HPI states that Petitioner's primary problem is pain located in the left hip/buttock, which he described as sharp, constant and moderate. He rated his pain at 8/10. He stated that such pain is made worse with walking and sitting on the left side. He noted that his pain is not improving and that the medication does not help. Ibuprofen and Norco was prescribed. Petitioner was provided with a restricted-duty work status note. (PX 6)

Petitioner testified that Respondent accommodated his restrictions.

Petitioner returned to Ingalls Occupational Health on July 9, 2014 and July 11, 2014. At each of those visits, he was kept on restricted duty. On the July 11, 2014, Petitioner reported that he is performing restricted-duty work with difficulty. The physician's assistant recommended that he consult with an orthopedic surgeon for a cortisone injection that will hopefully relieve his symptoms. (PX 6)

On July 16, 2014, Petitioner sought medical care with the Illinois Orthopedic Network ("ION"). Petitioner provided a history of driving a vehicle with half of the cushion missing. He

reported hitting a large pothole and then immediately feeling a sharp pain in his lower back and radiating down his left leg to the knee. (PX 2) Brittany Macleod, P.A., diagnosed Petitioner with lumbar facet syndrome, prescribed physical therapy and took him off work.

Petitioner initiated physical therapy on July 18, 2014 with H & M Medical. (PX 4) In a "REQUEST FOR TREATMENT" form dated "7/18/14", Petitioner provided the following description of the injury:

> "On 06-27-14 I complained to Joseph Thurman, and Brian Fryer (safety) of pain in my buttocks and upper left thigh. Do to (sic) seat on left side mising (sic) my butt hit all steel and hurt my butt real bad." (PX 4)

Petitioner returned to ION on August 6, 2014 and saw Sajjad Murtaza, M.D. (PX 2) He reported to the doctor that while he was driving a forklift with a faulty seat (half the cushion was missing) and an iron rod, he went into a pothole and felt a sharp pain in the left side of his body. Ever since the pothole incident, Petitioner reported, he has experienced low back pain that wraps around into the front and radiates down the front of his leg. He also reported that his knee has been giving out and that he has numbness, tingling and burning that radiates down the leg. Dr. Murtaza prescribed an MRI of the lumbar spine, as well as a Medrol Dosepak, and a TENS unit. (PX 2)

The MRI was performed on August 18, 2014. The radiologist, Satnam Papa, offered the following impression of the MR images:

1. Small right paramedian and foraminal protrusion at L4-5 with mild to moderate foraminal stenosis and narrowing of the lateral recesses, greater on the right.
2. Mild foraminal narrowing at L3-4. (PX 2)

Dr. Murtaza reviewed the MRI on August 21, 2014 and proposed a left-sided epidural steroid injection at L4-5. (PX 2)

On September 29, 2014, Petitioner was examined by Respondent's Section 12 physician, Michael Kornblatt M.D. Petitioner reported constant central low back pain that radiated more towards his left with intermittent anterior thigh pain. (RX 4B) He told Dr. Kornblatt that he experienced leg symptoms two to three times per week. (Id.) Upon examination, Dr. Kornblatt found a negative straight leg raising test. After examining Petitioner and reviewing the MRI, Dr. Kornblatt concluded that Petitioner had a self-limiting lumbosacral sprain and contusion, that his physical exam failed to reveal abnormal objective findings, and that the MRI was consistent with pre-existing degenerative disc disease. (RX 4B) Dr. Kornblatt further concluded that Petitioner could perform his full gainful employment without restrictions. (Id.)

On October 16, 2014, Petitioner received an epidural steroid injection at the L5-S1 disk level. (PX 2) At his follow-up examination on October 30, 2014, Petitioner reported that for one week he had 100% relief of his pain, but then the pain returned. After conducting a physical examination, Dr. Murtaza found that Petitioner has positive facet loading maneuvers on the left side at L3-4 and L5. He also found hypertonicity and hyposegmental motion in the lumbar spine, worse on the left than the right. He found negative Babinski's, Hoffman and clonus signs. Dr. Murtaza recommended a repeat injection at L4-L5 on the left and possibly at L3-L4. (PX 2)

On December 11, 2014, Dr. Murtaza ordered an EMG study, which was conducted on December 16, 2014. Aleksandr Goldvekht, M.D., offered the following impressions of the results:

Electrodiagnostic Impression:

1. There is electrodiagnostic evidence of bilateral L5-S1 radiculopathy, with chronic neurogenic changes and reinnervation. No active denervation was observed.
2. There is evidence of length-dependent and axonal lower limbs peripheral polyneuropathy, as is seen in diabetics.
3. There is no definite evidence of sacral plexopathy, focal peroneal or tibial neuropathies in their knee or ankle segments, lateral plantar neuropathies in their ankle or foot segments, or myopathy. (PX 2)

Clinical Impression/Recommendations:

Lumbar spine neuroimaging correlation for possible structural causes of nerve root disease is advised to be considered. (PX 2)

Petitioner was seen by neurosurgeon Geoffrey Dixon, M.D., on January 30, 2015. (PX 2) Petitioner reported pain in his back with radiation into the leg and down to the knee. Dr. Dixon examined Petitioner and reviewed the MRI. He discussed with Petitioner further conservative therapy versus surgical intervention consisting of an L4-5 microdiskectomy. Petitioner elected further conservative care and Dr. Dixon recommended a second epidural injection. (PX 2)

The second epidural injection was administered on April 2, 2015. (PX 2) Petitioner followed up with Dr. Murtaza on April 16, 2015 and reported 90% relief and stated that he felt better on the left side but had more pain on the right side. Dr. Murtaza recommended a third injection to the right side. (PX 2)

On June 11, 2015, Dr. Murtaza administered an epidural injection to Petitioner's right side at L4-5 and also gave him a trigger point injection. (PX 2)

On June 25, 2015, Dr. Murtaza wrote that Petitioner received two transforaminal epidural steroid injections on the left side that significantly improved his low back pain and left lower extremity pain. Most recently, Petitioner received a right-sided L4-5 transforaminal epidural steroid injection which he states has also helped significantly, but the pain on the left side has resumed. Upon examination, Dr. Murtaza found, *inter alia*, that Petitioner has increased axial back pain, but no radicular symptoms on the straight leg raise test. Dr. Murtaza assessed Petitioner with low back pain with an L4-5 disc herniation and bilateral lower extremity radiculopathy. Dr. Murtaza wrote that he will administer a repeat injection at L4-5 on both the right and left sides, will hold off on any more physical therapy and will continue to keep him off work. (PX 2)

On October 12, 2015, Petitioner returned to Dr. Dixon. It was noted that Petitioner had undergone two additional epidural injections that were mildly helpful, but did not have a lasting effect. Dr. Dixon diagnosed Petitioner with an L4-5 herniated disk with bilateral L5 radiculopathy and recommended a microdiskectomy and decompression at L4-5. Petitioner expressed a desire to undergo such procedure. Dr. Dixon opined, based on a reasonable degree of surgical certainty, that his diagnosis constitutes a work-related injury. (Id.)

Petitioner followed with Krishna Chunduri, M.D., of ION on December 18, 2015. Dr. Chunduri noted positive straight leg raise exam on the left side and decreased sensation along the L5 dermatome. (PX 2) Dr. Chunduri recommended an updated MRI and a consultation with Dr. Wingate. The MRI was carried out on January 4, 2016. The radiologist's report indicates a 2-mm. diffuse disc protrusion at L4-5 with right preponderance effacing the thecal sac compromising the spinal canal. (PX 2) Dr. Chunduri re-examined petitioner on February 18, 2016. Petitioner reported that his primary pain was in his lower back, left side of his buttock and approximately three times per week he experienced shooting pain down his leg. (PX 2) Dr. Chunduri recommended a left S-1 joint steroid injection. (PX 2)

On May 2, 2016, Petitioner was examined by Jeffrey K. Wingate, M.D., who is associated with Illinois Bone & Joint Institute. (PX 2) Petitioner reported left thigh pain and burning pain into his toes. Dr. Wingate reviewed Petitioner's medical treatment to date as well as the two MRI scans and the EMG. Dr. Wingate performed a physical examination, which he found was remarkable for significant discomfort with both sitting and standing. Dr. Wingate noted a strong positive straight leg raise on the left side and a loss of complete muscular control and function with elevation of the left heel a half inch above the floor. Dr. Wingate found significant evidence of clinical symptoms of both axial and radicular pain and leg pain symptoms, respectively. Dr. Wingate disagreed with Dr. Dixon's recommendation of a microdiskectomy as he did not feel it would provide a meaningful and lasting relief of Petitioner's symptoms emanating from L4-5 and L3-4. It was his recommendation that Petitioner undergo a discographic evaluation to provide a more meaningful insight to the overall pain generators from the lumbosacral spine. Dr. Wingate stated that Petitioner has had a clear

radiculopathy for almost two years and agreed with Dr. Dixon and Dr. Murtaza that Petitioner's condition was more likely than not caused by his described injury. (PX 2)

Petitioner returned to Dr. Kornblatt on August 1, 2016. Dr. Kornblatt authored another report. (RX 5) Dr. Kornblatt reviewed additional records through October 12, 2015, Dr. Dixon's second office visit. He did not review the notes from Dr. Wingate's evaluation. Petitioner reported constant and severe central low back pain which at times radiated down his right leg and at other times down his left side. Dr. Kornblatt concluded that Petitioner's subjective complaints were consistent with low mechanical back pain and bilateral lower extremity pain. Dr. Kornblatt maintained that there was no objective medical documentation to support his subjective complaints as Petitioner refused formal examination. He also stated that Petitioner exhibited multiple Waddell signs and symptom magnification. It was his opinion that Petitioner's subjective complaints were unrelated to the work incident of June 27, 2014 and that he had reached maximum medical improvement on September 29, 2014. (RX 5)

On October 27, 2016, Petitioner underwent a second EMG. The EMG was interpreted as abnormal with a right L5 radiculopathy and an indication of lower extremity peripheral neuropathy. (PX 2) Petitioner was seen by Dr. Murtaza on November 3, 2016. On that visit, Petitioner reported low back pain with right greater than left lower extremity pain. Dr. Murtaza reviewed the EMG and recommended a right L5 selective nerve root block to assess his candidacy for another epidural steroid injection. Petitioner's last visit to ION was on November 30, 2016. Petitioner reported that his symptoms were unchanged. Petitioner was instructed to follow up once the injection was approved. (PX 2)

On cross-examination, Respondent's Counsel presented Petitioner with the document entitled "Refusal of Medical Treatment" that was dated June 27, 2014. (RX 3) Petitioner acknowledged his signature, but did not recall the document. He noted that before working with Respondent, he worked for twenty years as an ordained pastor with his grandfather at Kenwood United Church. He testified that he remained a pastor at the church at the time of Arbitration. Prior to working at Kenwood United Church, he worked with his father at Christ Everlasting Church. Petitioner testified that he fed and assisted the homeless.

Respondent's Counsel showed Petitioner a document that he had signed and dated June 26, 2014. (RX 1) Such document is entitled "Employee Statement," which was to be completed by the injured employee. Petitioner indicated on such document that "Rick" witnessed Petitioner's injury. Petitioner described the nature of the incident as follows:

> *"Driving the flat bed with ½ the seat on the left side mising (sic) and my tail bone bouncing on steel. Now it's in pain moving to the front of my leg."* (RX 1)

When asked if anything unusual or unexpected happened, Petitioner wrote: *"Just driving and my tail bone started paining (sic) real bad."* (RX 1) Petitioner also wrote that a work condition contributed to this injury and suggested that Respondent fix the seat on the flatbed vehicle. Petitioner indicated that on June 26, 2014, he first noticed the pain/injury/illness, and reported it to his supervisor. Petitioner also indicated on such document that the pain developed gradually. (RX 1)

At Arbitration, Petitioner acknowledged that the "Employee Statement" did not specifically state that his vehicle hit a pothole.

Respondent's Counsel also showed Petitioner RX 2, which is the "Employee's Claim of Report." Petitioner signed and dated the report on July 21, 2014. Petitioner agreed that such report does not indicate that he drove over a pothole, but noted that it says he got hurt when his tailbone struck the metal. (RX 2)

On re-direct examination, Petitioner expressed uncertainty as to the date he put on the Employee Statement. He remembered that the accident occurred on a Friday.

In the "Incident Reporting & Treatment Form," Brian Fryer indicated that Petitioner's injury occurred on June 26, 2014 at 1:00 P.M. In the filed for "Incident Description," Mr. Fryer wrote: *"Employee is reporting pain in his left hip/Tail bone. Employee believes pain is*

caused from driving flatbed while sitting on seat w/ missing padding." (RX 3B) The report shows that Petitioner signed and dated Section B on June 27, 2014. (RX 3B) The report also shows that Dr. Dubois signed and dated Section C on June 28, 2014. (RX 3B)

Respondent Witness – Katherine Briguglio

Ms. Briguglio testified that she was hired as an investigator on the claim in August of 2016. She was provided Petitioner's name and date of birth in order to perform an investigation of the Petitioner via computer. Through her search, she identified several individuals associated with Petitioner. Ms. Briguglio contacted three of those individuals and questioned them over the telephone under the false pretext that she was a potential employer who was considering the hiring of Petitioner. Ms. Briguglio attempted to relate the conversations she had with those individuals, but Petitioner's Counsel objected to her testimony as hearsay. The Arbitrator sustained those objections. Petitioner's Counsel also objected to Ms. Briguglio's written report detailing those conversations, and the Arbitrator sustained the objection and rejected the exhibit.

Respondent Witness – Brian Fryer

Brian Fryer testified that he is the Environment, Health and Safety Manager for Respondent. He testified that his duties include handling injury claims, safety aspects and recruiting. Mr. Fryer testified he was Petitioner's Safety Manager in June of 2014. He testified that Petitioner reported pain in his buttocks and hip from driving around on a burden carrier. He testified that he noticed missing padding.

After Petitioner's reported his injury, paperwork was filled out. Mr. Fryer conducted an investigation to determine the cause of the injury and how future injuries could be prevented. A "fishbone" diagram was constructed. (RX 3A) The participants in developing such diagram were Petitioner, Brian Fryer and Veronica Quintanilla.

Mr. Fryer testified that Petitioner did not report driving over a pothole. He testified that Petitioner did not report driving outdoors. He testified that in the fishbone diagram, he would have noted that Petitioner drove over a pothole or had driven outside if Petitioner had indicated either scenario.

On cross-examination, Mr. Fryer acknowledged the presence of potholes over the concrete surfaces outside the assembly plant. He did not recall how he was notified about Petitioner's injury, but thinks he did go outside following the report of such injury. He did not recall Petitioner driving over anything.

Deposition of Dr. Kornblatt – November 23, 2015

Dr. Kornblatt's testimony was consistent with his September 29, 2014 report. (RX 4, RX 4B) Based on his review of the medical records and physical examination, Dr. Kornblatt testified that Petitioner sustained a lumbosacral strain with mechanical low back pain. (RX 4, p. 19) The doctor further testified that Petitioner's MRI findings were within normal limits for a man Petitioner's age. (Id.) Dr. Kornblatt testified that Petitioner reached MMI and did not require additional treatment. (Id at 20) He further testified that Petitioner did not exhibit signs of clinical radiculopathy. (Id.) Dr. Kornblatt assigned an impairment rating of zero. (Id. at 21)

On cross-examination, Dr. Kornblatt testified that Petitioner did not report any radicular type complaints. (RX 4, p. 26) Dr. Kornblatt acknowledged that Petitioner reported pain into the anterior thigh, but stated that it was not a radicular pain. (Id. at 27) Dr. Kornblatt discounted the EMG as having any value. (Id. at 28) Dr. Kornblatt acknowledged that an epidural injection does have a diagnostic element, but believed that the three epidural injections that Petitioner had, which provided him with immediate though temporary relief, made no sense to him. Dr. Kornblatt testified that Petitioner did not present any type of surgical indication when he examined him. (Id. at 31)

Deposition of Dr. Jeffrey Wingate – July 18, 2016

Dr. Wingate testified that it was his understanding that Petitioner sustained an injury when the vehicle he operated hit a pothole that slammed his back and buttock downward onto an uncushioned seat. (PX 5, p. 13) He described it as an unprotected axial load without the benefit s of muscular preparation to guard oneself against injury. Dr. Wingate performed a records review including the reports of Dr. Dixon and Dr. Kornblatt.

Upon examination, Dr. Wingate noted that Petitioner informed him that he had no history of any medical treatment for his spine dating back to childhood. (PX 5, p. 17) Dr. Wingate was asked on direct examination the significance of Petitioner's immediate relief of pain following the October 16, 2014 epidural injection. He responded that it was very significant and that it was something a surgeon could hang his hat on in that it establishes a one to one relationship between what is going on in the spinal canal and the source of inflammation. (Id. at 21) Dr. Wingate felt that the epidural served both a therapeutic and diagnostic purpose. (Id. at 22)

Dr. Wingate also reviewed the MRIs and noted disc degeneration on the left side. Specifically, he testified that Petitioner's first MRI indicated a loss of signal at L3-4 and tearing of the annulus. (Id. at 22-24) He also noted a left-sided herniation of disc material at L4-5 and facet arthropathy. (Id. at 25) He reviewed the second MRI of January 4, 2016, which revealed further loss of height of the disc spaces at L3-4 and L4-5. (Id. at 26) He was particularly worried about the L5 nerve root because it was dissolved at two levels and pinched at two places. (Id. at 26, 27)

Dr. Wingate testified that when he examined Petitioner, he exhibited various pain behaviors with certain maneuvers. (Id. at 27-29) He further stated that there was evidence of spasm when he asked Petitioner to lean backwards. (Id. at 29) He also described a loss of muscular function and control along the lower lumbar nerve roots on the left side. (Id. at 35) Dr. Wingate did not find any inconsistencies between Petitioner's presentation and the objective findings. (Id.) He further did not find any guarding or any over-exaggeration of symptoms. (Id. at 36)

After reviewing the other physicians' reports, the injection records, the MRI scans and all the other studies, Dr. Wingate opined that Petitioner had a left L4-S1 radiculopathy. (Id.) He noted radiculopathic signs from all three nerve roots, L4, L5 and S1 on the left side. (Id. at 36, 37)

It was Dr. Wingate's recommendation that Petitioner return to Dr. Murtaza for an assessment via discogram to determine the discogenic versus facetogenic nature of Petitioner's pain. (Id. at 38) If surgery is necessary, he would recommend a transforaminal lumbar interbody

fusion procedure. (Id. at 39) The proposed surgery would be either two or three levels depending on the results of a discogram. (Id. at 41) Dr. Wingate felt that the proposed surgery was reasonable and necessary considering the specific pain syndrome, the time duration of his complaints, the global nature of the pathology that can be seen, and the pathology confirmed on objective examination. (Id. at 42)

Dr. Wingate further testified that the sudden axial load from Petitioner's reported injury was the defining source in the creation of Petitioner's pain syndrome. (Id. at 43)

Dr. Wingate disagreed with Dr. Kornblatt's diagnosis of a lumbar strain. (Id. at 44) He pointed out that a strain does not have any direct involvement of nerves and is not associated with radiculopathy findings and positive EMG findings. (Id.) He also noted several different findings on physical examination that Dr. Kornblatt dismissed. (Id. at 45)

CONCLUSIONS OF LAW

In support of his decisions relating to issues (C) "Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?", and (F) "Is Petitioner's current condition of ill-being causally related to the injury? the Arbitrator finds as follows:

Petitioner testified that on June 27, 2014, while driving a flatbed vehicle and just before he drove up the ramp to the rubbish shed, the vehicle bounced up, then bottomed out at which time the metal part of the seat struck him in the tailbone. He immediately experienced pain in his back that traveled up his legs. Petitioner further testified that he could not see the pothole he struck because it was raining very hard. However, David Jones continued, such pothole was approximately 12" in diameter, but not a perfect circle. He testified that the parking lot was full of potholes due to the semi-trucks that drove through such lot.

Petitioner provided unrebutted testimony that Ken Mason, his Team Lead/Supervisor witnessed the accident because Mason was behind him in another vehicle, and that shortly after

the accident, when he saw the expression on Petitioner's face, Mason asked him: "Man, are you alright?"

Petitioner further testified that Brian Fryer, Respondent's Safety Supervisor, and Joseph Thurman, Brian's supervisor, arrived on the scene shortly thereafter. They took him to the office and wanted him to sit there.

Petitioner further testified that he told them he needed to go to urgent care, but that no one had time to drive him to urgent care because the plant was shut down and Respondent's employees were busy working. However, Respondent produced a document entitled "Refusal of Medical Treatment" that both he and Brian Fryer signed and dated June 27, 2014. (RX 3)

Though the initial documents filled out by Petitioner on the date of injury did not specifically state that he hit a pothole, such documents do specify that he injured his tailbone from bouncing on the steel surface of the vehicle in which half the seat cushion was missing. This history is not inconsistent with Petitioner's testimony in which he testified that after hitting the pothole, his vehicle bottomed out and bounced up injuring his tailbone.

Petitioner's account of injury is also consistent with the HPI Quick Orthopedic note of Ingalls Calumet City written on June 28, 2014 that described Petitioner's injury from a "blunt trauma by direct blow" after driving a flatbed at work that was missing half of the seat cushion.

Respondent's witness, Brian Fryer, testified that Petitioner reported that part of the seat cushion was missing. Mr. Fryer acknowledged the presence of potholes over the concrete surfaces outside the assembly plant. With Petitioner and Veronica Quintanilla, Mr. Fryer constructed a fishbone diagram to determine the cause of the pain in Petitioner's hip/tailbone area. The diagram identified factors that included "Driving flatbed many hours a day (4 or more days a week)" under MAN and "Causes EE to sit unevenly" - "Seat Missing Cushion Material (Big Chunks)" under MATERIAL. (RX 3A)

The Arbitrator recognizes that at the time of the accident, Petitioner had pre-existing conditions.

In his September 29, 2014 report, Dr. Kornblatt concluded that the MRI of the lumbar spine was consistent with pre-existing degenerative disc disease. (RX 4B) Dr. Kornblatt testified that Petitioner's MRI findings were within normal limits for a man Petitioner's age. (RX 4)

Dr. Wingate reviewed the MRIs and noted disc degeneration on the left side. (PX 5)

The medical records state that Petitioner has Type II diabetes. Dr. Goldvekht found evidence in the EMG of length-dependent and axonal lower limbs peripheral polyneuropathy, as is seen in diabetics.

Notwithstanding Petitioner's pre-existing condition, an accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was *a* causative factor. *Rock Road Construction v. Indus. Comm'n*, 37 Ill.2d 123, 127, 227 N.E.2d 65 (1967)

The Arbitrator notes that RX 1 indicates Petitioner claims that the injury occurred on June 26, 2014. In Section A of RX 3B, Brian Fryer notes that the date of injury was June 26, 2014. However, Petitioner signed RX 3B on June 27, 2014 and he refused medical treatment on June 27, 2014. (RX 3) The fishbone diagram is dated June 27, 2014. (RX 3A) Moreover, Petitioner testified that he struck the pothole on a Friday, and June 27, 2014 was a Friday. Furthermore, all the medical records from July 2, 2014 forward identify June 27, 2014 as the date of injury.

Based on the foregoing, the Arbitrator finds that on June 27, 2014, Petitioner sustained an accident when he injured his lower back and tailbone as a result of the bouncing of the flatbed truck he operated while in the course of performing his job duties for Respondent. Both Petitioner and Mr. Fryer testified as to the numerous potholes on the roads outside the Ford assembly plant.

The medical records reflect that Petitioner immediately reported symptoms in his tailbone and left buttock, and on July 16, 2014, also complained of radicular pain down his left leg. (PX 6, PX 2) On December 11, 2014, Dr. Murtaza ordered an EMG study. Dr. Goldvekht found electrodiagnostic evidence of bilateral L5-S1 radiculopathy, with chronic neurogenic changes and reinnervation. (PX 2) Subsequently, Petitioner received epidural steroid injections to his back that provided pain relief which lasted only a few days.

Petitioner's treating physicians, Dr. Murtaza, Dr. Dixon and Dr. Wingate have all opined that Petitioner's condition is related to his reported accident. (PX 2)

Dr. Wingate testified that this sudden axial load has been the key factor in creating Petitioner's pain syndrome as none of these symptoms predated the occurrence of this injury. He further testified that an axial load can be a very defining blow to the human lumbar spine. (PX 5, p. 43)

Dr. Wingate further testified that it is not uncommon for a patient who has a newly torn or newly herniated disc to develop leg symptoms over four weeks or even eight weeks after the reported injury because that's the amount of time it takes for the inflammation to build within the affected structures inside the spine. (PX 5, p. 57)

Respondent's physician Dr. Kornblatt opined in both of his examinations that Petitioner had nonspecific low back pain and chronic pain behaviors that were unrelated to the work incident. He disputed that Petitioner had any radiculopathy and felt that Petitioner was at maximum medical improvement.

Dr. Wingate provided detailed and cogent testimony regarding his examination and his review of the diagnostic studies. He felt that the temporary relief Petitioner received from the epidurals was significant in identifying the inflammation within the spinal canal. (PX 5, p. 21) He found abnormalities within the MRIs reflecting tearing of the annulus at L3-4 and a herniation of disc material at L4-5. (Id at 24, 25) He identified facet arthropathy at L4-5 which was acting as a pincher around the L4 or L5 nerve roots. (Id. at 25) He noted that the second

MRI taken on January 4, 2016 showed some settling and further loss of structural height at L3-4 and L4-5 and dissolving of the L5 nerve root. (Id. 26, 27) With regard to his examination, he observed pain behaviors consistent with left-sided lower back pain. His exam revealed specific pain in the left sciatic notch, the back part of the buttocks where the sciatic nerve exits. (Id. at 28) He further found evidence of an extensor lag which did not allow Petitioner's muscles to extend to an upright posture. (Id. at 29) Dr. Wingate further noted spasm of the paraspinous muscles with the Petitioner leaning backwards. (Id.)

The Arbitrator is persuaded by the opinions of Dr. Wingate, Petitioner's treating physician, over those of Dr. Kornblatt, Respondent's Section 12 physician. Dr. Wingate provided convincing testimony that Petitioner's ongoing medical issues were causally related to his injury. His findings were supported by objective diagnostic studies as well as his clinical examination. Dr. Kornblatt, on the other hand, found no abnormalities within the diagnostic studies, found no significance in the temporary relief Petitioner received from the injections, and found the EMG results of no importance. His examination findings are completely contrary to the three treating doctors who all noted positive straight leg raises as well as other objective findings that correlated with his subjective symptoms.

Even if one of the medical witnesses was equivocal on the question of causation, it is for the Commission to decide which medical view is to be accepted, and it may attach greater weight to the opinion of the treating physician. *International Vermiculite Co. v. Industrial Comm'n.*, 77 Ill. 2d 1, 394 N.E.2d 1166 (1979) citing *Holiday Inns of America v. Indus. Comm'n*, 43 Ill.2d 88, 89-90 (1969); *Proctor Community Hospital v. Indus. Comm'n*, 41 Ill.2d 537, 541 (1969).

Respondent argues that Petitioner sustained an intervening accident that triggered right-sided, radiating pain. The March 6, 2015 records from Ingalls Hospital indicate that the previous Sunday, Petitioner slipped on ice and twisted his right ankle. There is no indication that Petitioner twisted his back or fell to the ground. Petitioner is not claiming that he injured his right foot on June 27, 2014. Therefore, the Arbitrator finds that Petitioner did not sustain an intervening accident.

Every natural consequence that flows from an injury that arose out of and in the course of one's employment is compensable under the Act absent the occurrence of an independent, intervening accident that breaks the chain of causation between the work-related injury and an ensuing disability or injury. *National Freight Industries v. Ill. Workers' Comp. Comm'n*, 993 N.E.2d 473, 373 Ill. Dec. 167 (5th Dist. 2013)

Based on the foregoing, the Arbitrator finds that Petitioner's present condition of ill-being of his left buttock and low back is causally related to the accidental injury of June 27, 2014.

In support of his decision relating to issue (J) "Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?", the Arbitrator finds the following:

The Arbitrator has reviewed the medical records and relies on the opinions of Dr. Wingate that the treatment rendered Petitioner was appropriately indicated and directed. (PX 5, p. 18) The Arbitrator finds that the office visits, diagnostic tests, physical therapy and injections were reasonable and necessary to treat Petitioner's lower back and leg symptoms that resulted from his work-related injury. Consequently, the Arbitrator awards Petitioner $82,854.94, which is the total of the submitted medical bills listed below (PX 1), pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Dates of Service	Provider	Balance
10/3/16	Skan National Radiology	1,500.00
10/27/16	Jackson Park Medical	2,099.00
1/4/16	Premium Healthcare Solutions	2,486.00
10/22/14 3/3/15	Toxicology Management Svcs LLC	2,676.50 2,676.50
12/3/15	Metro Health Solutions	2,988.79
6/25/15	Metro Health Solutions	2,988.79
2/27/15	Metro Health Solutions	2,988.79
8/6/14 – 6/11/15	EqMD	1,463.34
6/11/15	Metro Anesthesia Consultants	1,982.78
12/16/14	Premium Healthcare Solutions	3,150.00
8/18/14	Premium Healthcare Solutions	1,986.45
7/18/14 – 2/15/16	H and M Medical	33,963.39

7/30/14	G&U Orthopedic	2,530.50
10/6/14	G&U Orthopedic	4,025.20
8/6/14	Core Medical	986.64
3/3/16 – 6/3/16	ATI	1,102.23
10/16/14-11/30/16	ION	11,260.04

In support of his decision relating to issue (K) "Is Petitioner entitled to any prospective medical care?" the Arbitrator finds as follows:

Petitioner has received extensive conservative treatment in the form of physical therapy and injections. None of the treatment received has provided anything more than temporary relief of his symptoms. Dr. Wingate opined that Petitioner likely requires surgery to provide a long-lasting effect. However, prior to performing any surgery, Dr. Wingate recommended a discogram "as a way of assessing specifically where his pain generators are coming from." (PX 5, p. 41) The Arbitrator relies on the findings of Dr. Wingate and directs Respondent to authorize the discogram, and, if necessary, the transforaminal lumbar interbody fusion that Dr. Wingate has recommended, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

In support of his decision relating to issue (L) What temporary benefits are in dispute? TTD", the Arbitrator finds as follows:

Petitioner was taken off work at his first visit with ION on July 16, 2014. Thereafter, his doctors have continuously kept him off work through the date of hearing as they await authorization for the prescribed treatment. (PX 2)

Based on the foregoing, the Arbitrator finds that Petitioner was temporarily totally disabled from July 16, 2014 through January 25, 2017, which represents 132-1/7 weeks. Petitioner is entitled to TTD benefits for that period at the TTD rate of $364.66 per week.

Respondent is entitled to a credit for TTD benefits paid in the amount of $1,640.97.

The parties agreed that Respondent claims they paid $76,831.04 in other benefits for which credit may be allowed under Section 8(j) of the Act. (AX 1) However, PX 6 indicates Respondent paid a total of $52,575.83 in disability benefits and AX 1 indicates the parties agree

that Respondent paid $0 in medical bills for which credit may be allowed under Section 8(j) of the Act.

Respondent is entitled an 8(j) credit in an amount equal to the total disability, medical and other benefits rendered to Petitioner through their group plan.

Brian T. Cronin
Arbitrator

6-1-2017
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF DU PAGE)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kelly Foster,
Petitioner,

vs. No. 04 WC 29203

School Association for Special Education of DuPage (SASED),
Respondent.

17IWCC0843

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 benefit rate (average weekly wage), causal connection, medical expenses, vocational rehabilitation, tuition reimbursement, prospective medical care, temporary disability and permanent disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Arbitrator awarded Petitioner all of her medical expenses for treatment received through September 2011, except for treatment provided by Physiotherapy Associates, which was denied entirely. The Arbitrator also awarded Petitioner the treatment provided by Advocate Occupational Health, Good Samaritan Hospital, Dr. Barakat, Dr. Heller and Dr. Koehn, all through 2013. The Arbitrator awarded her 250 weeks of permanent partial disability at a rate of $368.36 per week for her injury, which caused a 50% loss of use of the person as a whole as provided in Section 8(d)2 of the Act. The Arbitrator denied Petitioner's claim for additional TTD, vocational rehabilitation, tuition reimbursement, and benefits under Section 8(d)1 of the Act.

The underlying facts of this claim were laid out in the Arbitrator's Decision, which is incorporated by reference herein. On December 17, 2002, Petitioner, then 23 years old, was working her first job as a special education teacher when a student grabbed her arm, causing a right wrist sprain. Four months later, her injury progressed to Reflex Sympathetic Dystrophy ("RSD"), a diagnosis confirmed by multiple medical providers including the Mayo Clinic, though disputed by one of her treaters, who believed her injuries were self-inflicted. After Petitioner's accident, Respondent accommodated her right arm lifting restrictions for the rest of that school year; during the 2003/2004 school year, Respondent also accommodated Petitioner's further restrictions to perform office work only. Following that year, Petitioner chose to quit her job and pursue a Master's degree in guidance counseling.

With regard to Petitioner's **average weekly wage**, the Arbitrator found it to be $613.93, calculated by dividing Petitioner's prior year's earnings by the sixteen (16) weeks and parts thereof that she worked for Respondent. The Arbitrator found Petitioner's prior year's earnings to be $31,924.36. The Arbitrator relied upon *Elgin Board of Education School District U-46 v. Illinois Workers' Compensation, 409 Ill.App.3d 943 (First District, 2011),* which affirmed the Commission's use, in that case, of the 3rd method set forth in §10 of the Act of calculating the average weekly wage for employees, "whose employment prior to the injury extended over a period of less than 52 weeks." That method of calculation mandates, "dividing the earnings during that period by the number of weeks and parts thereof during which the employee actually earned wages." *820 ILCS 305/10.*

Petitioner incorrectly alleges the parties stipulated that her earnings during the year preceding her accident were $32,625.00. Respondent did not. On the Request for Hearing form, Petitioner claimed that figure to be her annual salary, but Respondent did not stipulate to that figure. As noted, prior to her injury date Petitioner had only worked 16 weeks, during which she earned $9,822.93.

Petitioner's relies on the case, *Washington Dist. 50 Schools v. Illinois Workers' Compensation Comm'n, 394 Ill.App.3d 1087 (3rd Dist, 2009),* which held that a salaried teacher under contract who chose to be paid her salary over a 52-week period rather than the 39 weeks of school year during which she actually worked, should have her annual salary calculated by dividing her annual salary by 39 weeks, not by 52. The facts in the current claim, however, distinguish it from *Washington Dist. 50 Schools.* In that case, the claimant worked for her employer for longer than one year; presented evidence that she had an annual contract with her employer, and testified she only had to work 39 weeks in order to receive an annual salary. Petitioner herein presented no such testimony or evidence.

The Commission finds the most reliable evidence of Petitioner's earnings to be Respondent's Wage Statement (RX8). That document establishes that Petitioner cumulative earnings for the 16 weeks she worked for Respondent prior to her accident totaled $9,822.93. Using the third method of calculation prescribed in §10 of the Act – dividing $9,822.93 by the 16 weeks and parts thereof which Petitioner worked – results in an average weekly wage of $613.93, the figure calculated the Arbitrator. The Commission affirms that average weekly wage. However, because Petitioner only worked 16 weeks prior to her injury, the Commission finds that her earnings in the year prior to her accident were not $31,924.36, as found by the Arbitrator, but rather, were $9,822.93, as reported in Respondent's Wage Statement, (RX8).

With regard to medical expenses, the Arbitrator awarded Petitioner all of her expenses incurred through September 2011;[1] in addition, the Arbitrator awarded Petitioner payment for the treatment provided by Advocate Occupational Health, Good Samaritan Hospital and Drs. Barakat, Heller and Koehn – through the end of 2013. The Arbitrator denied all treatment provided by Physiotherapy Associates, finding it not reasonable and necessary. In denying that treatment, the Arbitrator relied upon the September 2011 retrospective utilization review (RX6), which non-certified, as of September 20, 2010, further occupational therapy to Petitioner's right forearm.

At the January 2016 arbitration hearing, some 13 years post-injury, Petitioner testified she was still attending occupational therapy sessions, approximately once every two weeks. Petitioner still experiences RSD symptoms to her right arm, including pain, swelling and tingling. Two or three times a year, she develops "flares," during which her skin breaks open and oozes or bleeds. Petitioner claims that her therapy to her right arm helps her symptoms. However, Petitioner also admitted at arbitration that this therapy does not provide lasting relief. As early as 2004, Dr. Koehn recommended Petitioner be transitioned from therapy to more home activities. Dr. Koehn reported that Petitioner was given instructions to switch over her "strategy," or therapy, to a family member. On August 30, 2007, Dr. Koehn wrote that Petitioner was, *"able to control her flares on her own. She is basically at maintenance, arrest of progress level."* Dr. Koehn released Petitioner from his care at maximum medical improvement on that date, although thereafter until May 2013, he has continued to recommend therapy.

The Commission finds that Petitioner's right arm therapy from Physiotherapy Associates was reasonable and necessary from her date of accident until September 19, 2010, and modifies the Arbitrator's denial of medical expenses from that provider accordingly. In finding that Petitioner's therapy on and after September 20, 2010 to not be reasonable and necessary, the Commission relies upon the opinion of the utilization review physician: that occupational therapy commencing September 20, 2010 and thereafter was not appropriate. The Commission finds that physician's opinion regarding reasonableness and necessity to be more credible than the opinion of Kristine Yung, Petitioner's therapist, who is not a doctor. The Commission rejects, as too speculative and old, Dr. Gilbert's 2006 opinion that at *that* time, Petitioner *may* need future treatment.

For these reasons, the Commission modifies the Arbitrator's award of medical expenses to Petitioner. The Commission now awards Petitioner, in addition to the other medical expenses awarded by the Arbitrator, treatment provided by Physiotherapy Associates from Petitioner's date of accident until September 19, 2010. The medical expenses of Physiotherapy Associates incurred on and after September 20, 2010 remain denied, the Commission finding that treatment to not being reasonable and necessary.

Lastly, the Commission notes other clerical errors in the Arbitrator's Decision, which misstate the date of Petitioner's accident as December 17, 2012, rather than the correct date of December 17, 2002. Those errors are found in the decision on pages numbered 1 (under Findings of Fact, second paragraph), and 4 (under Conclusions of Law, first paragraph). The Commission corrects those clerical errors in this award.

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[1] The Arbitration Decision, page 4, notes this date as, "September 20111." The Commission hereby corrects this clerical error to read, "September 2011."

17IWCC0843

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 25, 2016, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of medical expenses to Petitioner is modified as stated hereinabove.

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.

DATED: DEC 29 2017

o-11/01/17
jdl/mcp
68

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FOSTER, KELLY
Employee/Petitioner

Case# **04WC029203**

SCHOOL ASSOCIATION FOR SPECIAL EDUCATION OF DuPAGE (SASED)
Employer/Respondent

17IWCC0843

On 2/25/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1505 SLAVIN & SLAVIN LLC
DAVID VANOVERLOOP
100 N LASALLE ST 25TH FL
CHICAGO, IL 60602

1120 BRADY CONNOLLY & MASUDA PC
MATTHEW SHERIFF
10 S LASALLE ST SUITE 900
CHICAGO, IL 60602

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

KELLY FOSTER
Employee/Petitioner

v.

SCHOOL ASSOCIATION FOR SPECIAL EDUCATION OF DUPAGE (SASED)
Employer/Respondent

Case # 04 WC 29203

Consolidated cases: ___

17IWCC0843

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Wheaton**, on **January 26, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 **Tuition Reimbursement**

FINDINGS

On **12/17/2002**, Respondent ***was*** operating under and subject to the provisions of the Act

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$31,924.36**; the average weekly wage was **$613.93**.

On the date of accident, Petitioner was **23** 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 **$124,199.80** for TTD, **$-0-** for TPD, **$-0-** for maintenance, and **$-0-** for other benefits, for a total credit of **$124,199.80**.

Respondent is entitled to a credit of $-0- under Section 8(j) of the Act.

ORDER

Respondent shall pay the Petitioner permanent partial disability benefits of $368.36 per week for 250 weeks because the injury sustained caused 50% loss of use of the person as a whole as provided in Section 8(d)2 of the Act.

Petitioner's claim for additional TTD, vocational rehabilitation, tuition reimbursement, medical expenses from Physiotherapy Associates and benefits under Section 8(d)(1) of the Act are denied.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

2/24/16
Date

17IWCC0843

FINDINGS OF FACT

This case involves a Petitioner alleging she sustained injuries while working for the Respondent on December 17, 2002. Respondent does not dispute the Petitioner's accident, however, the parties are disputing the following issues: 1) causation; 2) average weekly wage; 3) medical expenses; 4) prospective medical care; 5) TTD; 6) vocational rehabilitation; and 7) nature and extent.

The Petitioner testified that she was working as a Special Education Teacher for the Respondent on December 17, 2012. On that date, she was working on a special project with the students when she was grabbed by a particular student who twisted her right arm.

The Petitioner testified, and the evidence indicates, that she began employment with the Respondent in August of 2002. She worked a period of approximately four months or 16 weeks prior to the incident. During this time, she was paid a total of $9,822.95 for the 16-week period. (R.X. 8.)

The Petitioner testified that immediately after the incident, she felt some pain in her right arm and it "got red." She testified that she went to the school nurse who referred her to the emergency room. The Petitioner eventually went to Advocate Occupational Health and was seen by Dr. Richardson who recommended physical therapy. (P.X. 1.)

The Petitioner was then referred to Dr. Barakat who continued occupational therapy. The Petitioner testified that she noticed no improvement in her condition during this time.

In March of 2003, the Petitioner sought treatment with Dr. William Heller through Advocate Occupational Health. At the first examination, Dr. Heller thought the Petitioner needed an MRI because she had objective findings of swelling and redness in the arm. However, the radiographs were normal. (R.X. 1.)

On March 5, 2003, the Petitioner obtained an MRI of her right wrist which showed a localized area of soft tissue thickening, likely due to a small area of swelling. The remainder of the right wrist evaluation was unremarkable.

When the Petitioner returned to Dr. Heller in April of 2003, he examined the MRI and diagnosed the Petitioner with a right wrist sprain/strain, now four months, with persistent pain and swelling. He thought this was consistent with possibly CRPS but it was not "work disruptive." (R.X. 1.)

Meanwhile, the Petitioner also began treatment with Dr. Gary Koehn who, based on his examination, believed the Petitioner was suffering from CRPS Type 1 in the right hand and wrist area. The doctor was recommending injections which he administered on several occasions. (R.X. 1.)

The Petitioner returned to Dr. Heller on May 8, 2003, following ganglion injections previously performed by Dr. Koehn. Based on the Petitioner's response to the injections, Dr. Heller did not feel that this was a "typical case of RSD." Dr. Heller felt that the Petitioner should possibly obtain a second opinion from Dr. Daniel Mass of the University of Chicago who has "extensive experience in upper extremity disorders." The Petitioner did not present to Dr. Mass.

On May 19, 2003, the Petitioner presented to Dr. Paul Papierski for an independent medical evaluation at the request of the Respondent. Dr. Papierski reviewed the Petitioner's medical treatment records up to that point

and examined the Petitioner. He found the Petitioner to likely be suffering from a wrist sprain with a positive diagnosis. The doctor felt that the objective findings of swelling and redness in the right forearm and wrist were not consistent with the original injury and, in the doctor's opinion, may be "self-induced." (R.X. 2.) He felt that perhaps a casting was appropriate for the forearm in order to protect the area and that the Petitioner should still continue to work with a restriction of use of the right hand and fingers as tolerated. Dr. Papierski was also of the opinion that the Petitioner should be able to return to work in a full duty capacity in 4 – 6 weeks following removal of the cast. (R.X. 2.)

Following the independent medical evaluation, the Petitioner returned to Dr. Heller on May 29, 2003. Dr. Heller agreed with Dr. Papierski's opinion that the swelling and redness present in the Petitioner's right forearm and wrist area was "self-induced trauma." (R.X. 1.) Dr. Heller also added that he "suspected this for months" but wanted to rule out other issues. (R.X. 1.) Apparently, the Petitioner had already planned to go to Mayo Clinic for an additional evaluation, which the doctor indicated would be appropriate.

In June of 2003, the Petitioner presented to Mayo Clinic. After a number of tests, the diagnosis of RSD/CRPS was confirmed by the Mayo Clinic physicians. (P.X. 19.)

The Petitioner testified that she continued to receive treatment with Dr. Koehn including occupational therapy, though this did not provide any "lasting improvement." She further testified, and the medical treatment records indicate, that she has had ongoing therapy through the Advocate Good Samaritan Physical Therapy Department and Physiotherapy Associates from 2005 through the present date. (P.X. 3, 20 – 28.) She testified that she continued to attend therapy every other week with techniques usually involving massages to reduce pain and swelling.

The Petitioner's therapist throughout the majority of this time, Ms. Kristine Yung, also testified at the hearing. She stated that she is employed as an Occupational Therapist and has been treating the Petitioner since 2003. Ms. Young testified that she performs modalities, which she termed as myofascial release that work to remove the tightness in that area. Ms. Young testified that following appointments with the Petitioner, she would notice a decrease in swelling and improvement in her range of motion.

During the course of her treatment, the Petitioner submitted for a second independent medical evaluation with Dr. Hugh Gilbert, an Associate Professor at the School of Medicine at Northwestern University in March of 2006. Dr. Gilbert had an opportunity to review all of the medical treatment records dealing the Petitioner's treatment up to that point. Dr. Gilbert also thoroughly examined the Petitioner. Dr. Gilbert opined that the Petitioner did meet the diagnostic criteria for having sustained CRPS, though it was unclear as to how it would progress over time. (R.X. 3.) Dr. Gilbert further opined that the injections previously administered by Dr. Koehn, "never established with medical certainty that the blocks are effective in reducing sympathetic activity," to fully confirm a CRPS diagnosis. (R.X. 3.) Dr. Gilbert also mentioned that, as previously indicated by Drs. Papierski and Heller, he could not account for the denuded skin on the surface of the forearm and the fact that the Petitioner's right arm showed no clinical sign of atrophy. (R.X. 3.) Dr. Gilbert was also of the opinion that the redness and condition of the right forearm may be a self-induced condition. (R.X. 3.) Dr. Gilbert also indicated in his report that he could not identify any significant impairment that precludes returning to teaching if the Petitioner could get back having altered sensory processing in the right dominant hand and forearm. (R.X. 3.) Finally, Dr. Gilbert set out a number of treatment options which the Petitioner could undergo including pain medications, psychological treatment, and occupational therapy. (R.X. 3.)

17IWCC0843

The Petitioner worked for the Respondent in her special education position through the 2003/2004 school year. The Petitioner felt that in her opinion she, "physical couldn't do it" anymore and resigned from her position. Shortly thereafter, the Petitioner began working with counselors at MedVoc Rehabilitation for evaluation and job placement purposes. The specialist met with the Petitioner and detailed educational and medical data in a report dated May 20, 2005. (R.X. 5.) This report indicates that the Petitioner advised the specialist that although she stopped her work with the Respondent, she was continuing to perform work privately dealing with an autistic child. The Petitioner indicated that she worked two times per week for 3 – 4 hours per day receiving an hourly rate of $14.00. The Petitioner also indicated that she could possibly obtain that as a full-time position, but could not in her "current situation." (R.X. 5.)

Throughout the program in 2005 as detailed by reports, the specialist was working to get the Petitioner certified as a non-special education teacher so that she could resume her career. There were some issues in this regard as it was very unclear as to what were the Petitioner's current restrictions based on her prior treatment with Dr. Koehn, and the therapist had some difficulty in obtaining information from schools as to what would be needed. (R.X. 5.) It was eventually determined that the Petitioner would likely need 24 hours of schooling in order to obtain a teaching certificate to be a teacher in a non-special education classroom. (R.X. 5.) The Petitioner testified that she believed that obtaining such a certificate would require a two-year program. Additionally, the Petitioner testified that during vocational rehabilitation, she was advised by her counselor that they would not recommend that she pursue an education and career as a Guidance Counselor, as it was a lower paying position than transitioning to a regular teaching position. Despite these efforts, the Petitioner took it on her own initiative to begin a program at Lewis University for additional schooling to become a Guidance Counselor. The Petitioner incurred expenses associated with tuition. (P.X. 33) However, Respondent never advised Petitioner that the tuition would be paid or reimbursed. Petitioner testified that her schooling to become a Guidance Counselor was paid for out-of-pocket by the Petitioner or her family. (T. at pp. 29-30.)

On December 7, 2007, the Petitioner presented to ATI Physical Therapy for a functional capacity evaluation at the direction of Dr. Koehn. The results of the FCE indicated that the Petitioner could work at the light-to-medium level, and that she was capable of lifting up to 30 pounds with frequent lifting of 20 pounds. The Petitioner's job description at that time was a special needs teacher, which was also considered a light duty position which would be met by the Petitioner. (R.X. 4.)

Despite the results of the FCE, the Petitioner continued with school at Lewis University and obtained employment through Oswego Community School District, beginning in August of 2008. The Petitioner was originally hired to cover for one of the school counselors who was on maternity leave. The Petitioner testified that she then transitioned into the learning lab for the school year of 2008/2009 and was paid on an hourly basis. The Petitioner then testified that she obtained a part-time job as a resource teacher at an elementary school through Oswego School District for the school year of 2009/2010, which was a salaried position. She testified that she was supervising a small group of students with learning disabilities at that time. Finally, beginning in 2010, she gained employment as a Guidance Counselor which is the position she still holds today.

The records obtained from Oswego Community Unit School District #308 note that there were no medical or emotional problems or conditions that would affect the Petitioner's ability to hold this employment. In the opinion of the nurse who conducted the examination, the Petitioner should have no problem in meeting the strength and mobility challenges to deal with children in the age category of 0 – 12 years of age. (R.X. 7.)

During the course of the Petitioner's treatment, as she testified, she was obtaining fairly consistent myofascial treatments at Physiotherapy Associates from 2008 through the present. In a Utilization Review/Peer Report

dated September 12, 2011, it is noted that these procedures were not certified as being medically necessary. The report, signed by Christopher Robinson, M.D. noted that there was insufficient documentation to support this ongoing treatment. (R.X. 6.) The Petitioner testified and the medical records show that she was last seen by Dr. Koehn in 2013. (P.X. 18) She testified that despite the ongoing myofascial treatment she is receiving at Physiotherapy Associates, nothing received up to this point has provided what she would term as "lasting relief."

The Petitioner testified to the Respondent's Union Teacher Salary Scales which fluctuate based on years of service as well as educational background. She further testified that her pay would be increased due to the Master's Degree she has obtained as a Guidance Counselor. (P.X. 34.)

CONCLUSIONS OF LAW

1. With regard to the issue of causation, the Arbitrator finds that that the Petitioner has met her burden of proof. This finding is supported by the Petitioner's testimony and the medical evidence. The Petitioner testified, and the medical treatment records indicate, that the Petitioner appeared for immediate treatment at Advocate Occupational Health and was under the care of those physicians for a wrist strain which developed into a more serious condition throughout 2002 and 2003. The Arbitrator notes that the independent medical evaluation physicians, Drs. Papierski and Gilbert, indicate that the Petitioner suffered some sort of a right arm/wrist injury on December 17, 2002. Accordingly, the Arbitrator concludes that the Petitioner's current condition of ill-being in her right wrist – that being the complex regional pain syndrome - is causally related to her undisputed December 17, 2012 accident.

2. Regarding the issue of average weekly wage, the Arbitrator finds that the Petitioner's average weekly wage at the time of the accident was $613.93. This finding is based on Petitioner's yearly earnings of $31,924.59. The Petitioner first began her employment with the Respondent in late August of 2002, approximately four months prior to the alleged incident. Thus, there is not a 52-week period to determine wages but, rather, a period of approximately 16 weeks. The case of Elgin Board of Education School District U-46 v. Illinois Workers' Compensation Commission, 409 Ill.App.3d 943 (First District, 2011), indicates the proposition that a teacher's average weekly wage should be calculated by dividing actual earnings by the number of weeks actually worked prior to the date of injury in a situation such as this. In this particular instance, the evidence shows that the Petitioner earned a total of $9,822.95 in the 16-week period prior to this accident. In dividing the Petitioner's total actual earnings of $9,822.95 by the 16 weeks Petitioner actually worked, the Arbitrator concludes that the Petitioner's average weekly wage is $613.93.

3. With respect to the issue of medical expenses, the Arbitrator finds that the Petitioner's medical treatment provided through September, 20111 and the treatment provided by Advocate Occupational Health, Good Samaritan Hospital, Dr. Barakat, Dr. Heller, and Dr. Koehn through 2013 – were all reasonable and necessary in addressing Petitioner's condition related to her December 17, 2002 accident. Accordingly, the Arbitrator awards payment for any related medical expenses from those providers for those time periods and Respondent shall receive a credit for any such medical expenses it has already paid. However, with regard to the medical expenses incurred from Physiotherapy Associates through the present date, the Arbitrator finds that this treatment was not reasonable and necessary, and accordingly does not award expenses from this medical provider. In support of this finding, the Arbitrator relies on the unchallenged September, 2011 Utilization Review assessment indicating that the treatment from this provider was not verified by the Petitioner's improving condition or lack thereof, nor medical treatment or clinical notes. Petitioner herself testified that the

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treatment she currently receives from this medical provider has not provided her "lasting relief." Accordingly, Petitioner's request for payment of the medical expenses from Physiotherapy Associates is denied.

4) Based on the Arbitrator's findings with regard to the issue of medical expenses, the Arbitrator finds that the Petitioner's request for prospective medical care from Physiotherapy Associates is not reasonable and necessary, and is hereby denied.

5) Regarding the issue of TTD, the Arbitrator finds that the Petitioner's request for additional TTD is denied. This finding is supported by the Petitioner's testimony and the medical evidence. Petitioner testified that she voluntarily resigned her employment from Respondent because she felt that she could not do the job. Petitioner's own feelings of not being able to do her job with Respondent are clearly at odds with the medical records that indicate the Petitioner was able to do her job. The evidence also shows that the Petitioner took a private job with a family to care for their autistic child after she voluntarily left her job with Respondent. She was able to successfully obtain employment with another school district doing a variety of jobs. Furthermore, she was able to go back to school to obtain an advanced degree despite her testimony that she could not write or type much because of her injury. All of these factors lead the Arbitrator to concluded that the Petitioner was not temporarily totally disabled for the periods she alleges and her claim for TTD during that time is denied.

6) Regarding the issue of vocational rehabilitation - specifically, the Petitioner's request for reimbursement of her educational expenses - the Arbitrator finds that the Petitioner has failed to meet her burden of proof. This finding is supported by the Petitioner's testimony, the medical evidence and the vocational rehabilitation evidence. The Arbitrator notes that in the functional capacity evaluation of 2007, the Petitioner was released to a duty level which would have allowed her to not only return to her prior position as a special education teacher but also to a position as teacher in a non-special education classroom. The Petitioner testified and the vocational rehabilitation report indicated that some additional certification may have been necessary. However, because she did not feel she could handle the physical demands of a general education teacher, she chose to undergo additional education as a guidance counselor. The job she chose was against the recommendation of the vocational rehabilitation specialist and provided her a lower paying position. The Arbitrator finds that the Petitioner is certainly entitled to choose the occupation of her choice, however, the Respondent should not be found liable for payment of education or training expenses if the Petitioner chooses an occupation that is against the recommendations of the vocational rehabilitation expert, which is lower paying than one she could physically occupy. As such, the Petitioner's request for reimbursement of her vocational rehabilitation expenses in the form of her tuition costs in this case are denied.

7) With respect to the issue of nature and extent, the Arbitrator finds that the Petitioner has sustained a 50% loss of the person as a whole. This finding is supported by the Petitioner's testimony and the medical evidence. There is some conflicting evidence, earlier on in this case in 2003, that some of the petitioner's symptoms were self-induced. Putting that aside, the Petitioner has been diagnosed as having RSD/CRPS by the physicians at Mayo Clinic as well as Dr. Koehn. Despite this, the Petitioner's testimony, and the information from Oswego School District - which reflects that the Petitioner would have no medical or psychological concerns in working in a classroom setting - indicates that the Petitioner is capable of returning to work at a level higher than the job she eventually chose. The Arbitrator finds that a wage differential under Section 8(d)1 would be inappropriate in this case as the Petitioner has the ability to function in her prior position or a position that would compensate her at the same or even higher level. The Petitioner chose to pursue a different occupation on her own volition and did not offer any evidence to counter the findings of the vocational rehabilitation expert. To award a wage differential, would be based purely on speculation and counter to the Labor Market Survey presented by the Respondent. Because of this, the Arbitrator finds that the Petitioner should be compensated in what is normally

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considered a "loss of occupation" amount. Thus, the Arbitrator finds that the Petitioner has suffered a loss of 50% loss of use of the person as a whole as a result of the incident of December 17, 2002.

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	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gregory Riddick,
Petitioner,

vs.

No: 13 WC 03682

17IWCC0844

State of IL / Illinois Youth Center -Joliet,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) has been filed by Respondent, following the Decision of Arbitrator Doherty filed on July 21, 2016. Petitioner, a 53-year-old correctional officer, alleged injury most prominently to his right knee, as well as injury to low back and neck, which injuries were sustained on January 10, 2013 during an assault by inmates. The Arbitrator found that the entirety of Petitioner's current condition of ill-being -- to right knee, cervical spine and lumbar spine as alleged -- was related to the work-related accident. She awarded temporary total disability (commencing January 11, 2013 up through the date of hearing, or 178 and 1/7 weeks), medical expenses, and prospective treatment, specifically total right knee replacement that was prescribed in July 2013. Petitioner has filed a cross-petition for penalties and attorney's fees.

The Commission, after considering issues including causal connection as to current condition of ill-being, medical expenses, and prospective treatment, and being advised of the facts and law, modifies the Arbitrator's Decision as described herein. Particularly, the Commission reverses the Arbitrator's Decision regarding the Petitioner's neck and back. With respect to injuries sustained to those body parts, Petitioner has proven no more than strain injuries that have since resolved. The Commission otherwise affirms and adopts the Decision of the Arbitrator, which Decision is attached hereto and made a part hereof. Petitioner's cross-petition for penalties and attorney's fees is denied.

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, 35 Ill. Dec. 794 (1980).

I. BACKGROUND

A. Accident and Treatment

As mentioned above, Petitioner, 53, was injured on January 10, 2013 during an altercation involving two inmates. He was wrestled to the ground, landed on his right knee, and was struck on the face and neck. He reported an acute increase in right knee pain as well as neck and back pain. He was immediately treated at Provena St. Joseph's, where he was diagnosed with right knee sprain, back sprain, some facial injuries, and closed head trauma. (PX 2).

A week later, Petitioner sought treatment with Dr. Artelio Watson of Health Benefits Pain Management. (PX 3). Dr. Watson prescribed medication and an MRI of the right knee and lumbar spine. The lumbar spine MRI of January 25, 2013 disclosed degenerative changes at the levels of L3 through S1, including loss of disc height and some central and foraminal stenosis. (PX 6). The right knee MRI of January 21, 2013 disclosed evidence of advanced osteoarthritic degeneration, including a partial tear of the anterior cruciate ligament, strain of the medial collateral ligament, and medial and lateral meniscal tears, as well as bone marrow edema. (PX 5). Petitioner was referred by Dr. Watson to the orthopedists at Southland Bone & Joint, where he first saw Dr. Anil Kesani, who treated him mostly for his neck and low back with medication and physical therapy. Petitioner's last visit to Dr. Kesani was in March 2013. (PX 8).

With respect to Petitioner's right knee, Dr. Kesani referred him to his partner, Dr. Ram Aribindi. Dr. Aribindi evaluated Petitioner on April 17, 2013. On that day, Petitioner was noted to have some significant medial side tenderness in his knee along with mild swelling diffusely throughout. Dr. Aribindi administered a corticosteroid injection to the knee. After some physical therapy failed to provide much improvement, Dr. Aribindi recommended knee replacement surgery on July 29, 2013. Thereafter, Petitioner followed up with Dr. Aribindi on about a monthly basis up through February 2014. Dr. Aribindi consistently assessed a need for knee arthroplasty on those visits. Dr. Aribindi also noted in the treatment records his belief that Petitioner suffered an acute aggravation of his preexisting knee arthritis during the inmate assault. (PX 8). In March 2014, Petitioner sought a second opinion from Dr. Scott Rubinstein of Illinois Bone & Joint Institute. Dr. Rubenstein also recommended total knee replacement. (PX 10). Dr. Rubinstein would generate narrative reports on October 18, 2015 and May 6, 2016 wherein he opined that the traumatic incident of January 2013 significantly aggravated Petitioner's knee pain and brought about the need for knee replacement. (PX 11 and PX 14).

Regarding Petitioner's cervical and lumbar spine issues, Petitioner testified that after the accident, he had neck and low back pain and that this pain has persisted to the date of hearing. Dr. Watson did diagnose lumbar radiculopathy by April 2013. Petitioner underwent physical therapy from February 2013 through November 2013. (PX 9). Petitioner asserted that, as of the date of hearing, his low back pain was worse than his neck pain; he described the back condition as involving "pain, stiffness, weakness, less mobility." He also described pain travelling into both legs. (Tr. 42-43). As to future treatment for his

asserted spinal issues, he testified that his doctors wish to perform the knee replacement first before addressing the spine. (Tr. 48).

Petitioner has not returned to his correctional officer job since he was taken off-work by Dr. Watson in January 2013. Petitioner has continuously treated for pain at Health Benefits Pain Management, which treatment over the years has included narcotic medications, muscle relaxants, and injections. Since Dr. Watson's departure from that group, Petitioner has been seeing Dr. Randolph Chang there for all his current symptoms. Dr. Chang continues to keep Petitioner off-work for both his spine and right knee issues. (Tr. 46-48). At some point, the reasons for Petitioner's off-work status were supplemented with the fact of his continued narcotics use for pain. (Tr. 53-54; PX 3).

B. Pre-Accident Medical History including Chronic Knee Pain

Petitioner's medical history is notable for his longstanding, symptomatic osteoarthritis in the bilateral knees.[1] While in the Air Force, Petitioner had arthroscopy in his left knee in the 1980s. He had arthroscopy in his right knee in the mid-2000s. (Tr. 19-20). Regarding the progression of this condition, the records from Jesse Brown Veterans' Administration Medical Center, consisting of about 200 pages from August 2010 through late 2014, disclose his increasing pain. (PX 1). These records indicate that Petitioner had been obtaining narcotic medications there for his knee pain since before the work-related accident[2] *and* he had requested them at least once after the accident, even though by then he was being provided with Norco from Health Benefits Pain Management.[3]

Significant events noted in the VA records include:

- On November 2, 2010, Petitioner stated he wanted Hyalgan injections to his knees bilaterally and "would like to eventually consider knee replacement." It was also noted that he had previously been scheduled for x-rays of bilateral knees and for an orthopedic evaluation, but he missed his appointment. (PX 1 at 180).

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1 See, e.g. progress note dated September 8, 2011 of Jesse Brown Veterans' Administration Medical Center, indicating that Petitioner was requesting "ortho consult for his chronic knee pain that he has had for 15 years." (PX 1 at 164).

2 See, e.g., progress note indicating that Vicodin was "re-prescribed PRN for [bilateral knee pain] at night" on November 2, 2010. (PX 1 at 163). As well, a prescription for hydrocodone 5/acetaminophen was filled in July 2012. (PX 1 at 111). It appeared that Petitioner's habit was to go to the VA hospital's urgent care clinic for various ailments and for refills of prescription medication.

3 A progress note dated October 2, 2014 indicated that Petitioner presented to the urgent care clinic to request a parking placard and Vicodin. However, the VA's doctor would not fill out the parking placard as the doctor was unfamiliar with Petitioner (he needed to see his PCP) nor would the doctor "fill Vicodin as he gets this through his outside PCP and needs to stick with one provider for this kind of medication." (PX 1 at 92). By this time, Petitioner was already being prescribed Norco by Dr. Watson; Petitioner testified that since the accident he has been on Norco "most of the time." (Tr. 41).

- On October 3, 2011, Petitioner stated that both knees have been getting worse for 5 to10 years, that he rated the right knee pain consistently worse than the left, and on his worst day the pain was 9 out of 10 in both knees. It was noted that he had previously received Synvisc injections in the knees, about "6 times total," and that he had been wearing bilateral knee braces recently. It was further noted that he "explicitly states that he wishes to prolong knee replacement as long as possible." (PX 1 at 159).

- On November 14, November 21, and November 28, 2011, Petitioner underwent a total of 5 Hyalgan injections in bilateral knees at the VA's rheumatology clinic. (PX 1 at 141).

- On January 28, 2012, he requested a refill of Vicodin for knee pain ("takes Vicodin for his knee pain, ran out of his Rx recently"). (PX 1 at 136).

- On September 25, 2012, Petitioner requested a repeat treatment with the Hyalgan injections, which he "says helped his pain significantly." He was also taking Vicodin and Tylenol for his knee pain. (PX 1 at 109).

Regarding the September 25, 2012 visit – the last VA visit involving his knees prior to the accident – Petitioner testified that, while the repeat injections were approved, he did not undergo them, claiming at hearing that his knees "just felt better." (Tr. 24-25). When questioned about the mentions of knee replacement in November 2010 and October 2011, Petitioner stated that the doctors had not made any surgery prescription at those points in time, that they told him knee replacement could be had "later on," and that the discussions were more or less advisory. (Tr. 36-37)

II. EXPERT OPINIONS

Four experts -- Drs. Gregory Primus; Scott Rubenstein; Kern Singh; and Anthony Rinella -- submitted a total of six narrative reports in this matter (two each from Drs. Primus and Rubenstein regarding Petitioner's knee; one each from Drs. Singh and Rinella regarding Petitioner's spine).

A. Knee Opinions

1) Dr. Gregory Primus: Dr. Primus authored two independent medical evaluation reports dated about a year apart: May 1, 2014 and April 14, 2015. (RX 2 and RX 3). For the first report, Dr. Primus noted that he only had post-accident records for review -- Dr. Primus was not given the VA records -- and he issued provisionally favorable opinions for Petitioner:

> "If there are records that indicate that Mr. Riddick had had a symptomatic right knee related to his preexisting disease in the form of recent treatment within the timeframe leading up to his work-related incident, then the indication of the surgery would be solely related to his preexisting disease. If it is determined that Mr. Riddick had not sought any medical care related to his right knee, and there is no evidence to support that he was symptomatic with his right knee leading up to the work-related incident, then I would regard the incident as a progressive aggravation of a preexisting disease due to the work-related incident. In the absence of such records, it is my opinion that the work-related

> incident aggravation made an asymptomatic degenerative arthritic knee symptomatic, necessitating the need for treatment and the recommendation for total knee arthroplasty."

(RX 2 at 12). About a year later, having been given the VA records, Dr. Primus submitted another report, dated April 14, 2015. In this report, Dr. Primus noted the newly-obtained information and opined:

> "The diagnosis and cause of the current condition is right knee degenerative osteoarthritis, and is solely related to his pre-existing condition, and not related to his work-related injury back on January 10, 2013. We stated that he sustained an aggravation to his right knee given his extent of pre-existing disease and degree of symptoms that had not seemed to be resolved with time. With these new medical records, our opinion has changed. We would like to acknowledge, instead, that he sustained a temporary exacerbation of his pre-existing right knee arthritis in the form of a contusion. Contusions such as these should heal and stabilize by three to four months."

(RX 3 at 5). Dr. Primus indicated that Petitioner's knee arthritis was end-stage and he was a good candidate for joint replacement, but that Petitioner was at risk for non-optimal pain management afterwards, given that he had been using narcotics to treat his arthritis pain for several years now.

2) Dr. Scott Rubinstein (Illinois Bone & Joint Institute): In his first medical opinion letter, dated October 18, 2015, Dr. Rubinstein expressed his agreement with Dr. Aribindi's assessment that Petitioner had a need for arthroplasty that was "significantly accelerated by the traumatic incident that occurred in his workplace in January of 2013." Further, Dr. Rubinstein wrote:

> "My evaluation in the office showed relatively symmetric arthritis of both the right and left knee with near bone-on-bone evaluation [sic] of the medial compartments bilaterally... This would suggest relatively symmetric radiographic appearance of the patient's arthritis and a chronic nature of that. In view of the trauma and then acute worsening of only the right knee arthritis and not the left, the implication would be that he had a significant aggravation of his right knee pain directly related to the trauma as prior to this over many years, the arthritis and symptoms were relatively symmetric bilaterally."

(PX 11 at 2). Sometime after this first report, it was discovered that Dr. Rubenstein was given only half of the VA records to review (the original records were double-sided, but the set that was sent out to Dr. Rubenstein was copied on only one side). After presumably reviewing the full VA records -- and after he learned that Petitioner consistently rated his right knee pain to be worse than his left -- Dr. Rubinstein authored a supplemental report dated May 6, 2016, wherein he stated that his opinions remained unchanged:

> "Petitioner indicated he had previous arthritis of his knees bilaterally but that after the accident, the right knee became much worse following the trauma where the left knee stayed relatively the same, suggesting probable significant aggravation from the trauma and accelerated the need for knee arthroplasty beyond that of his equally involved left knee, which has remained relatively asymptomatic."

(PX 14).

B. Lumbar/ Cervical Spine Opinions

(1) Dr. Kern Singh (Midwest Orthopedics at Rush University Medical Center): On April 4, 2016, Dr. Singh performed an independent medical evaluation on Petitioner and authored a report. (RX 4). Dr. Singh's diagnoses were (1) lumbar muscular strain; and (2) degenerative disc disease at L4-L5 and L5-S1. As to causation, he wrote that Petitioner "sustained a soft tissue muscular strain to his lumbar spine which resolved approximately 4 weeks from the date of injury." Dr. Singh stated that Petitioner has preexisting degenerative disc disease at L4-5 and L5-S1, and also preexisting cervical neck pain as documented by VA physician Dr. D. Schaefer on March 30, 2012.

Dr. Singh opined that medical treatment to date has not been reasonable and necessary; instead, "it has been prolonged in nature" and that "4 weeks of physical therapy 3 times per week" would have been appropriate and reasonable. Finally, Petitioner had reached maximum medical improvement, needed no additional medical treatment, has a prognosis of "guarded," and could work full duty without restriction. Dr. Singh also noted that Petitioner had five positive Waddell findings (indicating a non-organic or psychological component to pain complaints). (RX 4 at 4).

(2) Dr. Anthony Rinella (Illinois Spine & Scoliosis Center): In response to Dr. Singh's report, Petitioner's counsel had Petitioner evaluated by Dr. Anthony Rinella on April 20, 2016. Dr. Rinella authored a narrative report. (PX 13). Dr. Rinella noted that Petitioner, in addition to the neck, low back, and right knee pain, reported "right lower extremity radicular symptoms" after the accident. Dr. Rinella wrote that "while I see no acute injuries on the imaging studies themselves that can be directly attributed to the injury itself, it is clear the preexisting foraminal stenosis at L4-5 and L5-S1 became symptomatic the day of the injury." Dr. Rinella ultimately opined that the following four conditions were causally related to the workplace incident: (1) cervical and thoracic strain (aggravation of preexisting degenerative disc disease); (2) lumbar strain (same); (3) right lower extremity radiculopathy (caused by work-related injury); and (4) right knee pain (aggravated by work-related injury). Dr. Rinella opined that total knee replacement was "in his best interest," but Petitioner's "right lower extremity radiculopathy does not seem to be significant enough to require a surgical intervention at this time."

III. DISCUSSION

It is clear to the Commission that, at the time of the accident, Petitioner's knee arthritis was very near end-stage, and the need for joint replacement was imminent. However, it is undisputed that Petitioner did suffer a violent work-related accident that day. Insofar as he has shown that the accident aggravated his condition so as to result in a more immediate need for surgery, the Arbitrator's finding of causal connection as to the right knee is affirmed. On this front, providing critical corroborative evidence for Petitioner at the hearing was fellow correctional officer, Matthew Petty, who witnessed the assault and its aftermath. Mr. Petty testified that he witnessed the inmates assault Petitioner and that, after the skirmish was over, Petitioner was in "quite a bit of pain. He was limping. He pulled up his pants leg to look at his leg and it was swollen." (Tr. 14-15). Mr. Petty also testified that prior to that day, Petitioner's gait was normal. (Tr. 15).

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Regarding the remaining asserted ill-being in the spine, however, Petitioner's evidence is thin. The Arbitrator based her favorable finding of causal connection on the records of his treating physicians Drs. Watson and Kesani, indicating onset of neck and back pain after the accident. The Arbitrator wrote that, other than causal connection for the current neck and low back conditions, she made "no further findings with regard to those conditions as the request for 8(a) relief in the instant hearing pertained only to Petitioner's right knee." Regarding the injury suffered by Petitioner, Commission finds the opinion of Dr. Singh persuasive, finds that the accident caused muscular strains in the back and neck that have since resolved, and that current ill-being to the spine as may be extant at the time of the hearing has not been proven to be causally related to the accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on July 21, 2016, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $ 902.31 per week for 178 and 1/7 weeks, for the period commencing 1/11/2013 to 6/10/2016, under § 8(b) of the Act. Respondent shall have credit for all amounts paid to or on behalf of Petitioner on account of said accidental injury.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of medical benefits is modified. Respondent shall pay only the reasonable and necessary medical expenses for treatment -- incurred and prospective as recommended -- to the right knee only, under § 8(a) of the Act and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner interest under §19(n) of the Act, if any.

DATED: DEC 29 2017

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Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

RIDDICK, GREGORY
Employee/Petitioner

Case# **13WC003682**

ST OF IL DJJ IYC JOLIET
Employer/Respondent

17IWCC0844

On 7/21/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0924 BLOCK, KLUKAS & MANZELLA PC
MICHAEL D BLOCK
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5855 ASSISTANT ATTORNEY GENERAL
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BUREAU OF RISK MANAGEMENT
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0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

JUL 21 2016

Rachel A. Piaia
RACHEL A. PIAIA, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(A)

GREGORY RIDDICK
Employee/Petitioner

v.

STATE OF IL DJJ IYC JOLIET
Employer/Respondent

Case # 13 WC 03682

Consolidated cases: _____

17IWCC0844

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **CAROLYN DOHERTY**, Arbitrator of the Commission, in the city of **NEW LENOX**, on **6/10/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. xx What temporary benefits are in dispute?
☐ TPD ☐ Maintenance xx TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **01/10/2013**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$70,380.00**; the average weekly wage was **$1,353.46**.

On the date of accident, Petitioner was **53** years of age, ***married*** with **1** dependent child.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$66,384.14** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of **$66,384.14**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of his causally related medical conditions incurred pursuant to Sections 8 and 8.2 of the Act. PX 16-24. Respondent shall receive a credit for amounts paid and shall hold Petitioner harmless for payments made by the group carrier, if any.

Respondent shall pay Petitioner temporary total disability benefits of $902.31/week for 178 1/7 weeks, commencing 01/11/2013 through 06/10/2016, as provided in Section 8(b) of the Act. Respondent shall receive the credit for amounts paid as specified above.

Respondent shall authorize and pay for the recommended surgery and its attendant care pursuant to Sections 8 and 8.2 of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Carolyn M. Wheeler

Signature of Arbitrator

7/20/16
Date

JUL 21 2016

FINDINGS OF FACT

At trial, Petitioner testified that on January 10, 2013, he was a 53 year old correctional officer at the Illinois Youth Center in Joliet. The parties stipulated that on 1/10/13 Petitioner sustained a work related accident when he was assaulted by two inmates. Arb Ex 1. Petitioner testified that on 1/10/13, he was at work moving the lunch line when he was struck by an inmate and landed on the ground. A second inmate then jumped on Petitioner. Petitioner testified that during the altercation he struck his right knee twice on the concrete ground. Petitioner also testified that in addition to his right knee, Petitioner sustained immediate pain in his lower back and neck area.

At trial, Petitioner's co-worker, Matthew Petty, currently a Sergeant at Sheridan Correctional Center, testified that he observed a juvenile punch Petitioner in the face and observed a second inmate attack Petitioner from behind. Mr. Petty testified that the men fell to the hard floor surface with Petitioner on the bottom. After the assault, Mr. Petty noticed Petitioner attending to his right knee which appeared swollen. Prior to the incident, Sergeant Petty worked with Petitioner frequently and testified that he never observed Petitioner have any problems while performing his job duties including responding to code calls.

Petitioner testified that in the mid 1980's he had a left knee arthroscopy and a right knee arthroscopy in the mid 2000's. Between 2010 and 2012, Petitioner treated intermittently at the VA hospital for pain in both knees. An entry dated November 2, 2010, indicates that Petitioner presented to urgent care requesting evaluation of both knees and that he had a history of long standing osteoarthritis in both knees. The notes further indicate that Petitioner "wants injections to his knees bilat and would like to eventually consider knee replacement." PX 1, p. 180. Petitioner testified that he treated between 2010 and 2012 for sporadic knee pain which spiked on occasion but would always subside. The VA Hospital records from October 3, 2011 indicate a history of "... bilateral knee osteoarthritis... presents for referral for evaluation of chronic knee pain. Patient notes knees have been getting "worse" for 5-10 years. Patient rates pain as 5/10 in both knees right know. Patient states right knee pain consistently worse than left. Rates pain 9/10 on his worse day in both knees. Pain is the worst in the evening, after moving around all day. Pain stays in knees. Patient denies swelling or redness of knees. Notes pain is "achy" quality. Patient notes knees crack when walking up and down stairs. ...Patient has gotten CSI/Synvisc injections in the past... patient wearing bilateral knee braces recently which helps. Patient explicitly states that he wishes to prolong knee replacement as long as possible." PX 1, p. 160.

Petitioner underwent a series of injections to both knees in October and November of 2011 at the VA rheumatology department which Petitioner testified helped his bilateral knee pain significantly such that he was able to remove the knee braces. Petitioner was prescribed re-fill pain medication for his knee pain in January 2012. On March 3, 2012 he was seen at the VA complaining of neck pain and muscles stiffness but not knee pain. PX 1, p. 128. On September 25 2012, Petitioner returned to the VA requesting more bilateral knee injections for chronic bilateral knee pain. Petitioner reported that his last set of injections in November 2011 helped his pain "significantly" so he was again requesting the injections. PX 1, p. 109. However, Petitioner testified that although given a referral back to rheumatology for more injections, he chose not to proceed with them as his knee pain subsided.

Based on those records, the last actual treatment Petitioner had for his knees was the hyalgen injections in November 2011, over a year before the accident, although he was taking medications and using home remedies through September 2012 for chronic bilateral knee pain. Petitioner testified that between 2011 and the day of the accident on 1/10/13, he worked full duty with no time off for any knee problems. Petitioner testified that his

duties required him to be on his feet all day and handle students and that he was able to perform his full duties prior the accident of 1/10/13 without problem. Petitioner testified that prior to the 1/10/13 accident, no physician told him a total right knee replacement surgery was required.

Immediately following the incident, Petitioner was driven by a facility van to Presence St. Joseph Hospital in Joliet where they treated his right knee, his neck and his head (Pet's. Ex. 2). Petitioner testified that the onset of his low back pain was the following morning.

On 1/17/13, Petitioner sought treatment from Dr. Artelio Watson at Health Benefits Pain Management Services (Pet's. Ex. 3). His complaints were of the neck and head, low back and right knee, for which Dr. Watson prescribed medication and an MRI of the right knee and lumbar spine (Id. @ 2-3). Petitioner stated that he had prior right knee arthroscopic surgery but that he had no significant right knee pain until he landed on his right knee during the assault. PX 3, p. 2. The MRI of the right knee, performed January 21, 2013, showed marked ostheoarthritic changes in the right knee, but also bone marrow edema and mild to moderate knee joint effusion, as well a partial anterior fusion ligament tear, grade III tears of the interior horn of the lateral meniscus and posterior horn of the medial meniscus, mild intrasubstance degeneration of the posterior horn of the lateral meniscus, minimal suprapatellar bursitis, moderate to severe size baker's cyst, a grade 2 sprain of the medial collateral ligament, mild deep infrapatellar bursitis and soft tissue edema of the anterior, medial and lateral aspect of the knee (Id. @ p. 2). X-rays and MRI of the lumbar spine showed degenerative changes, and stenosis at L3 thru S1 with disc bulges, some osteophytes and at two lumbar levels hypertrophy of the facet joints.

Petitioner was referred by Dr. Watson to Southland Bone & Joint Institute in Olympia Fields, where he first saw Dr. Anil Kesani who treated him mostly for his neck and low back with medication and physical therapy. Dr. Kesani referred the Petitioner to his partner, Dr. Ram Aribindi with respect to his knee. Petitioner first saw Dr. Arbinidi, April 17, 2013, with complaints since an injury at work mostly over the medial and anterior aspects of the knee, pain with weight bearing and ambulation, with stairs as well as getting up from a chair, as well as some swelling and some grinding sensation on motion. Petitioner denied locking of the knee but reported buckling of the knee. He further reported no pain improvement with NSAIDS. PX 8, p. 14. Dr. Aribindi noted that the MRI revealed medial and lateral meniscal tears as well as some arthritic changes about the knee. He diagnosed right knee pain with medial and lateral meniscal tears and underlying osteoarthritis. Dr. Aribindi gave him a steroid injection and referred him to physical therapy (Id. @ p. 13 – 14). He also noted that Petitioner could perform light duty with no kneeling or squatting. PX 8, p. 14.

Petitioner continued with physical therapy for his neck, back and right knee from February 21, 2013, through November 21, 2013. PX 9. Dr. Aribindi and Watson restricted Petitioner from full duties. (Pet's. Ex. 8, p. 22). After having prescribed therapy on two occasions, on July 29, 2013, Dr. Aribindi prescribed a right knee replacement, noting he has medial and lateral meniscal tears as well as underlying arthritis of the knee. Petitioner was continued on light duty with limited walking (Id. @ 26).

Dr. Watson sent Petitioner for a second opinion regarding right knee total replacement from an orthopedic surgeon with Illinois Bone & Joint Institute, Dr. Scott Rubenstein (Pet's Exs.: 10 and 11) on March 5, 2014. In his office note of March 5th Dr. Rubenstein noted that on X-ray Petitioner has fully advanced arthritis present in both knees to a relatively symmetric basis, that he was getting along pretty well on his left, uninjured knee, and his right knee is significantly limiting, with Petitioner walking with an antalgic right limp (Pet's. Ex. 10, p. 11). He felt Petitioner had a significant knee injury that led him to no longer be able to function at the level needed for his work place, having been treated with medications and injections, all without adequate relief. He felt that the need for surgery was directly caused by the workplace injury that significantly aggravated his arthritis,

noting that the left knee, which was not injured in the accident, was still relatively asymptomatic. He also limited Petitioner from work (Id, @ 11 – 12).

Petitioner was sent by Respondent for a Section 12 exam with Dr. Primus an orthopedic surgeon on April 18, 2014. Petitioner reported his past medical history significant for bilateral knee arthroscopy and injections and therapy. He also referred to degenerative disc disease, with epidural injections for radicular symptoms. As to the spine, he testified he was referring to the treatment by Dr. Watson following the accident. His current symptoms included a decreased ability to walk, with persistent pain. The doctor noted the antalgic gait on his knee exam (Id p. 2). Dr. Primus reviewed Petitioner's medical records dated after the accident of January 2013. No records prior to the accident were reviewed. RX 2. He also noted the MRI of 11 days following the episode showed anterior soft tissue swelling which could be attributable to acute bruises along with right knee bone on bone OA changes with degenerative meniscus tears, chondral wear, stress reactive bone changes with increased signal and associated bone cysts and a large posterior Baker's cyst. Id @ p. 3). Dr. Primus' opinion was that Petitioner had extensive pre-existing and degenerative joint disease which was the cause of his of his current condition. Dr. Primus further noted "We do have medical records that his pre-existing condition was aggravated during an altercation at work on January 10, 2013. In the absence of medical records documenting him seeking treatment in the time frame leading up to the January 10, 2013 work incident it is my opinion that the altercation . . . aggravated his underlying arthritis and therefore the current symptoms pertaining to the knee are due to the incident in question." He also noted the objective findings supported the subjective complaints (Id. @ p. 11) and that the MRI after the accident "revealed anterior soft tissue swelling which most likely was attributed to an acute knee contusion related to the work related incident."

Dr. Primus further stated that the recommended right knee replacement was "not necessary but can be recommended in a patient that continues to be very symptomatic with progressing knee pain and dysfunction. … in terms of direct causation, the indication to perform a total knee arthroplasty would be based on his extensive preexisting degenerative joint disease. If there are records that indicate that Mr. Riddick had had a symptomatic right knee related to his preexisting disease in the form of recent treatment within the timeframe leading up to his work related incident then the indication of the surgery would be solely related to his pre-existing disease. If it is determined that MR. Riddick had not sought any medical care related to his right knee, and there's is no evidence to support that he was symptomatic with his right knee leading up to the work related incident then I would regard the incident as a progressive aggravation of a pre-existing disease to the work related incident. In the absence of such records, it is my opinion that the work related incident aggravation made an asymptomatic degenerative arthritic knee symptomatic, necessitating the need for treatment and the recommendation for total knee arthroplasty."

Finally, Dr. Primus indicated that "… Mr. Riddick's knee symptoms have stabilized as it pertains to the work-related incident. I believe he sustained a knee bruise, which was noted on the MRI scan with increased soft issue swelling and edema. It does not appear that there was an acute change in his anatomy at the time of the injury that required healing. Given the fact that he has had this stable symptomatic degenerative knee, I do believe his symptoms have reached a baseline and are stabilized and he would be at MMI if he does not pursue a total knee replacement. If he elects to undergo total knee replacement, and this is purely and elective procedure, MMI can be predicted to occur by six months… if he elects to not undergo replacement surgery, he is considered at MMI, and no further treatment would be necessary at this time as it pertains to the work related aggravation." (Id. @ p.12). Finally, he agreed that Petitioner's work activities would be limited to the sedentary level (Id. @ 13).

One year later on April 14, 2015, a record review was performed by Dr. Primus, generating a supplemental report of April 14, 2015. (Resp. Ex. 3). Dr. Primus reviewed Petitioner's VA medical records from 2011

indicating the prior injections to his right knee and one record from January 2012. He wrote, "based on the new medical records provided, the diagnosis and cause of the current condition is right knee degenerative osteoarthritis, and is solely related to his pre-existing condition and is not related to his work related injury back on January 10, 2013. We stated that he sustained an aggravation to his right knee given his extent of pre-existing disease and degree of symptoms that had not seemed to be resolved with time. With these new medical records, our opinion has changed. We would like to acknowledge instead that he sustained a temporary exacerbation of his preexisting right knee arthritis in the form of a contusion. Contusions such as these should heal and stabilize by three to four months. His persistent pain, requirement for narcotics, injections and activity restrictions were very similar to his status pre dating the work injury as detailed in the records dating back to 2011. With these new findings I do not believe his current condition is any way related to the specific work related altercation that took place back on January 10, 2013." RX 3.

Following that report, Dr. Rubinstein generated a report of October 18, 2015. He opined that prior to the accident Petitioner had relatively symmetric arthritis at both the right and left knee with symmetric appearance of chronic arthritis on imaging. He noted that in view of the trauma and then acute worsening of only the right knee arthritis and not the left, the implication would be that he had a significant aggravation of his right knee pain directly related to the trauma, as prior to this for many years the arthritis and symptoms were relatively symmetric bilaterally (Pet's. Ex. 11, p. 2). The records from the Veteran's Administration clearly show only bilateral treatment as referred to by Dr. Rubenstein. Dr. Rubenstein then assessed that he agreed with Dr. Aribindi that the knee arthroplasty was the logical next treatment, as he has had a previous arthroscopy and that is not likely to adequately resolve the symptoms. He further agreed with Dr. Aribindi's opinions the need for arthroplasty was significantly accelerated by the traumatic incident that occurred in the work place in January of 2013. Dr. Rubenstein's opinion is that if he had not had the trauma to the right knee, he would be continuing to have symptoms similar to the left knee and would not currently require a knee replacement.

Dr. Rubenstein also reviewed Dr. Primus' supplemental report, which noted, as confirmed by the VA records themselves, there was no treatment rendered between January 2012, when he had completion of viscosupplementation (on page 136 of Exhibit 1) and January of 2013 when he had the injury at work. He could not understand why Dr. Primus had changed his mind, but disagreed with the "newly echoed opinion" again noting that the left knee would have been expected to progress the same as the right in the absence of a specific trauma (Id @ p. 3).

Regarding the spine, Respondent had Petitioner examined by Dr. Kern Singh on April 4, 2016. Dr. Singh was a spine surgeon and the exam was limited to the lumbar spine. He did note in his record review that the only complaints to the neck were the one referred to in cross-examination of Petitioner of March 30, 2012, with no other complaints either before, nor any treatment or follow up other than medication. No prior lumbar treatment was noted whatsoever. Dr. Singh's diagnosis was lumbar muscular strain and degenerative disc disease at L4 – L5 and L5 –S1, and he opined on causality that Petitioner sustained a soft tissue muscular strain to the lumbar spine which resolved approximately 4 weeks from the date of injury. RX 4.

Petitioner thereafter on April 20, 2016, underwent his own Section 12 exam with Dr. Rinella. Dr. Rinella opined that Petitioner's neck, low back and right lower extremity radiculopathy are causally related to the accident of 1/10/13. He further opined that the lumbar injury aggravated the prior existing degenerative disc disease in his low back based on the lack of low back symptoms at the time of the accident and the development of low back symptoms immediately after the accident. (Pet's. Ex. 13, p. 3). He felt the low back was not significant enough to require surgical intervention at this time, and that the priority would be to have the total knee replacement on the right before addressing the spine. PX 13.

Petitioner testified that he has been undergoing pain management for his right knee for three years while waiting for the recommended surgery. He also continues to treat for his low back with Dr. Chang for his low back (Dr. Watson retired). He has not been released to full duty work at any point. He testified to lost mobility, weakness and give way pain in the right knee. His right knee pain is constant, shooting or aching and he uses a steroid pain cream for pain. He is also taking Norco and is unable to work for Respondent while on Norco. He also takes Lyrica and Celebrex for his back and knee pain. He testified to continued neck pain and low back pain, stiffness and weakness. He testified that the low back injections he received did not alleviate the pain and PT for his neck and low back helped minimally. Walking and bending activities cause pain to Petitioner's knee and low back.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law.

F. Is Petitioner's current condition of ill-being causally related to the injury? K. Is Petitioner entitled to any prospective medical care?

In this case, there is no dispute that Petitioner sustained a work-related injury on January 10, 2013. ARB EX 1. The issue at trial is whether Petitioner's current condition of ill-being in his neck, low back and right knee are casually related to the January 2013 accident and whether the recommended procedure at issue (right knee total replacement) is casually related to work incident.

Based upon a preponderance of the credible evidence introduced at trial, the Arbitrator finds causal connection for Petitioner's current right knee condition and for the recommended right knee replacement surgery. In accordance with the VA medical records preceding the undisputed accident of 1/10/13, Petitioner credibly testified to longstanding chronic bilateral knee pain. The records support that Petitioner had bilateral pre-existing degenerative arthritis, which is not lost on the Arbitrator. However, the Arbitrator further notes that the records indicate Petitioner's last active treatment to the right knee at issue was in November 2011, over one year before the 1/10/13 accident. Petitioner credibly testified that he was able to work full duty after the successful series of injections in November 2011 and January 2013 without problem from his right knee.

Immediately after the undisputed accident wherein Petitioner struck his right knee twice on a hard surface, Petitioner had immediate and continuous right knee pain and symptoms which did not resolve with conservative care. Petitioner was now taken off work. The MRI done 11 days following the incident showed acute and chronic findings, and it was Dr. Aribindi's opinion that he had new medial meniscal tears as well. Although both knees were arthritic pre accident, in contrast to his right knee, Petitioner has not experienced any increased symptoms in his arthritic left knee despite relying more on his left knee due to his antalgic gait post accident. Lastly, the Arbitrator notes that the two references to right knee replacement contained in the VA record from November 2010 and October 2011 did not indicate that the procedure was either recommended, prescribed or imminent at that time, one year before the accident at issue. However, shortly after the accident of 1/10/13, based on the failure of conservative measures that had previously worked, Petitioner's treating physicians prescribed the right knee replacement surgery following the acceleration of his condition by the 1/10/13 accident. Accordingly, the record in its entirety supports a finding of causal connection for Petitioner's current right knee condition based on a preponderance of the credible evidence.

Based on the finding on the issue of causal connection for Petitioner's current right knee condition, the Arbitrator further finds that Petitioner is entitled to the right knee total knee replacement recommended by Dr.

Rubenstein pursuant to Section 8(a) of the Act. The Arbitrator finds that Respondent shall authorize and pay for the recommended surgery and the attendant care pursuant to Sections 8 and 8.2 of the Act.

With respect to the cervical and lumbar spine, the only evidence of a prior condition was one complaint in the Veteran's Administration records of a week's pain to the neck, with the records revealing no complaints of pain to the lumbar spine. The lumbar spine imaging after the accident shows degenerative changes which pre-existed the accident of 1/10/13. Petitioner credibly testified that his cervical and low back symptoms started immediately after the undisputed accident. The Arbitrator places greater weight on the treating physicians, Drs. Watson and Kesani in finding causal connection for Petitioner's current cervical and lumbar complaints and the accident of 1/10/13 based on the aggravation of previously asymptomatic cervical and lumbar degenerative conditions. Other than causal connection for the current neck and low back conditions, the Arbitrator makes no further findings with regard to those conditions as the request for 8(a) relief in the instant hearing pertained only to Petitioner's right knee.

J. Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

Based on the Arbitrator's findings on the issue of causal connection, the Arbitrator further finds that Respondent shall pay Petitioner the reasonable, necessary and causally related medical expenses incurred in the care and treatment of his causally related cervical, lumbar and right knee conditions pursuant to Section 8 and 8.2 of the Act. PX 16-24. Respondent shall receive credit for amounts paid and shall hold Petitioner harmless for payments made by the group carrier, if any.

L. What temporary benefits are in dispute? TTD

Petitioner remained off work or unaccomodated for the period of 178-1/7 weeks commencing 1/11/13 through 6/10/16 date of hearing. Based on the findings on the issue of causal connection, the Arbitrator further finds that Petitioner was temporarily and totally disabled for a period of 178-1/7 weeks. Respondent has paid TTD for a portion of that period and is entitled to credit for the agreed amount paid of $66,384.14. ARB EX 1. To the extent Respondent claims an additional credit of $25,651.36 representing payment of a non workers' compensation related benefit under the Act, that credit is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Larry Wells,
Petitioner,

17IWCC0845

vs.

NO: 07 WC 1130

Big Ridge Inc a/k/a Peabody Energy Inc,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of occupational disease, evidentiary rulings, 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 July 22, 2016, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: DEC 29 2017
O
DLS/rm
046

Deborah L. Simpson
Deborah L. Simpson

Stephen J. Mathis
Stephen J. Mathis

DISSENT

I respectfully dissent from the majority decision and would reverse the Arbitrator's decision to find accident and causal connection. Petitioner worked for 17 years in the coal mining industry, the majority of which he worked underground. Petitioner left the mining

industry in 1998 but he returned November 9, 2003 at the invitation of one of his former mining bosses. Petitioner returned to mining in the job classification of roof bolter and was exposed to coal dust for one day before deciding that he no longer wanted to work in mining. Petitioner testified that he first started noticing breathing difficulty while working in the mine and the problems worsened around 2004. Petitioner stated that from the first time he noticed breathing problems to the time he left the mine his breathing problems did not go away. Petitioner stated that since leaving the mine for good his breathing problems have remained about the same (Petitioner testified to being able to walk about a mile on level ground without becoming short of breath).

Dr. James Alexander performed pre-employment physicals for Respondent. Although he testified that Petitioner's chest and lungs were perfectly normal, Dr. Alexander also stated that Petitioner's x-rays showed hyperinflation as well as flattening of the diaphragms which is consistent with emphysema. Dr. Alexander further testified that a person can have damage to the lungs but still have pulmonary function studies within normal range.

Petitioner was examined by Dr. Saeed Khan, board certified in internal medicine and the director of the cardiopulmonary lab at Franklin County Hospital, who also reviewed the chest x-ray reports of Dr. Michael Alexander as well as Petitioner's chest x-rays. Dr. Khan diagnosed Petitioner with simple coal worker's pneumoconiosis (CWP) and moderate pulmonary emphysema. Dr. Khan related Petitioner's CWP condition to his 17 years of working underground in the coal mine. Dr. Khan related Petitioner's condition of emphysema to a combination of Petitioner's exposure to coal dust as well as his 20 year history of smoking.

At Petitioner's request, b-reader Dr. Henry Smith reviewed Petitioner's chest x-ray dated October 20, 2006. Dr. Smith found opacities bilaterally in the upper, mid and lower zones of the lungs and diagnosed Petitioner with simple coal-worker's pneumoconiosis. At Petitioner's request, b-reader/radiologist, Dr. Michael Alexander reviewed Petitioner's chest x-ray dated December 30, 2006. Dr. Alexander also found opacities bilaterally and diagnosed coal worker's pneumoconiosis.

At Respondent's request, Petitioner was examined by b-reader Dr. Jeffrey Selby. Dr. Selby reviewed Petitioner's x-rays and testified that he observed abnormalities that could be pneumoconiosis, however, he opined the x-rays were negative for CWP. Dr. Selby testified that the abnormalities on the x-rays were attributable to Petitioner's smoking and not to his 17 year history of coal mine exposure, although he did acknowledge that a person can have abnormalities on their x-rays attributable to smoking and CWP at the same time.

Dr. Khan as well as b-readers Dr. Henry Smith and Dr. Michael Alexander unequivocally opined the presence of CWP in Petitioner's lungs attributable to his coal mine exposure. Respondent's examiner, Dr. Selby, acknowledged that he did observe evidence of CWP on Petitioner's x-rays, however, attributed it Petitioner's history of smoking. Dr. Selby's opinion is equivocal at best given his admission that a person can have abnormalities on their chest x-rays from smoking and CWP at the same time. Furthermore, with all four physicians acknowledging the presence of abnormalities on Petitioner's x-rays, Dr. Selby's testimony attributing the abnormalities to smoking is much less persuasive in light of the fact that exposure to coal dust need only be a cause of Petitioner's condition. Dr. Selby's testimony did not provide a convincing basis as to how smoking alone caused Petitioner's condition.

17IWCC0845

The second reason given by the Arbitrator for denying Petitioner's claim is the history given by the Petitioner to Dr. Khan. Dr. Khan noted that the Petitioner was experiencing shortness of breath 4 years prior to leaving the coal mine in November of 2003. Petitioner testified at hearing that he began experiencing shortness of breath in 2004 or 2005. Additionally, Dr. Kahn noted that Petitioner could only walk 4-5 blocks before having to stop because of shortness of breath while at hearing Petitioner testified that he could walk about a mile before having to stop. The Arbitrator's reliance on these inconsistencies is misplaced. Whether Petitioner is experiencing shortness of breath is irrelevant to the question of the existence of CWP. Four doctors identified opacities in Petitioner's lungs (3 of whom diagnosed CWP). The overwhelming majority of doctors involved in this claim diagnosed CWP and opined a causal connection to Petitioner's exposure as an underground coal miner. Any inconsistencies as to the onset and extent of the symptomology (shortness of breath) in this claim has no relevance to a decision on the existence of CWP and is an insufficient basis to deny the claim

The Arbitrator's denial of Petitioner's claim on the basis of Dr. Selby's testimony and the history given to Dr. Khan is clearly erroneous. Accordingly, I would reverse the decision of the majority and find accident and causal connection and award benefits of 12.5% of a person as a whole.

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0845

WELLS, LARRY
Employee/Petitioner

Case# **07WC001130**

BIG RIDGE INC A/K/A PEABODY ENERGY INC
Employer/Respondent

On 7/22/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0755 CULLEY & WISSORE
KIRK CAPONI
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

1433 MVP LAW FIRM
STEPHEN A McMANUS
515 N 7TH ST
ST LOUIS, MO 63101

17IWCC0845

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Larry Wells
Employee/Petitioner

v.

Big Ridge Inc. a/k/a Peabody Energy, Inc.
Employer/Respondent

Case # **07** WC **1130**

Consolidated cases: **n/a**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **May 12, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Statute of Limitations, Statute of Repose**

FINDINGS

On **November 9, 2003**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

Petitioner's current condition of ill-being ***is not*** causally related to the accident.

In the year preceding the injury, per stipulation of the parties, Petitioner's average weekly wage was **$881.28**.

On the date of accident, Petitioner was **45** years of age, ***married*** with **0** dependent children.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

Respondent is entitled to a credit of $0 under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that he suffers from coal workers' pneumoconiosis and/or emphysema that arose out of and in the course of the exposures of his coal mine employment, and that his current condition of ill-being is casually related to his employment. All benefits are denied; the remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Melinda M. Rose Sullivan

Signature of Arbitrator

7/19/16

Date

JUL 22 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Larry Wells
Employee/Petitioner

Case # **07** WC **1130**

v.

Consolidated cases: **N/A**

Big Ridge Inc. a/k/a Peabody Energy, Inc.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he currently lives in University Place, Washington, and that he used to live in the Marion area. He testified that he is currently 58 years of age, is married and has no dependent children. He testified that he went to high school at Johnston City High School in Johnston City, and that this was the end of his education. He testified that he worked in the coal mines for about 17 years in total, and that almost all of them were underground. He testified that in addition to coal dust, he regularly breathed and was exposed to silica dust, roof bolting glue fumes and diesel fumes.

Petitioner testified that he worked his last day in the coal mine on November 9, 2003 at Respondent. He testified that his job classification on that day was that of a roof bolter. He agreed that he was exposed to coal mine dust on that day and that this was the only day he worked at that particular mine. He testified that he decided to go back into the mines because it was a steady paycheck, but that after getting down into the Big Ridge mine he decided that he was done. He testified that this particular mine had 4-4.5 foot ceilings.

Petitioner testified that he left Kerr-McGee in 1998 and was "lured back in" by one of his old bosses that worked at Respondent. He testified that after working the day, he told his boss that he was going to do something else. He testified that some of the reasons he left the mine included the low coal and the dust, as well as the diesel fumes. He denied telling Respondent the reasons why he decided to leave the mine. He testified that since he left the mine he has been a carpenter, a superintendent and has worked in quality control, and is now a site safety health officer for the federal government. He agreed that he has, for the most part, worked steadily since he left the mine.

Petitioner testified that he started mining in 1979 for Old Ben 27 and worked there until 1982. He testified that he was exposed to coal dust and rock dust. He testified that he also did roof bolting as well, which included drilling holes in the ceiling and putting bolts in to help support the ceiling. He testified that the glue pins contained an epoxy resin, and that when they broke they gave off an odor. He testified that he also ran a buggy, ran a miner, and did belt and power moves. He testified that he also worked at Kerr-McGee in 1985 and hired in as Miner 4, and that in between he worked in construction. He testified that at Kerr-McGee, his job duties included being a buggy runner, miner operator, roof bolter and a working foreman. He testified that he worked at Kerr-McGee until 1998, and that he did not work again in the mining industry until 2003 when he worked for one day for Respondent.

Petitioner testified that he first noticed breathing difficulties in 2004 or 2005, and that he noticed shortness of breath and was not able to do things like he used to. When asked if he noticed any breathing problems when he was back in the mine, Petitioner responded that in the mine he had a little trouble breathing depending on how dusty it was, how good the air was that was brought in and depending on how much diesel equipment was running. He testified that from the time he experienced difficulties in the mine up until when he completely left the mining industry, his breathing difficulties had stayed the same or gotten worse and did not go away. He then testified that his breathing has been the same since he left the mine.

Petitioner testified that he can walk about a mile on level ground at a normal pace before becoming short of breath, and he thought that he could climb 1-2 flights of stairs. He denied currently taking any breathing medications, and he further denied that his breathing affected his daily living. He agreed that he was a smoker from his 20's up until 2012 at which point he quit, and that he would typically smoke a pack a day. He testified that he is currently taking medication for water retention in his legs, and that he has a heart murmur for which he takes no medications.

On cross examination, Petitioner agreed that when he started at Respondent, he had to undergo a pre-employment physical. He denied recalling having undergone the examination with Dr. Alexander, and further denied having undergone a chest x-ray at that time. He agreed that he recalled having been sent to Harrisburg Hospital for a physical ability test, but did not recall filling out a questionnaire. He agreed that the information that he provided to Dr. Alexander and Harrisburg Hospital at that time was truthful and accurate.

On cross examination, Petitioner denied recalling having indicated that as of the date of the examination on October 6, 2003 that he had not had any episodes of bronchitis, shortness of breath, persistent cough, breathing difficulty or morning cough. He agreed that he recalled having been put on a treadmill, and that they were surprised by how fit he was.

On cross examination, Petitioner agreed that his first day at Respondent was actually November 7, 2003, and that he did eight hours of training at a college classroom. He agreed that on the second day, *i.e.*, November 8, 2003, the first four hours he was at the mine in the administrative office in a classroom and that during the second four hours he was in the mine doing orientation. He agreed that on November 9th, he worked nine hours doing roof bolting after which he decided to quit.

On cross examination when shown the Employee Information Change Form, Petitioner agreed that his writing appeared on the document. He agreed that it noted a voluntary resignation, and that he wrote in "family" on the form. He testified that he and his wife were separated at the time, so that may have been the reason that he indicated "family."

On cross examination, Petitioner testified that his family physician back in the 1990's and early 2000's was Dr. Javed in Johnston City. When questioned about Petitioner's Exhibit 5 regarding the office visit of December 23, 2008, Petitioner agreed that it was noted that there was no indication of fatigue, headaches, dizziness, chest pain or shortness of breath, and that it indicated that he used tobacco. He agreed that he tried to stop smoking on several occasions.

On cross examination when shown the medical records for the date of service of June 19, 2008, Petitioner agreed that it was noted that he was able to walk eight flights of stairs without shortness of breath or chest pain. He agreed that on March 7, 2007, it was noted that he was smoking 1-1.5 packs per day. He agreed that his primary care physician in the 1990's and early 2000's never diagnosed him with coal worker's pneumoconiosis.

On cross examination, Petitioner agreed that he graduated from high school in 1976 and went to work as a carpenter in 1977. He agreed that from 1979 to 1983 he worked at Old Ben No. 27, and that from 1983 to 1986 he did carpentry work which caused him to work both outside and inside. He agreed that from 1986 to 1998 he worked at Kerr-McGee, and that from 1998 until he went to work for Respondent in November of 2003, he did construction work.

On cross examination, Petitioner agreed that in addition to his smoking history, his father was a smoker. He testified that he left home at age 13. When asked whether he told Dr. Khan about all of his medical problems, Petitioner responded that he did not recall what Dr. Khan asked but knew he was sent there for a black lung x-ray. When asked whether he told Dr. Khan that he worked underground for Respondent for only one day, Petitioner responded that he did not and that it might have been a day and a half because he had the ½ day orientation underground. He agreed that he did not mention to anyone at Respondent that he felt he had black lung, coal worker's pneumoconiosis or any type of breathing difficulty or respiratory condition at any point after he last worked there, and that the first notification that Respondent would have had was when they received the Application for Adjustment of Claim.

On cross examination, Petitioner agreed that in the same year after he left Respondent he returned to carpentry work. He agreed that in 2007 he was working as a building superintendent in St. Louis, after which he moved to Washington which was where the next job was to which he was assigned for Korte Construction. He denied that when he worked in the construction field as a superintendent that he was doing carpentry work, and testified that he usually assigned people to do tasks. He agreed that when he first noticed his breathing difficulties, they would come and go. He agreed that since 2003 when he finished his day at Respondent up to the present time, his breathing conditions have been essentially the same. He agreed that from November 10, 2003 to the time of arbitration, he had not been in a coal mine again. He further agreed that from approximately November of 2003 until 2012, he continued to smoke.

On cross examination, Petitioner agreed that when he was asked if he had any problems going up stairs, he typically did not go anywhere that had more than two flights of stairs. He testified that he had no idea where it was that he would have been walking up eight flights of stairs in 2008 that was referenced in the medical records. He agreed that he was not taking any medications for respiratory or breathing conditions. He further agreed that the breathing issues that he has do not really have any direct impact on his daily activities.

On cross examination, Petitioner agreed that he is still working as a safety inspector, that in his job he has walk around throughout the day and that it can be a significant amount of walking. He agreed that he has not been disciplined or reprimanded for not being able to do his job completely. He agreed that he mows his own lawn with a self-propelled mower. He agreed that the water retention issue is a more recent issue, and testified that he had the heart murmur before he even worked at Respondent.

On redirect examination, Petitioner testified that when there were not complaints of shortness of breath in the medical records, he was not having complaints on that day but could have been having complaints two weeks before that. He testified that when he goes to the doctor, he tells the doctor about what is going on at the current time.

On further cross examination, Petitioner denied having been diagnosed with emphysema. He agreed that he was not aware that he was diagnosed with emphysema.

The transcript of the deposition of Dr. Saeed Khan was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Dr. Khan testified that he is board-certified in internal medicine. He testified that he practiced in England before coming to the United States, and that he had a chance to see people with coal worker's pneumoconiosis and coal mine-induced lung disease. He testified that

approximately 25-30% of his patients had pulmonary disease, and that about 20-25% had coal miners' black lung type of pulmonary problems. (PX1).

Dr. Khan testified that he examined Petitioner on July 3, 2007. Dr. Khan's report was typed into the deposition transcript, which noted that Petitioner had worked in the coal mines for 17 years and that he worked 17 years underground in an excessive amount of coal dust. It was noted that Petitioner resigned from the coal mine job in 2003, and that he stated that he left his coal mine job due to morning cough and shortness of breath. It was noted that Petitioner had smoked 1-1½ packs of cigarettes daily for 20 years and still smoked about 1 pack of cigarettes daily. It was noted that Petitioner stated that he was getting progressively short of breath for 4 years before he left his coal mine job in November of 2003. Dr. Khan noted that Petitioner complained of shortness of breath on slight exertion and occasional wheezing, that he had morning cough and a small amount of mucopurulent sputum, that he could walk slowly 4-5 blocks and then had to stop, and that he could climb one flight of stairs. Dr. Khan noted that Petitioner had markedly prolonged expiration and bilateral inspiratory expiratory rhonchi and bilateral dry crepitations, but he had no pleural rub. Dr. Khan noted that his review of the chest x-ray showed moderate pulmonary emphysema, hyperinflation of both lungs, prominent pulmonary blood vessels due to pulmonary hypertension due to moderate pulmonary emphysema, and bilateral interstitial fibrosis and pulmonary mottling, and that the findings were consistent with simple coal worker's pneumoconiosis, category p/p, 1/0, and moderate pulmonary emphysema with interstitial pulmonary fibrosis. Dr. Khan also noted that pulmonary function tests performed were only slightly abnormal or slightly impaired. Dr. Khan noted his diagnoses were that of (1) simple coal worker's pneumoconiosis; (2) moderate pulmonary emphysema. (PX1).

Dr. Khan testified that not every coal miner gets coal worker's pneumoconiosis, and that some people were more prone to coal worker's pneumoconiosis while others were less prone. He testified that coal worker's pneumoconiosis caused scarring in the alveoli, so they can cause obstructive lung disease and inflammatory changes or emphysema as well. He testified that the scarring was permanent in nature, and that it progressed slowly over the years. He testified that if one had coal worker's pneumoconiosis, there was some pulmonary impairment at the site of the fibrosis and that it was difficult to measure that segmental type of pulmonary function test. He testified that there was no cure for coal worker's pneumoconiosis other than to remove the individual from the coal dust environment. (PX1).

Dr. Khan testified that he reviewed the chest x-rays of October 20, 2006 and that they showed hyperinflation in both lung fields, and that the lateral view showed severe hyperinflation consistent with severe pulmonary emphysema. He testified that the cause of Petitioner's pulmonary emphysema was exposure to coal dust for 17 years as well as exposure to cigarette smoking for 20 years. He testified that further exposure to coal dust would be injurious to Petitioner's health based on the diagnosis of coal worker's pneumoconiosis, and that further exposure to coal dust would be injurious to Petitioner's health based on the diagnosis of emphysema as well. When asked whether he could form an opinion as to whether the coal worker's pneumoconiosis would have been present when Petitioner left the coal mine in 2003, Dr. Khan testified that Petitioner had symptoms of shortness of breath and cough before 2003 when he left the coal mine job so it would have been present at the time of his retirement or when he resigned from his job in November of 2003. He also testified that there was no cure for coal worker's pneumoconiosis except to remove the individual from the coal dust environment, and that Petitioner's emphysema was permanent. (PX1).

On cross examination, Dr. Khan agreed that he was not a pulmonologist and that he did not study to be a pulmonologist. He agreed that he did not study to be a radiologist, and that he never took a B-reading course in the United States nor did he study for it. He agreed that he has not had the standardized films from NIOSH at his office, nor has he ever had them. He agreed that Petitioner was sent to him by Petitioner's attorney. (PX1).

On cross examination, Dr. Khan testified that Petitioner denied having a primary care physician. He testified that he did not know who ordered the chest x-ray films that he reviewed, but that Petitioner brought them with him. He denied that Petitioner brought any medical records with him. He denied asking Petitioner if he could look at his past medical records. He testified that he was not aware of any other physician who had examined or treated Petitioner and confirmed the diagnosis of emphysema. (PX1).

On cross examination, Dr. Khan testified that you can diagnose emphysema without a chest x-ray, but to confirm it a chest x-ray was needed. He testified that Petitioner had bilateral inspiratory expiratory rhonchi, dry crepitations and prolonged expiration on both lung fields which would suggest Petitioner has pulmonary emphysema. He testified that emphysema was not treatable and was a slowly progressive disease, and further testified that one can treat the symptoms and that Petitioner had symptoms of cough and shortness of breath for four years. He testified that he did not recommend that Petitioner see a doctor for treatment for his breathing problems because he was not Petitioner's regular physician. (PX1).

On cross examination, Dr. Khan testified that he did not diagnose Petitioner with simple coal worker's pneumoconiosis 1/0, and indicated that the indication of "p/p" and "1/0" was diagnosed by Dr. Alexander. He testified that he had seen the NIOSH films while he trained in England, which he left some 38 years ago. He testified that he did not recall the year of the last NIOSH films that he looked at, and denied that there were any new NIOSH films and that there were no new classifications. He further testified that he did not know the year of the newest NIOSH standardized films. (PX1).

On cross examination, Dr. Khan agreed that Petitioner told him that he worked 17 years underground in an excessive amount of coal dust. He testified that the total amount Petitioner worked for the coal mine company was 17 years, but admitted that he did not know for long Petitioner worked for the last coal company in 2003. He admitted that he did not know for how many days, months or years between 1995 and 2003 Petitioner worked as a coal miner, but agreed that Petitioner told him that he was getting progressively short of breath for four years before November of 2003. He testified that to his knowledge, Petitioner did not have any chest x-rays taken before the films he saw from October of 2006. He agreed that it was possible that Petitioner did have x-rays taken, but he did not know about them. (PX1).

On cross examination, Dr. Khan testified that medications help during an acute exacerbation of acute bronchitis, chronic bronchial asthma and chronic emphysema. He agreed that he saw the same films as Dr. Alexander, and that Dr. Alexander diagnosed hyperinflation which was consistent with emphysema. He denied that Dr. Alexander found prominent pulmonary blood vessels, but that he found small round opacities in the lung fields. He testified that hyperinflation was consistent with bilateral interstititial pulmonary fibrosis. (PX1).

On cross examination, Dr. Khan testified that he did not know whether Petitioner wore a mask or respirator when he worked as an underground coal miner and admitted that he did not ask him. He testified that he did three trials for the pulmonary function testing performed, but that the machine only printed the best out of three. When asked why the machine printed out the exact same time for each trial, Dr. Khan responded that they were done at the same sitting in the same room at the same time. He denied that there were 2 to10 minutes between trials, and testified that some patients could do them faster than others. He agreed, however, that for some patients, there was a little bit of rest time between trials. (PX1).

On cross examination, Dr. Khan agreed that he saw Petitioner 3½ years after he last worked as a coal miner, and denied having any contact with Petitioner since July of 2007. He denied that Petitioner had called him because his breathing problems were getting worse. He testified that Petitioner did not have a heart murmur based on his examination, and he denied that Petitioner told him that he had been treated for a heart murmur in the past. He testified that Petitioner did not tell him that he had masses on his adrenal glands. He further testified that Petitioner came to his office for an occupational lung disease examination, that Petitioner did not tell him anything else and that he did not have symptoms of any other disease. He denied that Petitioner told him about treadmill tests that he had had in the past, and agreed that he did not know if he did well or poorly on those tests. He testified that if Petitioner did a treadmill test, he would do poorly as he had shortness of breath and cough in the morning and sometimes mucopurulent sputum. He agreed that when he saw Petitioner, he was still smoking one pack daily. (PX1).

On redirect examination, Dr. Khan agreed that the report of Dr. Alexander was the kind of report that he would rely on in the care and treatment of his patients. On further cross examination, Dr. Khan agreed that he did not treat Petitioner. (PX1).

The transcript of the deposition of Dr. James Alexander was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. Dr. Alexander testified that he is a family practitioner, and that as part of his practice he does pre-employment physicals for companies. He testified that he performed a pre-employment physical of Petitioner on or about October 6, 2003. He further testified that in addition to the physical examination, Petitioner would have had a chest x-ray, a pulmonary function test and a hearing screening test. (PX2).

Dr. Alexander testified that he obtained a history from Petitioner, and that he indicated that with respect to pulmonary or breathing problems, Petitioner indicated that he had some sinus issues but that was all. He testified that Petitioner had mentioned that he was a smoker, but he could not recall the exact conversation some seven years later. He indicated that Petitioner denied that he had complaints of bronchitis, asthma, shortness of breath, persistent cough or pneumoconiosis. He testified that had Petitioner indicated to him that he had a history of breathing problems, he would have questioned him more as to treatment, duration of symptoms and the like. (PX2).

Dr. Alexander testified that he performed a medical examination of Petitioner, and that with regard to his chest and lungs the examination was perfectly normal. He testified that the pulmonary function testing performed was normal, and that it was a valid study. He testified that the chest x-ray performed was normal and that he personally reviewed it. He testified that Petitioner was a smoker and had smoked for at least 25 years, and that the x-rays showed some hyperinflation as well as flattening of the diaphragms suggestive of emphysema, but that his pulmonary functions looked good. He testified that there were no fibrotic changes, infiltrate, nodules or scarring that he could see. (PX2).

Dr. Alexander testified that he was aware that Petitioner had worked at Kerr-McGee as a miner operator and a roof bolter, but he did not say for how long. He testified that Petitioner did not indicate when he stopped working for Kerr-McGee. He testified that there was physical agility testing that was performed on Petitioner at Harrisburg Medical Center on October 7th, which Petitioner passed and did not give him cause for concern. He testified that if there were any signs of stress, it would have been noted in the comments section and that it noted that his heart rate levels were good. (PX2).

When asked if Petitioner gave him any history of breathing problems at all when he met with him, Dr. Alexander testified that Petitioner only mentioned the sinus congestion and the fact that he smoked. He denied that Petitioner gave him any specific complaints of shortness of breath or morning cough. He agreed that there can be a complaint of a morning cough or something of that nature that

would be related to cigarette smoking. He denied that Petitioner voiced any complaints or concerns about returning to work as a coal miner because of breathing problems from coal dust. He denied that he had any contact with Petitioner since October of 2003. (PX2).

On cross examination, Dr. Alexander agreed that he has done pre-employment physicals for Big Ridge Mining as well as several other coal companies. He testified that he probably does 100 pre-employment physicals per year for mining companies. (PX2).

On cross examination, Dr. Alexander agreed that he was not a pulmonologist, a radiologist or a B-reader, and he denied ever having taken the B-reader exam. He testified that the chest x-ray taken at his facility was an analog x-ray. He testified that only he reviewed the chest x-ray taken on October 6, 2003 and that at the time, it was not required to be reviewed by a radiologist. He denied being a member of the American Thoracic Society. He further denied being familiar with an official position that they have taken concerning obstructive lung disease in the workplace. He also denied disagreeing with the position that the risk of inhalation of coal mine dust was as great as the risk from cigarette smoking in causing obstructive lung disease. (PX2).

On cross examination, Dr. Alexander denied that there was anything in his "data set" that could rule out coal dust as a causative factor in the hyperinflation and flattened hemidiaphragms. He agreed that coal worker's pneumoconiosis causes scarring or fibrosis. He testified that a fibrosed, scarred lung will not perform as a normal lung will. He agreed that there were many different kinds of pneumoconiosis, but testified that coal worker's pneumoconiosis was caused by coal dust and silica. He testified that he was not aware of a cure for coal worker's pneumoconiosis and that the scar tissue and fibrosis would be permanent. He also testified that coal worker's pneumoconiosis can progress in the absence of further exposure to coal dust. (PX2).

On cross examination, Dr. Alexander testified that for a person who had coal worker's pneumoconiosis, he doubted there was a safe dust level exposure. He admitted that he did not know what the predicted normals that the American Medical Association recommended were. He testified that his report showed the summary of three trials done on the pulmonary function tests, but further testified that the other two were not shown on the report. (PX2).

On cross examination, Dr. Alexander testified that the spirometry testing that was done was a global measurement of both lung functions. He agreed that a person can have damage to their lungs and still have pulmonary function studies/spirometry within the range of normal. He testified that he did not believe a person could have shortness of breath and still have pulmonary function studies within the range of normal. He also testified that a person with simple coal worker's pneumoconiosis can have normal pulmonary function studies early in the disease. (PX2).

On cross examination, Dr. Alexander testified that some individuals sometimes falsified information during the pre-employment physical so that they could get a job, but that if he found out that was going on he would fail those individuals. He testified that as a physician, he assumes people will tell him the truth but that in the course of a physical examination for a job, he can only assume the individual needs a paycheck and some insurance. (PX2).

On redirect examination, Dr. Alexander testified that he has failed individuals from going to work for companies that sent them to him for pre-employment physicals. (PX2).

The x-ray interpretation of Dr. Henry Smith dated January 27, 2014 of the x-ray dated October 20, 2006; CT scan interpretation dated December 5, 2013 of the films dated August 30, 2007 and Dr. Smith's *curriculum vitae* were entered into evidence at the time of arbitration as Petitioner's Exhibit 3.

The report dated January 27, 2014 noted an impression of simple coal worker's pneumoconiosis with small opacities, primary p, secondary s, upper mid and lower zones bilaterally, profusion 1/0 for radiograph films dated October 20, 2006. (PX3).

The report dated December 5, 2013 noted that Dr. Smith's review of a CT of the chest performed on August 30, 2007 was that of findings consistent with simple coal worker's pneumoconiosis with small opacities primary p, secondary p, upper mid and lower zones bilaterally of a profusion 1/1. (PX3).

The x-ray interpretation of Dr. Michael Alexander dated December 30, 2006 of the film dated October 20, 2006 and Dr. Alexander's *curriculum vitae* were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The report dated December 30, 2006 noted an impression of coal worker's pneumoconiosis, "category p/p, 1/0, em." The report pertained to chest x-rays dated October 20. 2006. (PX4).

The medical records of Johnston City Community Health were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. Petitioner was seen on December 23, 2008, at which time he denied shortness of breath, and it was noted that Petitioner had no rales, rhonchi or wheezes. At the time of the June 19, 2008 visit, it was noted that Petitioner was able to walk 8 flights of stairs without shortness of breath or chest pain; it was further noted, however, that he complained of shortness of breath. At the time of the March 7, 2007 visit, it was noted that Petitioner wanted to talk about Chantix and that he had used Smoke Away in the past which helped for a few weeks. It was also noted that Petitioner smoked 1-1.5 packs per day. At the time of the September 7, 2006 visit, Petitioner was noted to have sinusitis and pharyngitis and he was advised to stop smoking. (PX5).

The records of Johnston City Community Health reflect that at the time of the November 9, 2005 visit, Petitioner complained of a productive cough, among other issues. It was noted that Petitioner had decreased breath sounds on the right, and that he used tobacco. At the time of the December 12, 2003 visit, Petitioner complained of a cough and congestion, among other issues. The impression was that of pharyngitis and upper respiratory infection. At the time of the January 19, 2003 visit, Petitioner complained of chest pain, stress and smoking too much. At the time of the December 2, 1997 visit, Petitioner complained of a congested cough and fever, and was assessed with bronchitis. At the time of the October 21, 1997 visit, Petitioner was noted to have a productive cough and was assessed with bronchitis and cigarette abuse. (PX5).

The records of Johnston City Community Health reflect that Petitioner was seen on February 12, 1997, at which time it was noted that he had a continued cough and flu symptoms. Included within the records was an interpretive report for chest x-rays performed at Marion Memorial Hospital on October 21, 1997, which were interpreted as revealing clear lungs, no pleural fluid and a cardiac silhouette within normal limits. An endocrinology consultation report dated March 8, 2004 from Dr. Abedmahmoud noted that Petitioner smoked about 1-1 ½ packs per day, and that the physical examination revealed lung sound clear to auscultation. The report for a CT scan dated March 20, 2003 indicated that the examination was free of any apparent abnormalities at that time. (PX5).

The case of *Charles Cross v. Liberty Coal Co.* was entered into evidence at the time of arbitration as Petitioner's Exhibit 6.

The transcript of the deposition of Dr. Jeffrey Selby was entered into evidence at the time of arbitration as Respondent's Exhibit 1. Dr. Selby testified that he is a lung specialist and is board-certified in pulmonology and internal medicine. (RX1).

Dr. Selby testified that he examined Petitioner on August 30, 2007, at which time Petitioner indicated that he worked for Peabody Coal at the Willow Lake Mine for three days and quit. He testified that the physical examination performed revealed that it was basically entirely normal, particularly concerning his chest, and that it was clear with no wheezes, rales or rhonchi. He further testified that Petitioner's heart examination was also normal, without a murmur, gallop or rub. He testified that the chest x-rays he reviewed were negative for coal worker's pneumoconiosis, but there were some questionable abnormalities when the film was carefully scrutinized which he suggested were early x-ray changes in a cigarette smoker. He testified that Petitioner had a 40-pack-year history of cigarette smoking. (RX1).

Dr. Selby testified that he obtained a high resolution CT scan, which he interpreted as negative for coal worker's pneumoconiosis. He testified that the areas of scarring could be consistent with a fungal infection or possibly an old area of pneumonia. He testified that the pulmonary function testing results were all normal. He testified that that he was also able to obtain exercise testing, which was normal. He testified that based on the history from Petitioner, the physical examination performed, and the review of laboratory and radiology studies, he opined that Petitioner did not have coal worker's pneumoconiosis or any respiratory or pulmonary abnormality resulting from the coal mine occupation or coal mine dust inhalation. (RX1).

On cross examination, Dr. Selby agreed that for a person to have coal worker's pneumoconiosis, in addition to having coal mine dust in the lungs, a tissue reaction is required and that the tissue reaction was called scarring or fibrosis. He agreed that around the coal mine dust and the scarring that developed, there will be a halo of emphysema. He testified that the scarring of coal worker's pneumoconiosis cannot perform the function of normal, healthy lung tissue. He agreed that if a person has pneumoconiosis, they would necessarily have an impairment in the function of their lung at the very site of the scarring, whether that impairment could be measured by spirometry or not. He testified that spirometry measured the function of the entire lung. (RX1).

On cross examination, Dr. Selby agreed that a person can have shortness of breath and have pulmonary function tests within the range of normal, and that a person can have a lobe of the lung surgically removed and still have pulmonary function tests within the range of normal. He agreed that pulmonary function tests tell you the kind of abnormality you have, but not the etiology of it. He agreed that if one wanted to know if a miner's pulmonary function was impaired from what it used to be, a way to measure that would be to compare his pulmonary function to what it was before the insult or injury rather than comparing it to a range of normal. (RX1).

On cross examination, Dr. Selby agreed that for the most part, emphysema in any of its forms if it was causing any kind of ventilatory defect would be obstructive, not restrictive, but further noted that it did not totally exclude the possibility of restrictive functional defect. He testified that scarring in the lungs tended towards restrictive, but there were "shades of gray." He agreed that removal of any further exposure to coal dust was the only treatment for coal worker's pneumoconiosis and that coal worker's pneumoconiosis did not have a cure. He agreed that if a person continued their exposure after they had coal worker's pneumoconiosis, it was a chronic slowly progressive disease, and that continued exposure and progressing pneumoconiosis can progress to conditions called progressive massive fibrosis or *cor pulmonale*. He testified that *cor pulmonale* was not life-threatening, but was an indicator that there was something else that was possibly life-threatening. He agreed that progressive massive fibrosis was potentially life-threatening. (RX1).

On cross examination, Dr. Selby testified that the vast majority of coal worker's pneumoconiosis did not progress after exposure to coal dust ceased. He agreed that it was true that if you diagnosed someone with coal worker's pneumoconiosis at some time in their life, because of the nature of the

disease the expectation would be that they probably had the same level of pneumoconiosis when they left the mine. He agreed that it was possible for a person to have radiographically significant coal worker's pneumoconiosis and have normal findings on physical exam of the chest, and that it was possible for a person to have radiographically significant coal worker's pneumoconiosis and have normal pulmonary function tests and arterial blood gas tests. He further agreed that a miner could have coal worker's pneumoconiosis for a long time before he even knew that he had it. He also agreed that it would be his expectation that if a miner had Category 1 radiographic coal worker's pneumoconiosis that he probably would not be having abnormal pulmonary function tests, blood gases, physical examination of the chest or symptoms. (RX1).

On cross examination, Dr. Selby testified that CT scans were not recognized by NIOSH for the purpose of making B-readings, nor were digital chest x-rays. He agreed that NIOSH has simple films for reading analog chest x-rays to be guidelines for the reader, but they have no such films for digital x-rays or CT scans. He agreed that NIOSH has standards for the equipment used and how one was supposed to take analog chest x-rays, but they have no such protocol for the machines that take CTs or digital x-rays or the machines that display them. (RX1).

On cross examination, Dr. Selby agreed that the radiology reports did not typically indicate the intervals between slices, and that in the intervals between the cuts there was no radiographic presentation for that slice. He agreed that it was his standard practice that he would complete his examination and his report based on the examination prior to looking at the treatment records in order to assure that his opinions were not biased by anything that may be contained in the records. (RX1).

On cross examination, Dr. Selby agreed that, to some degree, he was familiar with the Federal Register of December 2000 which contains the position of the Department of Labor and NIOSH concerning the role of coal mine dust in the development of obstructive lung disease, as well as the review of literature that supports those issues. He testified that global literature was being applied to a specific region of the country, and that it was never intended for that and that they were guidelines. He testified that his experience from this region was that they saw nothing near the degree of obstruction purely from coal mine exposure as what was purported to occur in the literature. He further testified that he was not suggesting that he was differing so much as it was being too broadly used for the tri-state area. (RX1).

On cross examination, Dr. Selby agreed that the literature position that two years of coal dust exposure would equal one year of cigarette smoking was a greater ratio than what you would find in the tri-state area. He testified that based on his experience over the last 25 years, it rarely occurs that someone has chronic obstructive pulmonary disease purely from coal mining. He agreed that he was familiar with the official position statement in 2002 of the American Thoracic Society concerning obstructive lung disease in the workplace. He testified that it was not true in the tri-state area that the risk from inhalation of mine dust was as great as the risk from cigarette smoking. (RX1).

On cross examination, Dr. Selby agreed that while there were many insults that the lung may suffer, there were only a relatively few reactions it can have to those different insults. He testified that he believed there was a difference at the cellular level between the emphysema when it was caused by coal dust or emphysema when it was caused by something else, as there were 3,500 chemicals that were known to be contained in cigarette smoke that could incite their own chemical reactions different than inert carbon from coal dust. (RX1).

On cross examination, Dr. Selby agreed that he did not know why Petitioner quit mining. He agreed that he was not a radiologist. He denied using the AMA guidelines for a clinical evaluation and testified that the AMA guidelines were only guidelines that did not apply to each individual patient. He

agreed that an individual can have abnormalities on their chest x-ray from smoking and coal worker's pneumoconiosis at the same time. (RX1).

On redirect examination, Dr. Selby testified that a B-reader can distinguish between the abnormalities of both conditions on x-ray. He testified that the classic pattern for a cigarette smoker was s/t small opacities in the lower lung zones, and that the classic pattern for coal worker's pneumoconiosis was p or q typically, sometimes r, in the upper lung zones, particularly the right upper lung zone to start with. When asked if he had an opinion as to whether anything he found on examination or through testing was in any way related to a one- or two-day exposure while working at Willow Lake Mine in Illinois, Dr. Selby testified that there was nothing objectively that he could detect that would point out one particular mine or another or location. He testified that since Petitioner had no evidence of coal worker's pneumoconiosis, there was no evidence that one day working or three days working would have any affect. He further testified that he was unaware that it was even possible to get a pulmonary condition working in a coal mine for three days that could be detectable on any of the testing. (RX1).

On further cross examination, Dr. Selby agreed that coal worker's pneumoconiosis can result in s and t opacities, but stated that it was unusual. He testified that it was questionable whether it could also be in the mid and lower lung zones, and that if it was not in the upper lung zones it was probably not coal worker's pneumoconiosis. He testified that that he did not believe it was a true statement that the small opacities of simple pneumoconiosis were usually seen first in the upper lung zones. He agreed that if he saw abnormalities on a chest x-ray that were consistent with pneumoconiosis, he was required to mark that even though there was a place on the form that he could say why he did not believe it was pneumoconiosis. (RX1).

The transcript of the deposition of Dr. James Alexander was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The transcript was duplicative of that as contained in Petitioner's Exhibit 2.

CONCLUSIONS OF LAW

With respect to disputed issues of disease and causal connection, to recover compensation under the Workers' Occupational Diseases Act, a claimant must prove that he suffers from an occupational disease and that a causal connection exists between the disease and his employment. An occupational exposure need not be the sole or principal causative factor, as long as it was a causative factor in the condition of ill-being. *Bernardoni v. Indus. Comm'n*, 362 Ill.App.3d 582, 596, 840 N.E.2d 300 (3rd Dist. 2005).

In this case, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he suffers from coal workers' pneumoconiosis and/or emphysema that arose out of and in the course of the exposures of his coal mine employment, and that his current condition of ill-being is casually related to his employment. In so concluding, the Arbitrator finds opinions of Dr. Selby to be more persuasive than those of Dr. Khan in this case. While Dr. Khan opined that Petitioner has coal workers' pneumoconiosis, the Arbitrator notes that Dr. Khan made several significant admission on cross-examination, including the fact that he is not a B-reader, that he is not board-certified in pulmonary disease, that while he had seen NIOSH films while he trained in England some 38 years ago he did not recall the year of the last NIOSH films that he looked at, and that he did not know the year of the newest NIOSH standardized films. (PX1). These various admissions, particularly when coupled with the inconsistent testimony of Petitioner as to some of the facts upon which Dr. Khan's opinion was based, causes the Arbitrator to place greater reliance upon the opinions of Dr. Selby in this matter.

The Arbitrator notes that Dr. Khan noted that Petitioner stated that he was getting progressively short of breath for 4 years before he left his coal mine job in November of 2003, which is contrary to Petitioner's testimony at the time of arbitration that he began noticing symptoms in 2004 or 2005. (PX1). While Dr. Khan noted that Petitioner complained of shortness of breath on slight exertion and occasional wheezing, that he had morning cough and a small amount of mucopurulent sputum, that he could walk slowly 4-5 blocks and then had to stop, and that he could climb one flight of stairs, Petitioner offered no testimony whatsoever regarding any issues with being short of breath on slight exertion or the presence of a morning cough. Furthermore, Petitioner actually testified at the time of arbitration that he could walk about one mile on level ground at a normal pace before becoming short of breath, and that he thought that he could climb 1-2 flights of stairs. That said, the Arbitrator finds that some of the facts upon which Dr. Khan's opinions were based were not supported by Petitioner's testimony at the time of arbitration, which ultimately causes the Arbitrator to question the foundation on which his opinions were ultimately based.

Based upon the foregoing and the record in its entirety, the Arbitrator concludes that Petitioner failed to prove that he suffers from coal workers' pneumoconiosis and/or emphysema that arose out of and in the course of the exposures of his coal mine employment, and that his current condition of ill-being is casually related to his employment. All benefits are denied. The remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF 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

THOMAS McDONALD,

Petitioner,

17IWCC0846

vs.

NO: 15 WC 30628

ZURICH NORTH AMERICA,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of notice, causal connection, medical expenses, and the nature and extent of Petitioner's permanent disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner was employed as a Regional Sales Director for Respondent. On December 10, 2014, he sustained a compensable accident while traveling on business on Respondent's behalf. Petitioner sustained an injury to his left foot that was later diagnosed as an Achilles tendon tear. On January 20, 2015, Petitioner had surgery to repair the Achilles tendon tear. The Commission agrees with the determination of the Arbitrator on the issues of causal connection, notice, and medical expenses. Accordingly, the Commission affirms and adopts those portions of the Decision of the Arbitrator.

The Arbitrator awarded Petitioner 41.75 weeks of permanent partial disability benefits representing loss of the use of 25% of the left foot. In so doing, the Arbitrator applied the five statutory factors in determining permanent partial disability. The Arbitrator correctly gave no weight to an AMA guides impairment rating because none was submitted. He also gave "little weight" to the fact that Petitioner was able to continue working in his current position. He gave "some weight" to Petitioner's age (58) which meant he would have to live with the condition for several years. The Arbitrator gave "no weight" to the injury's effect on Petitioner's earning potential because no evidence of earning capacity was submitted. Finally, the Arbitrator gave the "most weight" to the corroborating evidence of disability in the record.

Regarding the evidence of disability in the record, Petitioner testified that currently, his ankle was stiff with reduced range of motion. He has real difficulty going down stairs and has to hold onto the rail. He is in the same condition as he was when he was released by the doctor. His leg was "certainly atrophied; it's almost four centimeters less than" his right calf, and strength in the left is about 60% of the right. His gait is guarded and he has to be aware of every change in surface. He still gets pain in his foot on occasion. Every morning he had pain/stiffness for about 30 minutes after he awakens.

The rest of the record has rather sparse information on the extent of Petitioner's permanent disability. Three months after the surgery, his surgeon, Dr. Vora noted that Petitioner had been very compliant and was doing well. He could increase activity and wean off the boot. He gave Petitioner a script for formal physical therapy. Petitioner had 15 physical therapy sessions over the course of two months, after which he was discharged from physical therapy. On July 15, 2015, Dr. Vora noted that Petitioner was doing better and was happier. He still had stiffness but did "not notice the limp." Dr. Vora recommended a strengthening program and transition to a home exercise program. He would see Petitioner again in a year, or sooner if necessary.

The Commission finds that the Arbitrator did not correctly apply all of the statutory factors in determining permanent partial disability. In particular, the Commission takes exception to the Arbitrator giving "no weight" to Petitioner's future earning capacity because no such evidence was submitted, and his giving "little weight" to his ability to return to work in his previous job as a Regional Sales Manager.

The Commission notes that Petitioner had a non-physical, executive-type job, he was able to return to that job, and he had no difficulty performing that job. These factors constitute competent evidence that the injury did not diminish his future earning capacity. Therefore, the Commission finds that the Arbitrator's giving no weight to that factor erroneous. In looking at the entire record before us and in assessing the statutory factors, the Commission finds that a permanent partial disability award of loss of 20% of the use of the left foot is appropriate in this case and modifies the Decision of the Arbitrator accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $735.37 per week for a period of 33.4 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of the use of 20% of the left foot.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $4,684.55 for his out-of-pocket medical expenses under §8(a) of the Act pursuant to the applicable medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

17IWCC0846

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $25,000.00. The party commencing the proceeding for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: DEC 29 2017

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/dw
O-12/14/17
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0846

McDONALD, THOMAS
Employee/Petitioner

Case# **15WC036028**

ZURICH NORTH AMERICA
Employer/Respondent

On 3/15/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.91% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

4276 COYNE REINKE LAW
JAMES F COYNE
120 W MADISON ST SUITE 900
CHICAGO, IL 60602

2542 BRYCE DOWNEY & LENKOV LLC
TIMOTHY A FURMAN
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

17IWCC0846

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

Thomas McDonald
Employee/Petitioner

v.

Zurich North America
Employer/Respondent

Case # 15 WC 036028

An *Application for Adjustment 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 Huebsc**, Arbitrator of the Commission, in the city of **Chicago**, on **2/15/2017 and 2/24/2017**. 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. [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 **12/10/2014**, 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 **$157,554.36**; the average weekly wage was **$3,029.89**.

On the date of accident, Petitioner was **58** years of age, *married* with **3** dependent children.

Petitioner *has* received all reasonable and necessary medical services.

Respondent *has not* paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0** 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 **$5,235.38** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner for **reasonable and necessary medical services of $4,684.55 for out of pocket payments**, as provided in **Sections 8(a) and 8.2 of the Act.**

Respondent shall pay Petitioner **permanent partial disability benefits of $735.37 per week for 41.75 weeks,** because the injuries sustained caused the **25% loss of the left foot, as provided in Section 8(e) of the Act.**

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

March 15, 2017
Date

MAR 15 2017

PROCEDURAL INTRODUCTION

The matter was heard by Arbitrator Huebsch on February 15, 2017 and February 24, 2017. Both Parties were represented by counsel at the hearings. Testimony and documentary evidence was submitted by the Parties at the February 15, 2017 hearing. No record was made of the February 24, 2017 hearing, due to scheduling conflicts for the attorneys and a lengthy trial docket for the Arbitrator. The Parties agreed that Respondent would submit RX 3, its itemization of §8(j) group medical benefits paid and Petitioner would submit PX 7, his itemization of out of pocket medical expenses. The attorneys and the Arbitrator initialed the said exhibits and their agreement is that the Record in this case shall be supplemented by same in the event of a review of the Arbitrator's decision. The Parties and the Arbitrator agreed to treat the matter as "proofs closed" as of February 24, 2017.

FINDINGS OF FACT

Petitioner was employed by Respondent as a Regional Sales Director, an executive level job similar in position to an assistant vice president. He was involved with sales and marketing of group life insurance products, long term disability and specialty market plans. His job involved traveling to meet with brokers and customers. He would travel every other week. He was hired on June 15, 2014.

On December 8, 2014, Petitioner flew from Chicago to Kansas City for a client meeting at Respondent's administrative function facility in Overland Park Kansas. (PX 5) On December 10, 2014, Petitioner was in the Kansas City airport for a return flight to Chicago. Petitioner was on an escalator, going up from the car rental return to the airport. A woman in front of Petitioner unexpectedly fell backwards and Petitioner caught her to prevent her from falling. As Petitioner caught the woman, he stepped backwards and missed the step that he was on, landing on the next step with his left foot. Petitioner's toes struck the stair first, with his heel and middle foot being up. He noticed a dull pain in his left ankle at that time. He felt swelling in the ankle and his ankle was stiff. Petitioner was able to walk to his plane and board the plane. On the flight back to Chicago, Petitioner noticed discomfort and swelling in his left foot. When Petitioner departed the plane, his ankle was stiff and he had a limp. He did not seek immediate medical attention. He went home.

Petitioner looked at his ankle when he went home and observed swelling. The next day, his ankle was sore, but Petitioner thought that it was not a big deal. Petitioner worked out of his home on occasion. He did not go to the office every day. Around December 11 or December 12, 2014, Petitioner told Jason Jobe, his supervisor, that he had hurt his foot and described the accident to Jobe. Petitioner worked closely with Jobe and talked with him several times about his injured ankle before having surgery on January 20, 2015.

Petitioner first sought medical care for his left ankle on December 18, 2014 at Greenleaf Orthopedics with Dr. Greg Caronis. At that time, Petitioner noticed increased pain in the ankle and decreased mobility. He had been limiting use of the ankle and icing and elevating it. Petitioner told Jobe that he was seeing a doctor regarding his foot.

Petitioner had not injured his left ankle prior to December 10, 2014. He had no medical treatment for his left ankle prior to December 10, 2014. Petitioner did not injure his ankle between the time of the accident and the first visit with Dr. Caronis.

On December 18, 2014, Petitioner was seen by Lori Recker, PAC and Dr. Caronis. Petitioner provided a history of being at an airport about a week prior and was on an escalator when the person in front of him slipped. He

stepped back suddenly, did not feel a pop in his ankle or appreciate any pain at the time, but subsequently has developed some soreness in the left heel. The initial impression was left Achilles bursitis or tendonitis. Dr. Caronis prescribed physical therapy and Petitioner was fitted for an equalizer boot. (PX 1)

Petitioner began physical therapy on December 23, 2014 and continued through January 16, 2015. He provided a history in the initial evaluation of attempting to help a woman and misstepped with immediate Achilles pain. The medical records confirm that Petitioner was being treated for a partial tear of his left Achilles and his symptoms began on December 10, 2014. He presented in therapy with significantly decreased left ankle range of motion and strength, as well severe limitations in all activities of daily living. His ankle continued to worsen despite wearing the boot, attending physical therapy and not having any new falls or injuries. (PX 2)

Petitioner testified that he wore the equalizer boot all the time through the date of surgery, January 20, 2015, unless he was sleeping, showering or in physical therapy. On January 8, 2015, Dr. Caronis ordered an MRI. (PX 1)

A therapy note from Athletico, dated January 12, 2015 states that Petitioner's condition worsened after "he took his daughter back to school yesterday". The therapist noted that the patient had increased lateral ankle and Achilles pain with severe pain when walking in his boot. The therapist charted that the patient demonstrated aggravated symptoms with edema and bruising at lateral ankle and Achilles with significant tenderness and limitation in dorsiflection. (PX 2) No testimony was elicited regarding this chart note or of any worsening of Petitioner's condition after taking his daughter back to school. Around this time, Petitioner traveled to Boston on a business trip. He did not actually attend the client meeting because his pain had increased and he was unable to stand. He stayed in his hotel room and iced his foot. Petitioner never felt a "pop" in his foot, ever.

The MRI, done on January 16, 2015 confirmed a complete tear of the proximal to mid Achilles tendon. Petitioner was next seen by Dr. Vora at IBJ, who did not think that non-surgical management was appropriate, as the patient was 4 weeks post injury. Petitioner had surgery to repair the torn Achilles on January 20, 2015, done by Dr. Anand Vora. The procedure was: 1.) Left complex Achilles tendon repair, chronic rupture and 2.) Proximal gastrocnemius lengthening. The post-operative diagnosis was: Left Achilles tendon rupture, chronic. Petitioner followed up with therapy and further visits with Dr. Vora until he was discharged from care on July 15, 2015. (PX 3)

The Parties stipulated that all medical treatment provided was reasonable and necessary to treat Petitioner's injuries. Respondent disputed liability based on its accident, notice and causation defenses. Petitioner claimed $4,684.55 in out of pocket payments. (PX 7) Respondent claimed a §8(j) credit in the amount of $5,235.38. (RX 3)

Petitioner testified that he currently notices stiffness in his left foot. He has pain in the morning and with increased activity. He has less motion in the left foot than the right foot. He is guarded in his gait when he walks. He has balance issues and has difficulty descending stairs. It is difficult to bend over to pick up objects. Dr. Verma noted calf atrophy, which is still present.

In July of 2015, Petitioner had a conversation with John Miskel, the President of Zurich Life Insurance. Petitioner learned for the first time that he may have a workers' compensation claim.

Petitioner's employment with Respondent was terminated on September 23, 2015. The Application for Adjustment of Claim was filed on December 4, 2015. Petitioner obtained new employment at a job similar to

that at Respondent in April of 2016. There was no claim for lost time benefits, as Petitioner was a salaried employee.

As of the date of trial, Jobe no longer worked for Respondent. Petitioner's attorney furnished Respondent's attorneys with contact information for Jobe in July of 2016 and February of 2017. (PX 6) Neither party called Jobe as a witness.

On June 15, 2016, Petitioner was seen by an orthopedic surgeon, Dr. George Holmes, pursuant to §12, at the request of Respondent. Dr. Holmes prepared an Addendum Report dated July 11, 2016. (RX 1 & RX 2)

In his initial report, Dr. Holmes noted the following history:

> This injury occurred when he was traveling on business and he was on an escalator. He stepped back when another person fell on him. He missed a step and landed on his heel. He had worsening pain over several days. He saw an orthopaedic doctor who recommended a boot and physical therapy and stretching. He had no improvement. It then worsened after standing at an event in January. (RX 1))

Based on this history, Dr. Holmes opined that the need for the surgery was causally related to the accident as reported on December 10, 2014. (RX 1)

On July 11, 2016, after review of records provided by Respondent, Dr. Holmes provided an opinion that the Achilles tendon did not rupture on the date of accident and the surgery was not causally related to the December 10, 2014 work accident. He explains his change in opinion based on the initial date of treatment, December 18, 2014. He notes that Petitioner did not have pain and did not feel a pop in his ankle at the time of injury. He also notes that at the time of the December 18, 2014 evaluation, Petitioner had an intact Achilles tendon. Dr. Holmes states that this is a problematic case. "Almost 95% of patients with an acute rupture have an onset of a hematoma in the area of the rupture. They have acute pain as if someone stabbed or kicked them in the back of the ankle. They are immediately unable to walk." As none of these are noted in the history or initial examination, Dr. Holmes believes that the patient may have had a chronic rupture of the Achilles tendon that possibly predated the injury or came after the injury. The MRI suggests that this was an old injury as opposed to an acute injury of December of 2014. Dr. Holmes does not address any progression of symptoms or treatment after the initial treatment, when explaining his change of opinion. (RX 2)

Kenneth Domanus testified at the request of Respondent. He has been employed by Respondent as a risk management and TPA consultant since December 17, 2013. Respondent has an employee management policy regarding workers' compensation claims. Their system is called GEMS. The employee notifies his manager of the injury. The employee notifies HR. The employee is responsible to call Gallagher Bassett (the TPA for Respondent) and report the claim. Gallagher then prepares a loss notification, which Domanus receives. Domanus received notice of Petitioner's claim around January 4, 2016. This was on a report generated after the Application was received. Jason Jobe was Petitioner's supervisor at the time of the accident. Domanus did not know whether anyone contacted Jobe to investigate Petitioner's claim.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

The Arbitrator observed Petitioner's demeanor and testimony at trial. Petitioner's testimony is found to be credible.

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between his employment and his injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989) To be compensable under the Act, an injury need only be a cause of an employee's condition of ill-being, not the sole or primary causative factor. Sisbro, Inc. v. Industrial Comm'n, 207 Ill.2d 193, 205 (2003) Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT. THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on December 10, 2014, based upon Petitioner's credible testimony and the medical records.

Petitioner's unrebutted testimony establishes that he was a traveling employee for Respondent, actually engaged in traveling from Kansas City back to Chicago as a part of a business trip. Assisting a falling woman on an escalator is obviously a reasonably foreseeable occurrence when traveling. The histories given by Petitioner to the medical providers are consistent with the testimony of Petitioner. Petitioner experienced an immediate onset of symptoms after catching the falling woman and missing a step, forcefully landing on his left foot.

The accident arose out of and in the course of Petitioner's employment by Respondent.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that Petitioner gave Respondent timely Notice, within the meaning of §6 of the Act. Petitioner's unrebutted testimony is that he told his supervisor, Jobe, about hurting his left foot and how the accident occurred. The fact that Jobe did not report the injury to anyone and did not initiate a workers' comp claim speaks to a system failure at Respondent, which does not defeat Petitioner's claim.

Domanus' testimony does not negate Petitioner's testimony. It is important to recognize that Petitioner is an executive, not a tradesman or a factory worker who might be expected to recognize a workers' compensation injury and whose work rules/environment encourages the prompt reporting of injuries. No testimony was elicited that Petitioner had any familiarity with the GEMS program. Further, it is assumed that Petitioner did not sign daily attendance sheets confirming that he had not suffered any injury at work as a tradesman on a construction site might do. Also, it is not likely that a conspicuous sign at Respondent's office advises all employees to "report all injuries immediately", as might be expected in a factory environment.

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner's current condition of ill-being regarding his left foot, to wit: status post surgical repair of torn Achilles tendon, with residual pain and disability, is causally related to the injury, based upon the testimony of Petitioner and the treating medical records.

Petitioner's unrebutted testimony establishes that Petitioner had no prior injuries or medical treatment regarding his left ankle. He had no subsequent injuries to his left ankle. He never felt a "pop" in his ankle. Petitioner wore the prescribed boot at all times, except for showering, sleeping and in therapy. Petitioner gave a consistent history of injury to the medical providers. Initially, the treating doctor worked Petitioner up for left Achilles bursitis or tendinitis. Therapy did not yield good results. An MRI was ordered. The MRI took place after Petitioner took his daughter back to school and after further findings were noted in therapy (the significance of which was not explored by the Parties). The MRI confirmed a tear of the Achilles. Dr. Vora performed surgery to correct the tear. The Arbitrator is persuaded that the chain of events establishes causation in this case. International Harvester v. Industrial Comm'n, 93 Ill. 2d 59 (1982) It is well settled that that, in order to justify recovery for a work-related injury, an employee must only show that the injury was a causative factor in his condition of ill-being; it need not be the sole causative factor, or even the primary causative factor. Sisbro, Inc. v. The Industrial Commission, 207 Ill. 2d 193 (2003) Here, the injury on the escalator at the airport began a chain of events that led to the surgical repair of Petitioner's left Achilles tendon. The injury was at least a causative factor in the condition that led to the surgery, if not the primary causative factor.

Dr. Holmes' opinions have been considered, but they are found to be not persuasive in this case. First, Dr. Holmes' initial report supports causation. In his second report, Dr. Holmes does not explain why Petitioner is not one the 5% of patients that do not feel a "pop" and do not experience the other symptoms that he mentions in his report. Further, Dr. Holmes does not consider that Petitioner may have injured his Achilles tendon as a result of the injury, yielding the negative Thompson test on December 18, 2014, but also progressing to the MRI findings of January 16, 2015 and the surgical repair of January 20, 2015. If the ruptured tendon pre-existed the December 10, 2014 incident, as Dr. Holmes posits, wouldn't the Thompson test on 12/18 be positive? If the rupture occurred after 12/18, as Dr. Holmes alternatively posits, how could the incident of 12/10/2014 not be considered a causative factor, given Petitioner's unrebutted testimony of no prior injuries or medical treatment to his left foot? The Arbitrator has found Petitioner's testimony to be credible and believes that Petitioner's stoical response to the injury is not unexpected. He anticipated getting better and returning to work at his high paying job, not being involved in a workers' compensation claim.

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 Parties stipulated that all medical treatment provided was reasonable and necessary to treat Petitioner's injuries. Respondent has entered into evidence, after the close of testimony, without objection, a ledger of payments made by Petitioner's group health insurance confirming an 8(j) credit in the amount of $5,235.38. (RX 3) Petitioner entered into evidence a list of all out of pocket expenses after the close of testimony, without objection, totaling $4,684.55. (PX 7) Given the evidence adduced, Respondent shall pay Petitioner his out of pocket expenses of $4,684.55.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Pursuant to §8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records.

No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. Therefore, this factor is given no weight in determining PPD.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a Regional Sales Director at the time of the accident and that he was able to return to work in his prior capacity as a result of said injury. This factor is given little weight in determining PPD.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 58 years old at the time of the accident. This factor is given some weight in determining PPD, as Petitioner will likely live with the effects of the injury for several years.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that no evidence was introduced regarding future earning capacity, except that Petitioner was able to obtain new employment in a similar job after his employment by Respondent was terminated. This factor is given no weight in determining PPD.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner's subjective complaints are confirmed by Dr. Vora's records and by the nature of his injury. The calf atrophy has not resolved. The limitations bending/stooping and descending stairs will not resolve. The stiffness and residual pain that Petitioner experiences will likely persist. This factor is given the most weight in determining PPD.

Based on the above factors, and the Record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 25% loss of use of the left foot pursuant to §8(e) of the Act.

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	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gerald Hackman,
Petitioner,

17IWCC0847

vs.

NO: 12 WC 37627

County Tree Service, Inc. and Illinois State Treasurer as Ex-officio Custodian of the Injured Workers' Benefit Fund,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary disability, nature and extent and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 17, 2017, is hereby affirmed and adopted.

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 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.

17IWCC0847

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: DEC 29 2017
o11/9/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0847

HACKMAN, GERALD
Employee/Petitioner

Case# **12WC037627**

COUNTY TREE SERVICE INC INJURED WORKERS' BENEFIT FUND STATE TREASURER
Employer/Respondent

On 1/17/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.59% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

4788 HEATHERINGTON KARPEL BOBBER
PETER C BOBBER
120 N LASALLE ST SUITE 2810
CHICAGO, IL 60602

1994 DONALD V GALLAGHER PC
200 W BURLINGTON
CLARENDON HILLS, IL 60514

4980 ASSISTANT ATTORNEY GENERAL
COLIN KICKLIGHTER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

17IWCC0847

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

☒ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☐ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

GERALD HACKMAN
Employee/Petitioner

Case # **12** WC **37627**

v.

Consolidated cases: _____

COUNTY TREE SERVICE, INC., INJURED WORKERS' BENEFIT FUND, STATE TREASURER,
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 **Carolyn Doherty**, Arbitrator of the Commission, in the city of **New Lenox**, on **12/16/2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☒ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☒ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☒ What was Petitioner's age at the time of the accident?
I. ☒ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☒ TPD ☒ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **03/16/2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$13,933.00**; the average weekly wage was **$422.21**.

On the date of accident, Petitioner was **48** 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 **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$0.00**.

Respondent is entitled to a credit of **$0.00** under Section 8(j) of the Act.

ORDER

Respondent-Employer County Tree Service, Inc. shall pay Petitioner for reasonable and necessary medical services of **$121,078.18**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent-Employer County Tree Service, Inc. shall pay Petitioner temporary total disability benefits of $319.00/week for **172** weeks, commencing **3/17/2010** through **7/03/2013**, as provided in Section 8(b) of the Act.

Respondent-Employer County Tree Service, Inc. shall pay Petitioner permanent partial disability benefits of $319.00/week for **300** weeks, because the injuries sustained caused the **60%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.
STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Caerlyn M. Mecey

Signature of Arbitrator

1/12/17
Date

JAN 17 2017

FINDINGS OF FACT

The Arbitration of this matter proceeded against the Respondent County Tree Service, Inc., and the Injured Worker's Benefit Fund. Respondent County Tree received prior notice of the hearing which took place on December 16, 2016. (*See* P. Ex. 1 and P. Ex. 15). However, no one appeared at trial on behalf of Respondent County Tree Service, Inc. Further, Petitioner's Exhibit 2, a subpoenaed response from NCCI, reflects that Respondent County Tree Service, Inc. (hereinafter "CTS") had no workers' compensation insurance policy information showing such coverage for March 16, 2010 on file. Further, the Arbitrator notes that Nedeljko Mijic, individually and as President of County Tree Service, Inc. entered into an Insurance Compliance Settlement Agreement prior to trial with the Illinois Workers' Compensation Commission for its non-compliance with Section 4 of the Illinois Workers' Compensation Act requiring employers to have workers' compensation insurance coverage. (See R. Ex. 1). The State Treasurer and the Injured Workers' Benefit Fund are named as additional respondents and were represented by the Illinois Attorney General's office who appeared and participated at the hearing of this matter.

At trial, Petitioner testified that on March 16, 2010, he was 48 years old, married and had 2 dependent children who now live out of state. Petitioner's highest level of education completed was high school. After high school, Petitioner served in the military for over nine years after which he was honorably discharged. After working several years as an outside machinist working on ships, he began tree trimming work in 1994 and continued it through March 16, 2010.

Petitioner began working as a climber for CTS in 2007. Petitioner claimed that he was hired in Illinois and performed all work for CTS in Illinois and that CTS was a company that trims or removes trees and shrubs. Petitioner's work involved climbing trees, cutting the limbs and then cleaning up the cut material. Petitioner stated that CTS provided all tools, equipment, and vehicles Petitioner used to perform the job. Petitioner would start his work day at the lot where CTS's vehicles including bucket truck, dump truck, etc, were stored. Nedeljko Mijic, CTS's owner, would meet the crew, including Petitioner, and advise them of the work for the day. The crew would then drive the CTS vehicles to the job site to perform the work.

Petitioner testified that CTS paid Petitioner $15 per hour for his work. Mijic and Petitioner negotiated this rate. The amount of Petitioner's work for CTS varied based on weather and the amount of work performed. Petitioner identified copies of the pay checks he received from CTS. (See P. Ex. 3). On cross-exam, Petitioner claimed that he did receive a W-2 from CTS for the year 2010 but claimed that he could not find it because it was lost in a stack of papers. Petitioner admitted that he did not file any tax return for the year 2010. Petitioner did not offer any W-2 into evidence.

On March 16, 2010, Petitioner was performing tree removal work for CTS. While Petitioner was standing on the ground, a large branch fell from the crane which was relocating a cut tree limb. The branch, about 5 feet long, 5 inches in diameter and weighing approximately 50 pounds, fell approximately 55 feet, struck the ground then spiraled into the air and struck Petitioner in the head knocking him into the ground. Petitioner was not wearing any helmet or protection for his head. Petitioner recalls getting up following this accident and seeing brain matter on the ground. Mijic, Petitioner's boss, immediately came to his aid by wrapping Petitioner's head with his t-shirt, carrying Petitioner to a vehicle and driving him to the hospital.

Petitioner was admitted to Christ Hospital on March 16, 2010 at which time his employer was noted as County Tree Service (P. Ex. 5, p. 4). A history of blunt trauma to the head from a branch was noted. (P. Ex. 5, pp. 7, 9). A head CT Scan revealed fractures of the right frontal calvarium, the right zygomatic arch, the greater wing of the sphenoid bone, floor of the right sphenoid sinus and clivus, and acute fracture of the posterolateral wall of the right maxillary since and lesser wing og the right sphenoid. (P. Ex. 5, p. 56). In addition to the multiple

fractures, the CT also revealed acute right frontoparietal subdural hemorrhage and leftward midline shift with a small frontotemporal subdural hemorrhage, right frontal lobe parenchymal hematoma and diffuse subarachnoid hemorrhage. (P. Ex. 5, p. 57).

Petitioner was diagnosed with an acute right-sided hematoma with a 12 cm scalp laceration which was treated with emergency surgery involving right frontal temporoparietal crainiotomy and evacuation of subdural hemtoma, and repair of a complex, deep 12 cm frontoparietal scalp laceration. (P. Ex. 5, p. 15). Petitioner remained inpatient until March 21, 2010 when he was discharged and instructed to obtain follow-up care with a neurosurgeon and a plastic surgeon. (P. Ex. 5, p. 6).

Following his discharge from Christ Hospital, Petitioner remained off work and was unable to obtain follow-up care because he had no health insurance, there was no workers' compensation insurance and he had no other means to pay for any follow up care. His then wife, a nurse, took care of him and ultimately she helped get him care with her employer, University of Chicago Hospital.

Dr. Louis Portugal of the University of Chicago examined Petitioner on August 31, 2010. A consistent history of accident was noted. (P. Ex. 7, p. 50). Petitioner complained of a lesion in his neck which drained blood and puss.

Petitioner presented to the MacNeal Hospital Emergency Room by ambulance on September 4, 2010 after experiencing a seizure causing him to fall backwards and strike his head on the wood floor. (P. Ex. 6, p. 2). He was treated for a 4 cm scalp laceration and a grand mal seizure. (P. Ex. 6, p. 9). The head CT scan taken during that visit revealed encephalomalacia, hypodensity and loss of gray-white matter differentiation of the right frontal lobe. (P. Ex. 6, p. 16).

Dr. Portugal performed surgical removal of a 4cm wood branch from Petitioner's neck on October 1, 2010. (P. Ex. 7, p. 2).

Thereafter, Petitioner continued to suffer seizures after which he was taken to an emergency room. These seizures occurred on November 1, 2010 (St. Margaret Hospital (See P. Ex. 8)); November 11, 2010 and January 13, 2011 (MacNeal Hospital (See P. Ex. 6)); February 2, 2011 (LaGrange Memorial Hospital (See P. Ex. 9)); and August 24, 2011 (Porter Hospital (See P. Ex. 10)).

Additionally, Dr. Portugal referred Petitioner to Dr. Tao for neurological consult. Dr. Tao first examined Petitioner on November 18, 2010. Dr. Tao, noting a consistent history of the work accident while cutting trees, diagnosed Petitioner with seizure disorder as a result of the work accident. (P. Ex. 7, pp. 53-54). He advised Petitioner against driving or working at high altitude or using any heavy machinery. The EEG performed that same date revealed an abnormal study with right frontal slowing suggestive of focal dysfunction. (P. Ex. 7, p.55). Petitioner then followed up with Dr. Tao on February 17, 2011 at which time continued seizures were noted. Dr. Tao noted Petitioner's seizures were not being controlled well and indicated he needs medication for same and he should avoid driving or working in trees. (P. Ex. 7, pp. 57-58).

Petitioner also saw Dr. Atassi, a general practitioner, on September 14, 2012. Dr. Atassi noted a consistent history of the 2010 work accident and noted Petitioner complained of seizures, amnesia and headache. (P. Ex. 11, p.3). Presently, Petitioner obtains his seizure medication from the Veterans Administration.

Dr. Steven Rothke, board certified neuropsychologist and rehabilitation psychologist, performed a complete neuropsychological evaluation and testing on July 3, 2013. Relative to the March 16, 2010 work accident, Dr. Rothke diagnosed Petitioner with a traumatic brain injury with subdural hematoma and subarachnoids bleed and adjustment disorder with a depressed mood. (P. Ex. 12, p. 5). He went on to note that Petitioner has related

impairments with memory and new learning capacity. Dr. Rothke noted that Petitioner was unable to work since the 3/16/2010 accident and he requires further treatment. (P. Ex. 12, p. 6).

Dr. Rothke opined, with no evidence to the contrary, that Petitioner's cognitive impairments, adjustment disorder with depressed mood; seizure disorder and significant scarring of his head are causally related to the March 16, 2010 work accident.

Other than his injuries caused by his multiple seizures, Petitioner suffered no subsequent or intervening accident or injury to his brain or head.

CONCLUSIONS OF LAW

The foregoing findings of fact are incorporated into the following conclusions of law.

A. Was Respondent County Tree Service, Inc. (hereinafter "CTS"), operating under and subject to the Illinois Workers' Compensation Act on March 16, 2010?

At all times relevant hereto, CTS was engaged in the business of tree and shrub trimming and removal. In connection with that business, petitioner was required to use chain saws and other tools, and he drove a dump truck. The business also utilized a crane. The Arbitrator finds that Respondent County Tree Service, Inc. was engaged in the extra hazardous business which involved use of electric, gasoline or other power driven equipment. Accordingly, the Arbitrator finds that Respondent County Tree Service, Inc. was operating under and subject to the Act on March 16, 2012 pursuant to Sections 1 and 3(15) of the Act.

B. Was there an employee-employer relationship?

At arbitration, petitioner testified that he began working as a climber for CTS in 2007. He was hired in Illinois and performed all work for CTS in Illinois. CTS was a company that trims or removes trees and shrubs. Petitioner's work involved climbing trees, cutting the limbs and then cleaning up the cut material. CTS provided all tools, equipment, and vehicles petitioner used to perform the job. Petitioner would start his work day at the lot where CTS' vehicles including bucket truck, dump truck, etc, were stored. Nedeljko Mijic, CTS' owner, would meet the crew, including petitioner, and advise them of the work for the day. The crew would then drive the CTS vehicles to the job site to perform the work.

CTS paid petitioner $15 per hour for his work. Mijic and petitioner negotiated this rate. The amount of petitioner's work for CTS varied based on weather and the amount of work. Petitioner identified copies of the pay checks he received from CTS, (See P. Ex. 3), and he testified he did receive W2s from CTS but that he could not produce the W2 forms as they were lost.

The Arbitrator finds that CTS controlled the manner in which petitioner's work was performed directing when, where and how he performed the work; paid him hourly and issued W2s; maintained the right to discharge him; furnished all tools and equipment required to perform the job; and transported him to the job site in its vehicle(s).

Based on the above facts and petitioner's credible testimony with no evidence offered to the contrary, the Arbitrator finds that petitioner was an employee of employer/Respondent County Tree Service, Inc. on March 16, 2010.

C. Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent County Tree Service, Inc.? D. What was the date of accident? E. Was timely notice of the accident given to Respondent County Tree Service, Inc.?

On March 16, 2010, petitioner was performing tree removal work for CTS. While petitioner was on the ground, a large branch fell from the crane which was relocating a cut tree limb. The branch, about 5 feet long, 5 inches in diameter and weighing approximately 50 pounds, fell approximately 55 feet, struck the ground then spiraled into the air and struck petitioner in the head knocking him into the ground. Petitioner recalls getting up following this accident and removing his face from the ground. Mijic, petitioner's boss, immediately came to his aid by wrapping petitioner's head with his t-shirt, carrying petitioner to a vehicle and driving him to the hospital. Petitioner was admitted to Christ Hospital on March 16, 2010 at which time his employer was noted as County Tree Service (P. Ex. 5, p. 4). A history of blunt trauma to the head from a branch was noted. (P. Ex. 5, pp. 7, 9). A head CT Scan revealed fractures of the right frontal calvarium, the right zygomatic arch, the greater wing of the sphenoid bone, floor of the right sphenoid sinus and clivus, and acute fracture of the posterolateral wall of the right maxillary since and lesser wing og the right sphenoid. (P. Ex. 5, p. 56). In addition to the multiple fractures, the CT also revealed acute right frontoparietal subdural hemorrhage and leftward midline shift with a small frontotemporal subdural hemorrhage , right frontal lobe parenchymal hematoma and diffuse subarachnoid hemorrhage. (P. Ex. 5, p. 57).

Petitioner was diagnosed with an acute right-sided hematoma with a 12 cm scalp laceration which was treated with emergency surgery involving right frontal temporoparietal crainiotomy and evacuation of subdural hemtoma, and repair of a complex, deep 12 cm frontoparietal scalp laceration. (P. Ex. 5, p. 15). Petitioner remained inpatient until March 21, 2010 when he was discharged and instructed to obtain follow-up care with a neurosurgeon and a plastic surgeon. (P. Ex. 5, p. 6).

Based on the above, with no evidence offered to the contrary, the Arbitrator finds that on March 16, 2010, petitioner suffered an accident which arose out of and in the course of his employment by Respondent County Tree Service, Inc., and timely notice of same was provided as Respondent County Tree Service, Inc.'s owner, Mijic, was present at the time of the accident, provided first aid to petitioner and drove him immediately to Christ Hospital.

F. Is Petitioner's current condition of ill-being causally related to the injury?

Petitioner testified with no evidence to the contrary that prior to March 16, 2010, he never suffered any injury to his brain/skull.

Immediately following his March 16, 2010 work accident, Petitioner was admitted to Christ Hospital. A history of blunt trauma to the head from a branch was noted. (P. Ex. 5, pp. 7, 9). A head CT Scan revealed fractures of the right frontal calvarium, the right zygomatic arch, the greater wing of the sphenoid bone, floor of the right sphenoid sinus and clivus, and acute fracture of the posterolateral wall of the right maxillary since and lesser wing of the right sphenoid. (P. Ex. 5, p. 56). In addition to the multiple fractures, the CT also revealed acute right frontoparietal subdural hemorrhage and leftward midline shift with a small frontotemporal subdural hemorrhage , right frontal lobe parenchymal hematoma and diffuse subarachnoid hemorrhage. (P. Ex. 5, p. 57). Petitioner was diagnosed with an acute right-sided hematoma with a 12 cm scalp laceration which was treated with emergency surgery involving right frontal temporoparietal crainiotomy and evacuation of subdural hemtoma, and repair of a complex, deep 12 cm frontoparietal scalp laceration. (P. Ex. 5, p. 15). Petitioner remained inpatient until March 21, 2010 when he was discharged and instructed to obtain follow-up care with a neurosurgeon and a plastic surgeon. (P. Ex. 5, p. 6).

Following his discharge from Christ Hospital, petitioner remained off work and was unable to obtain follow-up care because he had no health insurance, there was no workers' compensation insurance and he had no other means to pay for same. His wife, a nurse, took care of him but ultimately, she helped get him care with her employer, University of Chicago Hospital.

Dr. Louis Portugal of the University of Chicago examined petitioner on 8/31/2010. A consistent history of accident was noted. (P. Ex. 7, p. 50). Petitioner complained of a lesion in his neck which drained blood and puss.

Petitioner then presented to the MacNeal Hospital Emergency Room by ambulance on 9/4/2010 after experiencing a seizure causing him to fall backwards and strike his head on the wood floor. (P. Ex. 6, p. 2). He was treated for a 4 cm scalp laceration and a grand mal seizure. (P. Ex. 6, p. 9). The head CT scan taken during that visit revealed encephalomalacia, hypodensity and loss of gray-white matter differentiation of the right frontal lobe. (P. Ex. 6, p. 16).

Dr. Portugal performed surgical removal of a 4cm wood branch from petitioner's neck on 10/1/2010. (P. Ex. 7, p. 2).

Thereafter, petitioner continued to suffer seizures after which he was taken to an emergency room. These occurred on 11/1/2010 (St. Margaret Hospital (*See* P. Ex. 8)); 11/30/2010 and 1/13/2011 (MacNeal Hospital (*See* P. Ex. 6)); 2/11/2011 (LaGrange Memorial Hospital (*See* P. Ex. 9)); and 8/24/2011 (Porter Hospital (*See* P. Ex. 10)).

Additionally, Dr. Portugal referred petitioner to Dr. Tao for neurological consult. Dr. Tao first examined petitioner on 11/18/2010. Dr. Tao, noting a consistent history of the work accident while cutting trees, diagnosed petitioner with seizure disorder as a result of the work accident. (P. Ex. 7, pp. 53-54). He advised petitioner against driving or working at high altitude or using any heavy machinery. The EEG performed that same date revealed an abnormal study with right frontal slowing suggestive of focal dysfunction. (P. Ex. 7, p.55). Petitioner then followed up with Dr. Tao on 2/17/2011 at which time continued seizures were noted. Dr. Tao noted petitioner's seizures were not being controlled well and indicated he needs medication for same and he should avoid driving or working in trees. (P. Ex. 7, pp. 57-58).

Petitioner also saw Dr. Atassi, a general practitioner, on 9/14/2012. Dr. Atassi noted a consistent history of the 2010 work accident and noted petitioner complained of seizures, amnesia and headache. (P. Ex. 11, p.3). Presently, petitioner obtains his seizure medication from the Veterans Administration.

Dr. Steven Rothke, board certified neuropsychologist and rehabilitation psychologist, performed a complete neuropsychological evaluation and testing on 7/3/2013. Relative to the March 16, 2010 work accident, Dr. Rothke diagnosed petitioner with a traumatic brain injury with subdural hematoma and subarachnoids bleed and adjustment disorder with a depressed mood. (P. Ex. 12, p. 5). He went on to note that petitioner has related impairments with memory and new learning capacity. Dr. Rothke noted that petitioner was unable to work since the 3/16/2010 accident and he requires further treatment. (P. Ex. 12, p. 6).

Dr. Rothke opined, with no evidence to the contrary, that petitioner's cognitive impairments, adjustment disorder with depressed mood; seizure disorder and significant scarring of his head are causally related to the March 16, 2010 work accident.

Other than his injuries caused by his multiple seizures, petitioner suffered no subsequent or intervening accident or injury to his brain or head.

Based on the above, the Arbitrator is persuaded by petitioner's credible testimony as well as Dr. Rothke's opinions and finds that petitioner's present condition of ill-being involving his cognitive impairments, adjustment disorder with depressed mood; seizure disorder and significant scarring of his head are causally related to the March 16, 2010 work accident.

G. What were Petitioner's earnings?

CTS paid petitioner $15 per hour for his work. Petitioner identified copies of the pay checks he received from CTS, (*See* P. Ex. 3). Petitioner's Exhibit 3 reveals that CTS paid petitioner $13,933.00 over 33 weeks during the 52 weeks prior to the March 16, 2010 work accident. As such, the Arbitrator finds that pursuant to Section 10 of the Act, the Average Weekly Wage is $422.21 ($13,933.00 / 33 weeks).

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?

At arbitration, petitioner testified that on March 16, 2010, he was 48 years old and was married. Petitioner further testified that he had one 18 year old child and one 15 year old child at the time of the accident. There being no evidence to the contrary, the Arbitrator finds that as of the March 16, 2010 accident, petitioner was 48 years old, married with 2 dependent children.

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 unpaid bills petitioner received are contained in Petitioner's Exhibit 4 and total $121,078.18. The Arbitrator notes that the initial emergency care petitioner received at Christ Hospital obviously was necessary as he had suffered a traumatic brain injury and he required the lifesaving care. Thereafter, petitioner underwent other emergency care to address his seizures and the effects thereof.

Based on the above, the Arbitrator finds that the services for the bills contained in Petitioner's Exhibit 4 were medically necessary and are reasonable to the extent of the Medical Fee Schedule. Therefore, the Arbitrator orders Respondent County Tree Service, Inc. to pay petitioner $121,078.18 for outstanding bills pursuant to Sections 8 and 8.2 of the Act.

K. What is the period of temporary total disability?

Petitioner testified without rebuttal that he has not worked since his March 16, 2010 work accident. Dr. Rothke opined that as of his July 3, 2013 evaluation, petitioner had not yet reached maximum medical improvement and he was unable to work since the March 16, 2010 accident. (P. Ex. 12, p.6). The Arbitrator notes that there is no medical evidence supporting temporary total disability after July 3, 2013.

There being no evidence to the contrary, the Arbitrator finds that petitioner was temporarily totally disabled from March 17, 2010 through July 3, 2013, totaling 172 weeks.

L. What is the nature and extent of the injury?

Noting that this accident precedes the 2011 amendments to the Act, the Arbitrator further notes that pursuant to Section 8.1(b) of the Act, the various factors the Arbitrator shall consider in determining permanency include any AMA impairment rating; the occupation of the injured employee; the age of the employee at the time of the injury; the employee's future earning capacity; and evidence of disability corroborated by the treating medical records. Each factor is to be considered, with no single factor predominating over another.

First, there was no AMA impairment rating offered. Therefore, that factor is not considered. Next, petitioner can no longer perform his given occupation performing tree trimming work due to his ongoing seizures and memory problems. Further, petitioner no longer has a driver's license due to his recurrent seizures. Dr. Rothke opined credibly that petitioner is unable to perform his prior work and his employability is limited due to his inability to

drive. (P. Ex. 12, p.6). Similarly, Dr. Tao of the University of Chicago opined that petitioner could not operate any heavy machinery, could not drive and should switch jobs. (P. Ex. 7, p. 54).

Regarding petitioner's age and future earning capacity, petitioner's age at the time of the accident was 48. Presently, he is 54 years old. His age is relevant to the extent it could affect his future employability as he may have difficulty locating future employment given that he is now in his 50's and would be considered an older worker and he has limited education of high school. Given his age, education and problems with his memory and seizures, successful vocational retraining is not likely. Because petitioner will not be able to return to tree trimming work that he performed for the last 16 years of his professional life, (1994-2010) and given that he has no training or education which would likely transfer to another occupation, petitioner's earning capacity has been impacted significantly in a negative way as a result of this accident. The Arbitrator finds that Petitioner has sustained a loss of trade as a result of this accident.

Lastly, the treating medical records show that petitioner suffered a significant injury to his head and brain as a result of this accident. Petitioner was diagnosed with an acute right-sided hematoma with a 12 cm scalp laceration which was treated with emergency surgery involving right frontal temporoparietal crainiotomy and evacuation of subdural hemtoma, and repair of a complex, deep 12 cm frontoparietal scalp laceration. (P. Ex. 5, p. 15). Thereafter he underwent surgical removal of a 4cm piece of wood from his neck, (P. Ex. 7, p.2). He developed a seizure disorder, (P. Ex. 7, pp. 52, 54), and also was diagnosed with adjustment disorder with depressive mood. (P. Ex. 12, p. 5).

Presently, petitioner continues to suffer from seizures periodically, suffers from short term memory loss, has some double vision and has difficulty with his equilibrium. He now has more of a flat affect. Based on the above factors, the Arbitrator finds that as a result of the injuries suffered in his March 16, 2010 work accident, petitioner suffered 60% disability to his whole body pursuant to Section 8(d)(2) of the Act.

M. Should penalties or feed be imposed on Respondent?

The Arbitrator makes no award of penalties or attorneys' fees in this matter.

N. Is Respondent due any credit?

Respondent County Tree Service never paid petitioner any benefits in connection with this claim. There was no evidence offered at hearing regarding any credit. Therefore, the Arbitrator finds respondent is not entitled to any credit.

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

Muhammad Babar,
Petitioner,

17IWCC0848

vs.

NO: 11 WC 33057

Vegas Corporation,
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 employment, nature and extent, medical, causal connection, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 9, 2016, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $10,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: DEC 29 2017
o11/8/17
DLS/rm
046

Deborah L. Simpson

Deborah L. Simpson

David L. Gore

David L. Gore

Stephen J. Mathis

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0848

MUHAMMAD, BABAR
Employee/Petitioner

Case# **11WC033057**

VEGAS CORPORATION
Employer/Respondent

On 9/9/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.47% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

4963 NEWLAND & NEWLAND LLP
DANA N BLUMTHAL
121 S WILKE RD SUITE 301
ARLINGTON HTS, IL 60005

1739 STONE & JOHNSON CHTD
J MURRAY PINKSTON
111 W WASHINGTON ST SUITE 1800
CHICAGO, IL 60602

17IWCC0848

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

Mohammed Babar
Employee/Petitioner
v.
Vegas Corporation
Employer/Respondent

Case # **11 WC 33057**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **June 14, 2016** and **July 19, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings 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 **Other Insurance Exhaustion and Exclusions**

FINDINGS

On **May 18, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$10,529.74**; the average weekly wage was **$202.50**.

On the date of accident, Petitioner was **48** years of age, ***married*** with **1** dependent child.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Respondent shall pay $6,050.65 for medical services, as provided in Section 8(a) 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 medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner.

Petitioner's claim for temporary total disability benefits is denied.

Petitioner's claim for temporary partial disability benefits is denied.

Respondent shall pay Petitioner permanent partial disability benefits of **$202.50**/week for **20** weeks, because the injuries sustained caused the **4%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Petitioner's claim attorneys' fees and penalties as provided in Section 16 of the Act, Section 19(k) of the Act, and Section 19(l) of the Act is denied.

Respondent's claim for exhaustion of other benefits is denied.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Milton Black

Signature of Arbitrator

September 9, 2016
Date

SEP - 9 2016

PROCEDURAL HISTORY

Petitioner, a taxi cab driver, filed this case on August 29, 2011. Respondent's workers' compensation insurance carrier was Dallas National Insurance. In 2014, Dallas National Insurance was placed in liquidation by Court Order. As a result, the Illinois Insurance Guaranty Fund (hereinafter "Fund") stepped into the shoes of the workers' compensation insurance carrier to defend and indemnify Respondent.

Petitioner also filed a negligence complaint in Circuit Court against the driver who struck his taxicab. The vehicle liability insurance carrier for that Defendant was Ulico Insurance Company. Ulico Insurance Company was also placed in liquidation by Court Order in 2014. As a result, the Fund stepped into the shoes of the automobile liability carrier to defend and indemnify that named Defendant. That lawsuit remains pending.

Thereafter, Petitioner pursued an uninsured motorist claim pursuant to a vehicle liability policy covering his taxicab. The vehicle liability insurance carrier is First Chicago Insurance Company. Under a subheading entitled "Exclusions" the uninsured motorist policy excludes coverage for certain claimants, including workers' compensation claimants (PX11). Based upon that coverage exclusion, First Chicago Insurance Company has denied coverage and has paid no benefits.

Petitioner now seeks adjudication of his workers compensation claim before the Worker's Compensation Commission. The Fund disputes all issues. Additionally, the Fund denies workers compensation coverage and asserts that Petitioner must first seek recovery as an uninsured motorist.

STATEMENT OF FACTS

Petitioner testified that Respondent did business as Sun Taxi Cab and that its business address was 4626 West Cornelia Avenue in Chicago, Illinois. Respondent, Vegas Corporation, is an Illinois corporation (PX10). Respondent's Illinois Corporation Certificate shows the legal name as the Vegas Corporation, the agent name as Taiwo Folarin, and the agent street address as 4626 West Cornelia Avenue in Chicago, Illinois (PX10).

Petitioner testified that he worked for Respondent as a cab driver for ten years. Petitioner testified that the taxicab was owned by Respondent. Petitioner testified that he leased his taxi cab from Respondent on a weekly basis and was assigned to work the night shift from 5:00 pm to 5:00 am. Petitioner testified that he shared his taxi cab with another driver who worked the morning shift. Petitioner testified that he had a set schedule with Respondent and that he could not change his shift without Respondent's permission. Petitioner testified he was not allowed to sublease his taxi cab to any other person and that Respondent had the power to terminate the lease.

Petitioner testified that all of the Respondent's taxi cabs were painted with the Sun Taxi Cab logo as wellas its contact information. Petitioner testified that the meter, insurance, and the medallion were provided by Respondent. When asked how he knew that the medallion was owned by Respondent, he testified that the names listed on the medallion were Vegas Corporation and its owner, Taiwo Folarin. Petitioner testified that he was required to bring the taxi cab to Respondent for inspections, that any repairs or vehicle issues were handled by Respondent, and that Respondent actually repaired the his damaged taxicab following the accident. Petitioner further testified that there was a vehicle radio that did not work.

Petitioner submitted his 2010 and 2011 tax returns. Petitioner's 2010 tax returns indicate that he reported business income, but there was no business name. His 2011 tax returns also show that he reported business income under the business name Sun Taxi Association (PX8).

Petitioner testified that an accident occurred on May 18, 2011. Petitioner testified that he was working his regular night shift and had driven to the arrival terminal at O'Hare International Airport. He testified that he

had picked up a passenger and was leaving the terminal, when another taxi cab driver pulled out of the pickup lane and struck the front passenger side of his vehicle. He testified that the police were called and that a police report was completed. Petitioner testified that the other driver was ticketed as at fault and that he was not. The Illinois Traffic Crash Report Petitioner as the driver of his vehicle, Taiwo Folarin as the owner, and First Chicago Insurance Company as the insurer (PX9).

Petitioner testified that he gave notice to Respondent of his accident by calling his dispatcher after he left the accident scene. He testified that the following day he again gave notice of the accident to his employer when he brought his taxicab in to Respondent's facility for repairs. He testified that he spoke with "John", who runs the office.

Petitioner testified that after impact, he felt pain in his back, neck, arm and leg. Petitioner testified that later that night, his pain worsened and he sought treatment at the emergency room at Advocate Lutheran General Hospital. Petitioner was given X-rays, prescribed pain medication, and instructed to follow up with his doctor in the next couple days (PX1). Petitioner testified that he followed those instructions and was evaluated and began treatment with Dr. Neil Elliot on May 25, 2011 (PX4).

Petitioner testified on direct examination that Dr. Elliot provided him with a four hour per day work restriction and prescribed physical therapy. Petitioner testified on cross-examination that he could not remember exactly when Dr. Elliot told him to only work four hours per day and that he would rely on the medical records in determining that exact date. Dr. Elliot's records state that Petitioner did not always work full days (PX4). Petitioner testified that physical therapy provided some relief but that he continued to experience pain in his neck, back, arm and knee. Dr. Elliot referred Petitioner for an evaluation with Dr. Christopher Morgan, an orthopedic specialist. Petitioner was seen by Dr. Morgan on June 2, 2011. Dr. Morgan advised Petitioner to continue with physical therapy and to stay on the same work restrictions that Dr. Elliot had provided (PX6).

On August 1, 2011, Dr. Elliot advised Petitioner that he could return to his full duty work. Petitioner was placed at maximum medical improvement and released from treatment (PX4).

Petitioner testified that he continued to work for Respondent throughout his treatment and following his release for a period of time. Petitioner testified that he now works as an UBER driver. Petitioner testified that he continues to have pain in his neck and back to this day following his injury.

CONCLUSIONS OF LAW

A. Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

Petitioner testified that he was injured while driving a taxicab. Petitioner testified that he and another person were assigned to drive the taxicab and that a manager and dispatcher worked in the office.

The Act applies automatically for carriage by land where the employer employs more than two employees. The Act also applies to any business or enterprise in which electric, gasoline or other power driven equipment is used.

Respondent employed more than two employees, as shall be shown below, and was a business or enterprise in which gasoline power driven equipment was used.

Based upon the foregoing, the Arbitrator finds that Respondent was operating under and subject to the Illinois Workers' Compensation Act.

B. Was there an employee-employer relationship?

Petitioner testified that the taxi cab was owned by Respondent, that Respondent owned the medallion which authorized the use of the vehicle as a taxi cab which had an inoperable radio, that Respondent owned the taxi cab meter, that Respondent paid for vehicle insurance, that he was required to bring in the taxi cab for inspection, that he called in to a dispatcher at Respondent's office regarding the accident, that Respondent took care of repairs, that Respondent actually repaired the damaged taxi cab, that Respondent's name and contact information were painted on all of its taxi cabs, that Respondent controlled the work shifts and work assignments, that he was prohibited from subleasing the taxicab to another driver, and that Respondent could cancel the lease.

Respondent's incorporated as Vegas Corporation and did business as Sun Taxi Cab. Respondent owned the important tools, namely the taxi cab, the taxi cab meter, and the taxi cab radio albeit inoperable. Respondent provided vehicle insurance. Respondent painted its name and its contact information on its taxicabs. Respondent had the power to cancel the lease. Respondent asserted substantial control over Petitioner's work activities and work relationship as evidenced by controlling its drivers' work shifts and work assignments, prohibiting subleasing which also meant prohibiting Petitioner from employing another driver, requiring vehicle inspections, performing its own vehicle repairs, and requiring Petitioner to call Respondent's dispatcher when there was an accident.

Based upon the foregoing, the Arbitrator finds that an employee - employer relationship existed between Petitioner and Respondent.

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 accident?

Petitioner testified without rebuttal that a motor vehicle collision occurred on May 18, 2011 at O'Hare International Airport while he was operating Respondent's taxicab. The Illinois Traffic Crash Report, admitted into evidence without objection, corroborates his testimony.

Based upon the foregoing, the Arbitrator finds that an accident occurred on May 18, 2011 that arose out of and in the course of Petitioner's employment by Respondent.

E. Was timely notice of the accident given to Respondent?

Petitioner testified that he gave notice to Respondent of his accident by calling his dispatcher after he left the accident scene. Petitioner was not asked on direct or cross-examination how he called in to his dispatcher. Petitioner testified that his radio did not work. It is a reasonable inference that Petitioner called Respondent by use of a mobile or landline telephone. Petitioner further testified that the day following the accident he additional gave notice when he brought his taxi cab in to Respondent's facility for repairs by speaking to "John", who runs the office.

Based upon the foregoing, the Arbitrator finds that timely notice of the accident was given to Respondent.

F. **Is Petitioner's current condition of ill-being causally related to the injury?**

Petitioner testified that he suffered back, neck, knee, and arm pain as a result of the motor vehicle collision. Dr. Elliot's records indicate that Petitioner's pre-existing polio was exacerbated by the collision. Petitioner testified that the pain has continued since the accident. Petitioner testified that the pain is worse when he wakes up. Petitioner's medical records document the treatment for his accident related injuries. Respondent has submitted no medical evidence to the contrary.

Based upon the foregoing, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the injury

G. What were Petitioner's earnings?

Petitioner was injured on May 18, 2011. Petitioner worked 32 3/7^{ths} (.429) weeks in 2010, and he worked 19 4/7^{ths} (.571) weeks in 2011 for a total of 52 weeks prior to the accident date. Petitioner's Schedule C in his tax returns showed net earnings of $10,459 in 2010 and $10,646 in 2011 from driving a taxi cab.

Petitioner's 2010 average weekly wage was $201.14.

Petitioner's 2011 average weekly wage was $204.74.

Multiplying Petitioner's 2010 average weekly wage of $201.14 by 32.429 = $6522.77.

Multiplying Petitioner's 2011 average weekly wage of $204.74 by 19.571 = $4006.97.

$6522.77 plus $4006.97= $10,529.74.

$10,529.74 divided by 52 equals $202.50

Based upon the foregoing, the Arbitrator finds that Petitioner's average weekly wage was $202.50.

H. What was Petitioner's age at the time of the accident?

Petitioner testified that he was born on June 19, 1962. The documents admitted into evidence corroborate his testimony.

Based upon the foregoing, the Arbitrator finds that Petitioner was 48 years old at the time of the accident.

I. What was Petitioner's marital status at the time of the accident?

Petitioner testified, without rebuttal, that he was married at the time of the accident. Petitioner also testified, without rebuttal, that he had a daughter who was born September 20, 1994.

Based upon the foregoing, the Arbitrator finds that Petitioner was married with a daughter age 17 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?

Respondent's defense on this issue is premised upon liability which has been resolved in favor of Petitioner. The medical professionals who treated Petitioner have documented the need for treatment due to his accident related injuries. Respondent has submitted no medical evidence to the contrary.

Therefore the claimed medical benefits are awarded.

K. What temporary benefits are in dispute? TTD and TPD

Petitioner testified that he could not remember exactly when Dr. Elliot told him to only work four hours a day. Petitioner testified that he would rely on the medical records in determining the exact date that Dr. Elliot told him to work only 4 hours a day. The records show that Petitioner was reporting to Dr. Elliot regarding current symptoms and current work activity. The records show that Petitioner told Dr. Elliot that he was sometimes working less than a full day or that he did not work. However, there is no specific authorization by Dr. Elliot to take off work. Furthermore, there is no specific authorization by any physician for Petitioner to take off work. Petitioner has not carried his burden of proof on this issue.

Based upon the foregoing Petitioner's claims for temporary total disability and temporary partial disability are denied.

L. What is the nature and extent of the injury?

Petitioner testified that he continues to have symptoms. Petitioner's medical treatment resulted in less than full improvement.

Based upon the testimonial evidence and the medical evidence in this case, the Arbitrator finds that Petitioner sustained the 4% loss of the person as a whole.

M. Should penalties or fees be imposed upon Respondent?

The Fund alleges "This is a complicated claim that with a current third party liability claim that is also being handled by the Illinois Insurance Guaranty Fund. The Fund has every right to investigate all cases upon receipt and explore all possible defenses. Here, there are a number of reasonable, valid defenses that would warrant the Fund to deny extending an offer of settlement in this matter. The Fund has been working through the number of issues in this case to determine whether or not a compromised settlement would be an appropriate way to dispose of this claim. Over time it became clear the issues surrounding employment, notice, the disputed TTD and TPD period, causation, and other insurance exhaustion were not going to sufficiently be clarified by Petitioner to the extent any sort of compromised offer could be made on this claim. Respondent has not benefited by any alleged delay and did not intend to delay the disposition of this matter as Petitioner alleges."

The Fund overstates and complicates its own position.

This is a relatively small and uncomplicated claim involving a motor vehicle accident with the right to pursue a third-party claim. Nevertheless, the Fund has treated this matter is if it were multi-district litigation, and it has placed every single issue in dispute. By way of one example, the Fund would not even stipulate to Petitioner's age, despite the fact that his date of birth is repeatedly shown throughout the documentary record.

Although the Fund has the right to pursue all possible defenses, it does not have the right to compel an injured worker to prosecute multiple causes of action in multiple jurisdictions and hearing venues against non-Worker's Compensation parties as a condition of receiving workers compensation benefits. Such unnecessary legal hurdles could litigate a Worker's Compensation claim out of existence.

The penalties and fees issue in this case is simple.

Because temporary total disability benefits and temporary partial disability benefits have been denied in this case, Petitioner would not be entitled to penalties or attorneys' fees for those benefits.

The Fund has refused to pay certain medical benefits in this case even though there is no medical evidence to the contrary. The denial of medical benefits is based upon a claims determination by an adjuster, not a medical determination by physician. Therefore, Petitioner would be entitled to penalties and attorneys' fees for the nonpayment of those benefits.

However, the Commission has interpreted that Section 534.3 (b) (ii), of the Illinois Insurance Act precludes the Arbitrator from assessing penalties and attorneys' fees under Section 19 (l), Section (k), and Section 16 against the Fund. Even the most egregious behavior is not subject to sanctions. Petitioner's remedy on this issue is with the Legislature or a reviewing revisit by the Commission or the Courts regarding the interpretation of the immunizing statute.

Based upon the foregoing Petitioner's claims for penalties and attorneys' fees are denied.

O. 'Other: Other insurance exhaustion and exclusions

The Fund denies workers compensation coverage and argues that Petitioner must first seek recovery as an uninsured motorist. The Fund cites Section 546(a) of the Illinois Insurance Act.

> An insured or claimant shall be required first to exhaust all coverage provided by any *other insurance policy*, regardless of whether or not such other insurance policy was written by a member company, if the claim under such other policy arises from the same facts, injury, or loss that gave rise to the covered claim against the Fund. The Fund's obligation under Section 537.2 shall be reduced by the amount recovered or recoverable, whichever is greater, under such other insurance policy. Where such other insurance policy provides uninsured or underinsured motorist

coverage, the amount recoverable shall be deemed to be the full applicable limits of such coverage. (emphasis added)

The Fund argues that the Illinois Insurance Act should be construed in a manner that would compel a Worker's Compensation claimant to prosecute and exhaust all separate causes of action in separate jurisdictions against non-Worker's Compensation parties as a precondition of receiving workers compensation benefits. The Fund cites no case law in which the Courts have mandated that an injured worker with a pending claim to do so.

Worker's Compensation is the public policy of the State of Illinois. The Worker's Compensation Act is a humane law and is remedial in its nature. The Worker's Compensation Act is meant to provide efficient remedies for and protection of employees and as such promotes the general welfare of the state. Claims for benefits arise under the Worker's Compensation Act, not policies of insurance. Worker's Compensation cases are adjudicated at the Worker's Compensation Commission, not in any other tribunal. The Worker's Compensation Act creates a no-fault administrative system. The intent of the legislature, as set forth in the plain and unmistakable words of Section 16, is that "The process and procedure before the Commission shall be as simple and summary as reasonably may be."

The Fund purports to rewrite the Act. The Fund is attempting to compel an injured worker to prosecute and exhaust any potential negligence claims against any third-parties in other jurisdictions as a precondition of receiving any workers compensation benefits. As such, the Fund seeks to compel fault based and complicated procedures. Such legal obstacles would ultimately litigate a Worker's Compensation claim out of existence. The Fund argues "This is a complicated claim". That is because the Fund unnecessarily makes it so.

The Arbitrator finds that no injured worker is required to prosecute any third party case as a precondition of obtaining Worker's Compensation benefits.

The Arbitrator finds that no injured worker is required to exhaust any potential benefits of any third party case as a precondition of obtaining Worker's Compensation benefits.

The Arbitrator finds that Petitioner is not required to prosecute the pending Circuit Court negligence case before receiving his Worker's Compensation benefits in this case.

The Arbitrator finds that Petitioner is not required to prosecute an uninsured motorist claim before receiving his Worker's Compensation benefits in this case.

Respondent's claim for "Other insurance exhaustion and exclusions" is denied

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (
☐ 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

Anthony Cherry,
Petitioner,

17IWCC0849

vs.

NO: 15 WC 18457
15 WC 18458

Atlas Staffing and Capsonic Group,
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, benefit rates, employment, jurisdiction, medical, notice, penalties and fees, permanent disability, temporary disability, fraud 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 14, 2017, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: DEC 29 2017
o11/9/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

17IWCC0849

CHERRY, ANTHONY
Employee/Petitioner

Case# **15WC018457**

15WC018458

ATLAS STAFFING & CAPSONIC GROUP
Employer/Respondent

On 3/14/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.91% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1452 CHASE & WERNER LTD
LOUIS G ATSAVES
300 W ADAMS ST SUITE 330
CHICAGO, IL 60606

2965 KEEFE CAMPBELL BIERY & ASSOC
JOSEPH F D'AMATO
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

17IWCC0849

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
CORRECTED ARBITRATION DECISION

Anthony Cherry
Employee/Petitioner

v.

Atlas Staffing & Capsonic Group
Employer/Respondent

Case # **15** WC **18458**

Consolidated cases: **15 WC 18457**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty** , Arbitrator of the Commission, in the city of **Wheaton**, on **November 3, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Determination for Workers' Compensation Fraud; Is Capsonic a Proper Party**

FINDINGS

On **May 9, 2015** Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did 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 **$11,477.44**; the average weekly wage was **$220.72**.

On the date of accident, Petitioner was **31** years of age, ***single*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Atlas Staffing is the proper employer for Workers' Compensation Purposes.

Petitioner has failed to prove he suffered a work-related accident to his right hand/wrist on May 9, 2015.

All remaining issues are moot and benefits are denied.

The Arbitrator will not make any findings as to whether or not Petitioner engaged in Workers' Compensation fraud as this issue is beyond the scope of the Arbitrator's authority.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Jessica C. Wyatt

Signature of Arbitrator

3-13-17
Date

MAR 14 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

17IWCC0849

ANTHONY CHERRY, Petitioner,	)	
v.	)	Case No. **15 WC 18458** consolidated with 15 WC 18457
ATLAS STAFFING/CAPSONIC, Respondent	)	

CORRECTED
ADDENDUM TO THE DECSISION OF THE ARBITRATOR

The matter was heard before Arbitrator Hegarty in the City of Wheaton, on November 3, 2016.

Petitioner has filed two claims which were consolidated. Although both claims were heard simultaneously, the Arbitrator will issue separate findings for each claim.

The Arbitrator notes the alleged accident date for 15 WC 18458 is May 9, 2015 and the alleged accident date for 15 WC 18457 is May 24, 2015.

FINDINGS OF FACT
15 WC 18458

Petitioner testified that in May of 2015, he was employed by Atlas Staffing who assigned him to work as a press operator at a warehouse operated by Capsonic where he operated heavy machinery presses that produce plastic molds for automobiles. (Id. at 11-12; 15). He was required to extract and box up thousands of plastic molds per shift.

Petitioner testified that on May 9, 2015, after working for five hours at Capsonic, he felt pain in his right hand. (Id. at 27-27.). Petitioner testified that he reported his pain to his supervisor that day and later presented to the emergency room at St. Joseph's Hospital. (Id. at 28.).

On cross-examination, Petitioner testified he reported to the hospital staff that the pain in his right hand was due to manipulating molds with his hand. (Tx. at 48.) The Arbitrator notes the Presence St. Joseph Hospital ER records do not corroborate Petitioner's testimony. rather, they reflect Petitioner's complaints of numbness to the right hand "since he was stabbed in the right forearm four months ago". (PX 1; RX A; Tx. at 48.).

The Presence St. Joseph records also contain a report showing that x- rays of Petitioner's right hand/wrist showed a remote fracture deformity of the ulnar styloid with non-union. Otherwise, no acute pathology was noted. The impression was urethritis with wrist pain. (PX 1; RX A). Petitioner testified he was discharged without work restrictions and that he returned to work at Capsonic the next day and worked through May 24, 2015. (TX. at 32). He testified he was in pain all day, every day. (Id.).

15 WC 18457

Petitioner's second claim, 15 WC 18457 alleges an accident date of May 24, 2015. (ARB. 2). He testified that on that date he worked at Capsonic on Press 42. (TX at 33.). After three hours of work, he reported hand discomfort to a supervisor and left work to see Dr. Arps at St. Jospeph Hospital. (Id. at 36.). Respondent's Exhibit B, contains Petitioner's employment records from May 24, 2015 which purport that claimant worked 12 hours on May 24, 2015.

Petitioner testified he presented to Dr. Arps on May 24, 2015, and that he saw Dr. Arps on two occasions. (Tx. at 39, 41.). The Arbitrator notes Dr. Arps has produced a narrative noting he only saw claimant on one occasion, May 28, 2015. (PX 1; RX A.).

Petitioner testified Dr. Arps performed a series of tests and "they hurt very bad." (Tx. at 41.). Petitioner testified Dr. Arps did not release him to return to work and the last day he worked at Capsonic was May 24, 2015. (Id. at 42.). The Arbitrator notes there are no records showing Dr. Arps issued any work restrictions with respect to Petitioner.

Petitioner testified he told Dr. Arps he noticed a tingling sensation and pain in his right hand while "working on the presses." (Tx. at 59.). He testified he explained to Dr. Arps what his job duties were and how he used his right hand on Press 72. (Id.).

Records from Dr. Alan Arps, a plastic and reconstructive surgeon, note that Petitioner presented on May 28, 2015 with a history of dull pain over the dorsum of his right little finger, ring finger and ulnar side of his hand to the wrist. (PX 1; RX B). The doctor noted Petitioner's report that for the past two weeks the pain had changed to constant sharp pain and he was unable to straighten his right little finger. (Id.). Dr. Arps noted, "[h]e reported to me that he was stabbed three months prior to presenting to me". (Id.). Petitioner reported that he received sutures and staples for that injury and that various hospitals, including St. Bernards, University of Chicago and Jackson Park provided care for the stabbing injury. Petitioner further reported to Dr. Arps that all of the hospitals recommended he consult with a specialist. (PX 1; RX A). On exam, the doctor noted a 35 mm scar on the ulnar side of his forearm, just proximal to the wrist, with local tenderness, decreased pinprick sensation to the dorsal-ulnar portion of his hand-proximal to the ring and little fingers. Dr. Arps noted, "At first he was unable to extend his little finger, but when he was distracted, he was able to extend". (Id). Petitioner was able to abduct and adduct. The flexor carpi ulnaris (FCU) and extensor carpi ulnaris (ECU) were palpable and intact. Dr. Arps noted the scar was between the FCU and ECU. Petitioner was able to flex and extend the metacarpal-phalangeal, proximal and distal interphalangeal joints. (Id.).

Dr. Arps' assessment noted he "felt Anthony had suffered an injury to the sensory branch of his ulnar nerve, with possible formation of a neuroma. Dr. Arps did not mention any future plan, although he did note that Petitioner had not returned to see him. (Id.).

Petitioner testified that today his right wrist/hand does not feel normal and that he has pain on the side of his wrist.

CONCLUSIONS OF LAW

C. ACCIDENT

There is no objective evidence that Petitioner suffered a work-related injury to his right hand on May 9, 2015.

Although Petitioner testified at the hearing that he reported a history to the staff at the ER on May 9, 2015 (15 WC 18457) of a work related injury, a review of the actual records shows that he complained of "numbness to the right hand since he was stabbed in the right forearm four months ago". (PX 1; RX A; Tx. at 48.). His initial

(and only) treating record with Dr. Arps does not contain a history of a work-related accident or condition. In fact, both records strongly suggest Petitioner's right hand/wrist problems are related to a stabbing incident that occurred around February of 2015.

The Arbitrator did not find that Petitioner presented as a credible witness with respect to his behavior and demeanor while testifying.

After reviewing the trial testimony and exhibits, the Arbitrator finds claimant has failed to meet his burden of proof with respect to the issue of accident.

E. NOTICE

Although all other disputed issues are moot, the Petitioner's Workers' Compensation file, introduced as Respondent's Exhibit B, confirms statutory notice of Petitioner's claims was provided to Atlas by Capsonic supervisor Tommy Phillips on or about June 8, 2015. Therefore, the Arbitrator finds notice was proper. See also, Tx. at 83-84.

The Arbitrator has determined Petitioner did not suffer a compensable work accident and finds it's more likely than not claimant's right hand/wrist problems are related to a stabbing incident that occurred in February of 2015, as noted in claimant's medical records. All remaining issues are moot.

The Arbitrator will not make any findings as to whether or not Petitioner engaged in Workers' Compensation fraud as this issue is beyond the scope of the Arbitrator's authority.