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

Russell Niepert,
Petitioner,
vs.

NO: 13WC040151

State of Illinois/ Menard Corr. Center,
Respondent,

17IWCC0061

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner, herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, 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 13, 2016, 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: FEB 2 - 2017
MJB/bm
o-1/24/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

NIEPERT, RUSSELL
Employee/Petitioner

Case# **13WC040151**

ST OF IL/MENARD CORR CENTER
Employer/Respondent

17IWCC0061

On 4/13/2016, 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 0.35% 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:

0969 THOMAS C RICH PC
6 EXECUTIVE DR
SUITE 3
FAIRVIEW HTS, IL 62208

0558 ASSISTANT ATTORNEY GENERAL
KENTON OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT SYSTEMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

APR 13 2016

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

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(a)

RUSSELL NIEPERT
Employee/Petitioner

v.

STATE OF ILLINOIS / MENARD CORR. CENTER
Employer/Respondent

Case # 13 WC 40151

Consolidated cases: _____

17IWCC0061

An *Application for Adjustment 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 **February 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 _____

17IWCC0061

FINDINGS

On the date of accident, **October 7, 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 **$65,604.00**; the average weekly wage was **$1,261.62**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **2** dependent children.

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

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

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

ORDER

The Petitioner failed to prove that he sustained accidental injuries arising out of and in the course of his employment with the Respondent on October 7, 2013.

The Petitioner failed to prove that the current condition of his upper extremities is causally related to his employment with the Respondent.

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

April 8, 2016
Date

APR 13 2016

STATEMENT OF FACTS

The Petitioner alleges that he suffers from bilateral carpal tunnel that was caused or aggravated by his work duties with the Respondent. From October of 1996 until April of 2011, Petitioner worked as a Correctional Officer (CO) at Respondent's maximum security Menard facility. During that time, the Petitioner worked the day shift (7:00 am to 3:00 pm) 90% of the time and the second shift (3 pm to 11 pm) 10% of the time. Petitioner testified that he spent about 12 of his years as a CO working in Respondent's segregation unit, where apparently the most difficult inmates were held. Petitioner testified that during the course of his duties as a CO he noticed symptoms of numbness in his hands from time to time, and as he has gotten older he has lost grip strength and his hands fall asleep for longer periods of time.

Per a Staff Assignment history, towards the end of his time as a CO, from March 1, 2009 to July 19, 2009 he worked as the North 2 personal property officer, and from September 16, 2010 to March 22, 2011 he worked as the North 2 infirmary officer. (See Rx5). During that time he didn't have to perform much, if any, bar rapping, and agreed that as infirmary officer he did not have to open as many cells. On April 1, 2011, Petitioner was promoted into the prison law library, initially to library associate, shortly thereafter to a paralegal position for 6 to 8 months, and ultimately to correctional counselor in February of 2012. After he started working in the library, he no longer had to rap bars, open cell doors or chuckholes, but he did have to open a number of mailbox padlocks.

Asked to what he attributes his condition, the Petitioner testified: "The repetitive pulling, shutting doors, I mean, struggling with several of them, too, for -- there was times you just had to yank them as hard as you could to get them open." Asked if he attributed his condition to his activities as a paralegal and counselor for the Respondent, Petitioner testified: "Not as much, say, but maybe from typing a little bit, but it was more from -- really from turning massive amounts of keys. I mean, it was nothing for me to turn 50 master locks every time I went down, you know, hundreds of times a day." (Tr. 40-41).

Petitioner testified that the Job Site Analysis of the duties of a Menard CO (Px9; Rx8) generally was accurate as to the physical demands of his job as a CO. He specifically agreed with the following descriptions: frequent lifting and/or carrying up to 25 pounds; pulling open cell doors from 2 ½ hours to 5 ½ hours per day, up to 200 times per day; frequently pulling open chuckhole doors; frequent cuffing and uncuffing of inmates; wrist turning 34-66% of the time, 2 ½ to 5 hours per day, or 33 to 300 times per day; 1 to 32 repetitions of lifting property boxes. He indicated that the documentation of how often a CO had to use keys in locks was significantly less than he did in reality. The Arbitrator notes this document reports multiple other activities are performed by COs, including work at the gatehouse, shakedowns, bar rapping, wing checks, "the crank", receiving and classification, tower, and weapons and ammunition training. Specific activities are also noted, with the designations of whether they are performed never, occasional, frequent or continuous. (Px9; Rx8).

The Petitioner testified that with two inmates per cell, a CO, assisted by a second CO, would have to cuff both, as well as use a lead cuff, which resembles a leash, to control and remove an inmate from a cell. He stated that it required grip strength and force to hold on to the lead cuff and control the cuffed inmate. Some inmates would resist during the cuffing process.

Petitioner testified that to open a cell door, he had to unlock the door with a large Folger Adams key, turn the locking mechanism, and then pull the door open at the same time. Turning the key moved a "dogleg" mechanism in the door upward, which in turn allows the door to be pulled open. He testified that these are particularly difficult to open because of the antiquated condition of the locks. Petitioner testified that he's opened cells tens of thousands of times in his career, and at times his hands would become numb after multiple unlockings. He has struggled with locks often and many times has had to call a locksmith to come and take panels off to get doors open. He testified the cell doors weigh several hundred pounds and most are very hard to open, noting it was sometimes harder to pull doors open in the summer due to hot temperatures causing them to swell.

Respondent's doors also have a locked "chuckhole", a solid steel panel through which items such as meals, trash, laundry and commissary are transferred to/from inmates. The chuckholes were padlocked, and opening some of the locks required force and grip to open due to age. The chuckhole panels themselves were sometimes difficult to slide open because of food, debris, and other items inmates would wedged inside.

Petitioner testified that he participated in performing shakedowns, which involved searching through inmate cells and personal property for contraband, using his hands and arms to lift mattresses and property boxes of various weights. Petitioner also testified that when the Menard facility would go on lockdown, the COs would be responsible for tasks for that inmate workers usually perform, such as feeding inmates, handling food trays, sweeping and mopping.

A video produced at Respondent's direction depicts the duties of a CO at Menard Correctional Center. (Px10; Rx9). The video depicts various job tasks, assignments, areas, equipment and mechanisms demonstrated by a variety of COs, including a demonstration of bar rapping, and walkthroughs of numerous areas of the facility. Each area requires opening and closing multiple doors and using a variety of keys, including Folger Adams keys. The Petitioner testified that the video was inaccurate: "Because it does not account for the many times when you try to open doors, take cells off of deadlock when the mechanisms themselves do not work." He further testified that the doors were opened "very slowly" and the pace depicted in the video is not the speed at which the doors are normally opened and closed. The Petitioner testified that he bar rapped every day as a CO, noting he was right handed and used the right hand to do so 100% of the time, and that it would produce a vibrating feeling in the arm and occasional numbness. The Arbitrator acknowledges that he reviewed the video and the activities of COs depicted therein.

The Petitioner described his duties as a correctional counselor:

> "A lot of paperwork. We do a lot of the paperwork as far as transferring inmates, classifying their escape risks, their security levels, whether they're minimum, medium or maximum. Most of ours, of course, are maximum. I am kind of a liaison between the families and the inmates whenever they need information. I also have to speak – we have a caseload of, approximately, 280 inmates that I have to regularly tour and talk to and see what their needs are, if they need copies of how much money they have on their transaction accounts or if they need, you know – I answer their grievances." (Tr. 33-34).

Petitioner testified as a counselor, much of the information he processes he records by computer and/or handwriting and consumes 75% of his work day. He estimated that 75% of his work is computerized and 25% of

his work is handwritten. Petitioner testified that his symptoms did not improve after becoming a correctional counselor, it just kept getting worse. He agreed that the counselor job was easier on his hands and arms than his job as a CO. The Petitioner testified that he is right handed, and thus that all handwriting is done with his right hand.

Respondent's Job Site Analysis for a correctional counselor at Menard indicated that a counselor works 37.5 hours per week and has an average of 278 inmates on a caseload. (Rx6). It was noted that a counselor may spend about 50% of their time or about 4 hours per shift on the computer (noting this includes notes, reports, emails and research), and 50% of their time or about 4 hours per shift on the phone. It also indicates that counselors handwrite notes during interviews with inmates and later enters the information into the computer system. A video submitted by the Respondent, and reviewed by the Arbitrator, purports to depict the job of a Menard correctional counselor via a tour of the various offices and job sites where they perform their job duties, including writing, clerical tasks, computer work, filing, and meeting with inmates. (Rx7).

Petitioner submitted what appears to be a self-prepared general work description for the jobs he held with Respondent since 1996. (Px6). Petitioner also introduced a Post Description for COs in various prison locations that was prepared, or at least signed off on, by Chief of Security Major Richard Harrington. (Px13). It describes duties including pulling cell doors twice to ensure the cells are securely locked, random checking of all locks on the gallery, checking cell locks prior to moving inmates into respective cells, performing inmate counts by looking in or opening the cells, removing inmates from cells for escort, monitoring all movement, searching cells prior to placement of inmates, checking all locks, doors and restraints to ensure they are in proper operational order and secured, shake downs, keying in and out inmates from cells for all movement that is not a mass line movement, searching inmates entering and leaving the gallery, and securing doors.

Respondent's representative at the February 4, 2016 hearing was Robert Hughes, a shift supervisor, who was called as a witness by Petitioner. He has worked for the Respondent for 23 years, all at Menard except for the period from 2004 to 2012, when he worked as an investigator. When asked, he could identify no discrepancies in Petitioner's testimony and testified that Petitioner was a good employee. On cross-examination, Mr. Hughes was asked about the doors in one of the galleries where Petitioner worked, the north 2 cell house. He testified:

> "Those doors-those doors are in bad shape. They're probably the worst in the facility, to be honest. When I hired in, that side was actually Menards site side, and those doors were regular solid doors, not solid doors but just regular bar doors. And probably in 1996, Menards site shut down its own facility, and Menard Correctional Center took over, and they made that the north 2 segregation unit. At that timeframe they started welding steel plates on all these doors, and it really screwed the doors up. The staff in north 2 do have a big issue with them doors [sic] because they're not made to add all these steel plates to." (Tr. p. 72)

Petitioner testified he had never previously sustained any work-related or non-work-related injuries to his hands or elbows, and had never sought any treatment for his hands or elbows until May 31, 2013. He does not suffer from gout, hypothyroidism, diabetes, or rheumatoid arthritis, and he does not engage in any strenuous recreational activities on a regular basis.

Petitioner initially sought care with his family physician, Dr. Mark Preuss, on May 31, 2013, with complaints of bilateral hand and arm discomfort, spasm, weakness and paresthesias. (Px3; Rx10). He also complained of discomfort around his neck or shoulder and that his whole arm gets numb at times, noting sometimes it occurred when he was sleeping, but other times he couldn't really say why. The report does not state whether the Petitioner reported a date of onset. Dr. Preuss noted that Petitioner seemed to have positive Tinel's signs bilaterally over the wrists with no visible atrophy, and made specific mention of Petitioner's job history, stating, "He has worked for a long time at Menard, the prison turning gates and locks, now has gone into some counseling there as his job so it's not as much as the turning of locks and keys but has noticed over time it's just getting worse." Dr. Preuss diagnosed bilateral carpal tunnel syndrome, possible thoracic outlet syndrome and prescribed EMG/NCV testing along with bilateral cockup splints. The August 30, 2013, EMG/NCV confirmed right carpal tunnel syndrome, and was otherwise normal. (Px3 & Px4). The Petitioner testified that splinting did not help his symptoms. When the Petitioner returned on October 7, 2013, Dr. Preuss noted the EMG/NCV confirmed carpal tunnel syndrome on the right, and recommended that Petitioner see a hand specialist for possible carpal tunnel release surgery. (Px3; Rx10).

With regard to claiming October 7, 2013 as the date of accident, or manifestation date in this case, the Petitioner agreed that Dr. Pruess initially reported that Petitioner complained of wrist/hand numbness and tingling on May 31, 2013, noted that he turned keys and locks at work, diagnosed carpal tunnel and prescribed splints. He also testified that he first heard of carpal tunnel from co-workers who were diagnosed with in in the late 2000's. However, he noted that on May 31, 2013 Dr. Pruess wasn't sure of the diagnosis, indicated it "could possibly be" related to work, noted possible thoracic outlet syndrome, and wanted EMG/NCV testing to confirm a diagnosis. Petitioner testified it was not until October 7, 2013 that Dr. Preuss reviewed the EMG/NCV, formally diagnosed carpal tunnel and attributed the condition to the Petitioner's work duties. It was after the October 7, 2013 visit that the Petitioner completed accident/injury paperwork for the Respondent, indicating an October 7, 2013 date of accident. (Px7, Rx1, Rx2). The Petitioner testified that Dr. Preuss referred him to Dr. Young.

The Arbitrator notes a September 29, 2003 report of Dr. Preuss indicated Petitioner complained of a work injury to the neck and left arm which resulted in symptoms of paresthesias in the left arm into the fingers. By October 30, 2003 the Petitioner indicated that the symptoms had resolved. (Rx10).

Petitioner completed a Notice of Injury with Respondent on October 21, 2013, and attributed his injury to repetitive trauma, with out further explanation as to what job duties were repetitive. (Px7; Rx1). The Form 45 indicates the injury occurred due to "repetitive motion of turning keys." A Supervisor's Report of Injury with the same date indicated Petitioner handed an incident report to supervisor Betsy Spiller, noting an injury due to "repetitive trauma." Ms. Spiller noted Petitioner's job involved providing clinical services to approximately 250 inmates, with duties including answering questions, submitting (illegible) and extensive use of DOC computer systems. The indication was right carpal tunnel occurring "over time." (Px7; Rx1, Rx2).

Petitioner sought treatment with Dr. Young at the Orthopaedic Institute of Southern Illinois (Px5; Rx11) on December 11, 2014, for evaluation of a two year history of upper extremity numbness, tingling and pain. The Petitioner reported that his symptoms had significantly increased over the past several months, and that he had symptoms with riding and driving. The Petitioner reported no relief with the use of splints. Dr. Young noted that Petitioner had undergone two NCVs, with one showing carpal tunnel and the other showing being negative for

carpal tunnel. Examination indicated positive Tinel's and median nerve compression tests at the wrists bilaterally with no thenar atrophy. Noting he reviewed the two NCV reports, Dr. Young diagnosed bilateral carpal tunnel syndrome, and recommended bilateral carpal tunnel releases, indicating the right side should be performed first given the symptoms were worse on that side. On cross examination, the Petitioner testified that he did not know what the noted history of symptoms with "riding" meant, as he does not ride horses or a motorcycle. He agreed with the noted history of symptoms for one to two years, agreed this would go back to 2012 or 2013, and that he was working as a correctional counselor during those years.

Respondent had Petitioner examined by Dr. Sudekum on March 10, 2014. (Rx12). Dr. Sudekum's physical examination showed a positive right wrist Phalen's test, but the NCV he performed in his office that day was negative for carpal tunnel in either wrist. Dr. Sudekum did not believe that the Petitioner suffered from carpal tunnel. He noted that Dr. Preuss indicated Petitioner "seems" to have a positive Tinel's sign, and had a negative Phalen's. He noted that while the EMG/NCV of August 30, 2013 was read as positive for right carpal tunnel, Dr. Sudekum indicated that without the reader providing information on what findings would be considered normal, he was unable to verify that the testing was actually positive on the right side. He noted Dr. Preuss initially noted complaints involving the entire arm being numb, offering a differential diagnosis of thoracic outlet syndrome, with numbness in all five fingers, but did not work that potential issue up further. His own examination was benign other than the Phalen's test in the right. He opined that the Petitioner did not suffer a repetitive trauma injury to either upper extremity while working as a CO. He noted that the Petitioner's last five years of work with the Respondent did not involve work as a general CO, but rather included personal property officer, library associate, paralegal and correctional counselor, and it was during this part of his employment that he developed symptoms. He did not believe that a repetitive injury would manifest after cessation of the potentially provocative job activities. With regard to many of his general opinions on the issue of causation of repetitive work related job activities, he cited to multiple medical studies in support of many of those opinions.

Dr. Young testified by way of deposition on August 17, 2015. (Px8). He testified that the nerve testing machine used by Dr. Sudekum is not as accurate as the standard EMG/NCV. He confirmed his belief that the Petitioner suffers from bilateral carpal tunnel syndrome based on the results of the diagnostic studies and Petitioner's clinical examination, and reiterated his recommendation for a right carpal tunnel release with possibility of left carpal tunnel release at a later date. (Px8).

Dr. Young testified via deposition on August 17, 2015 and October 27, 2015. (Px8). He opined that Petitioner had bilateral carpal tunnel syndrome. With regard to causation, Dr. Young testified that he reviewed Respondent's evidence, including the job video and the Job Site Analysis for a CO, and that the physical job demands as outlined, including bar rapping, turning keys, and handling inmates, could cause or contribute to the development of bilateral carpal tunnel syndrome. He stated:

> "For one, I think there were several mentioned that individually alone could contribute to the development. I think all of them together would certainly create an additive situation. There are situations where the individual utilizes some forceful gripping. There are situations where there is forceful pinching, flexion, extension of the wrist, vibration with the bar rapping. So I think that all of those together would definitely contribute to the development of carpal tunnel syndrome." (Px8, pp. 13-14).

He testified that the injuries from Petitioner's job duties were subject to a latency period, or a lapse in time during which pathology is developing but no symptoms are manifest. He explained, "Well, I think that everything he did prior to his new occupation or job duties likely contributed. That's essentially the latency period which you alluded to earlier." (Px8, p. 16). Dr. Young also testified that Petitioner's typing duties could contribute to the development of carpal tunnel syndrome. (Px8, p. 16-17).

On cross examination, Dr. Young opined that since Petitioner had already tried splinting without relief, that in his experience a steroid injection would likely be a temporary fix and that surgery would be recommended for long term relief, noting he would plan to proceed with right carpal tunnel release, and possibly left carpal tunnel release at a later date. Asked what work situation he believed could contribute to the Petitioner's carpal tunnel, Dr. Young indicated data entry and the writing or reports. He indicated that Petitioner reported that 25% of his job involved data entry. He agreed that there are medical studies which do not show a correlation between computer data entry and carpal tunnel, as well as that older studies which did indicate such correlation was based upon the use of old manual typewriters. He was not familiar with Petitioner's workstation, and he noted that, assuming that typing was done with the wrist in an abnormally flexed or extended position, it could increase pressure on the median nerve and, if done over long periods of time, it could be a contributing factor in carpal tunnel. Asked if there was anything else about Petitioner's job duties that could be contributory, Dr. Young stated: "Not that I see in what he's given me, no.", and indicated that he couldn't recall what activities the Petitioner may have performed prior to his most recent position as a correctional counselor. (Px8, p. 12, 14 (10/27/15)).

The deposition of Dr. Sudekum was obtained on January 29, 2015 and February 10, 2015. (Rx13 & 14). Dr. Sudekum had reviewed the job descriptions and videos for a correctional officer and correctional counselor at Menard, and also had toured the facility himself in 2011. Dr. Sudekum did not believe there was sufficient objective evidence to support that the Petitioner in this case suffered from carpal tunnel syndrome, and also testified that Petitioner did not have thoracic outlet syndrome. He testified that even if he believed Petitioner did suffer from carpal tunnel syndrome, he would not believe that any potentially provocative job duties were a factor unless Petitioner "had symptoms, had sought some kind of evaluation or at least made a complaint" during the course of those duties. While he noted that while the duties of a CO could potentially be provocative to median and ulnar neuropathies, because Petitioner had ceased being a correctional officer for an extended time before having complaints of numbness and tingling in his hands, Dr. Sudekum opined that the duties of a correctional officer would not have been an aggravating factor for carpal tunnel syndrome. Dr. Sudekum testified that current medical literature also does not establish a correlation between computer typing and carpal tunnel syndrome. (Rx13 & 14).

On cross examination, Dr. Sudekum testified that he has been involved in approximately 172 cases on behalf of the Respondent. Dr. Sudekum acknowledged Dr. Burger interpreted the results of his nerve conduction study as positive over Petitioner's right upper extremity, but purported that he was unable to interpret Dr. Burger's studies because there was no indication of what Dr. Burger used as "normal" values, and because of an inconsistency in the data. (Rx14).

Petitioner submitted a deposition of Dr. Sudekum (Px12) that purports to be a general deposition with regard to whether CO job duties can cause repetitive trauma injuries. As this was objected to by Respondent, and the deposition of Dr. Sudekum was taken with regard to this specific case, and thus both parties had the opportunity to ask any necessary questions of the doctor, the Arbitrator rejected this exhibit based on both hearsay and relevancy grounds. Petitioner also submitted a report of Dr. Sudekum in this same vein, Px11. There was no objection to this exhibit, and it was admitted into evidence. This report essentially indicates that Dr. Sudekum reviewed the CO Job Analysis (Px9; Rx8), as well as the job video (Px10; Rx9), and on March 22, 2011 visited Menard, toured the facility and performed many CO activities. His conclusion was that while the CO job activities would not be a primary etiologic factor, such activities could be an aggravating factor in the development and/or progression of upper extremity "repetitive trauma injuries" (Px11).

The Petitioner testified that Dr. Young has recommended carpal tunnel release surgery on the right, possibly on the left as well, and Petitioner indicated that he has bilateral symptoms, but that the right side seemed worse than the left. The Petitioner testified that he had some fearfulness about surgery, but that his symptoms had "gotten to the point that its become cumbersome in everyday life."

Petitioner submitted his claimed causally related medical expenses as Petitioner's Exhibit 1. The parties have stipulated that, should any or all of the bills contained in Px1 be awarded by the Arbitrator, the Respondent shall pay said expenses directly to the providers pursuant to the Fee Schedule contained in Section 8.2 of the Act.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT WITH 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:

The Arbitrator finds that, based on the greater weight of the evidence, the Petitioner failed to prove that the condition of his bilateral upper extremities is causally related to a repetitive work injury while employed with the Respondent.

In a repetitive trauma case, issues of accident and causation are intertwined. Here, the Arbitrator initially notes that it is unclear if the Petitioner is claiming that his upper extremity conditions were due to his work as a CO, his work as a counselor, or both. The Petitioner testified that he believed his condition was due to his employment as a CO with the Respondent, noting with regard to his work as a counselor, "maybe from typing a little bit." His testimony, and the evidence presented, with regard to the CO position was significantly detailed versus what was presented as to the counselor's position. In the documentation completed when the Petitioner initially reported a work injury to the Respondent, the Form 45 indicates the injury was due to turning keys, while the supervisor's report only references Petitioner's work duties as a counselor.

While it is possible that the work activities performed by the Petitioner as a CO could potentially have been considered to have involved an accident within the meaning of the Act, the fact is that all of the evidence in this case, other than Petitioner's current testimony, indicates that he did not have symptoms during that time. It was only well after he stopped working as a CO that he developed symptoms and sought treatment. As such, in the Arbitrator's view, those activities do not constitute an accident involving an October 7, 2013 manifestation date.

Ultimately, the issue of causation in a case like this is going to be determined by a medical opinion, as the Arbitrator does not necessarily hold the Petitioner to a standard of determining on his own which activities may have caused his condition.

The Petitioner's job duties as a correctional counselor are not well defined by the evidence in this case in terms of whether such activities would constitute repetitive activities that would constitute an accident within the Act in Illinois. There was no specificity provided with regard to how long the Petitioner would perform any one activity continuously, how much force was involved, how many breaks were taken, or how the Petitioner's day was broken up. It is clear to the Arbitrator that the Petitioner's job in this regard involved going to cells or galleries to interview inmates, notes were taken during these times, and the Petitioner would return to an office area to enter data, do research, use the telephone and answer inmate and family questions. There were general estimates as to how much of a day was spent doing various activities, but no specificity as to how those were performed with regard to the use of the upper extremities, and more importantly no specificity with regard to the information relied upon by Dr. Young. The Petitioner has cited case law in support of the fact that there is no specific standard required by law with regard to a specific repetitiveness threshold that must be proven by a claimant. Here, it is not so much that a specific threshold was not reached, so much as that the Arbitrator has determined that there was a failure to prove an accident occurred which arose out of and in the course of the employment.

The Arbitrator finds the opinion of Dr. Sudekum more persuasive than that of Dr. Young with regard to the causal relationship of Petitioner's duties as a CO. The fact is that the Petitioner stopped doing a significant amount of the key turning, cuffing and lock opening he previously did as a CO when he became a personal property officer in March, 2009, and again as a personal property officer in September, 2010. His duties as a CO ended as of April 1, 2011, when he started his employment in the prison library. He did not seek any treatment for his upper extremities until May 31, 2013 with Dr. Preuss. Thus, the first time he sought treatment was approximately 32 months after he became the property officer, and 26 months after he stopped working as a CO. While the Petitioner testified that he had symptoms while he was a CO, the history provided to Dr. Young indicated that his symptoms didn't begin until he moved into the library position. He also clearly testified that his condition continued to do worse after he started working in the library, noting this was "as he got older." While the Arbitrator acknowledges the testimony of Dr. Young with regard to a latency period, the Arbitrator believes that the evidence does not support this opinion as much as it supports that of Dr. Sudekum.

While Dr. Young testified that the Petitioner's job duties of data entry and writing reports contributed to his carpal tunnel. He indicated that per Petitioner report, 25% of his job involved data entry. He agreed that there are medical studies which do not show a correlation between computer data entry and carpal tunnel, as well as that older studies which did indicate such correlation was based upon the use of old manual typewriters, and did not testify regarding any studies which supported his causation opinion. He was not familiar with Petitioner's workstation. He testified that typing done with the wrist in an abnormally flexed or extended position could create increased pressure on the median nerve and, if done over long periods of time, could be a contributing factor in carpal tunnel. However, he did not testify with regard to whether Asked if there was anything else

about Petitioner's job duties that could be contributory, Dr. Young stated: "Not that I see in what he's given me, no".

In December, 2014 Petitioner reported that to Dr. Young that his symptoms began two years prior, which would be December, 2012, and that his symptoms had become significantly worse in the prior several months. This was well after the Petitioner's employment as a CO ended. When asked if this timeline was accurate on cross examination, Petitioner agreed it was and that he was not working as a CO at that time. The Petitioner testified not only that the counselor job was easier on his upper extremities than his job as a CO, but also that his symptoms did not improve after becoming a counselor, it just kept getting worse.

The Petitioner also reported to Dr. Young that his symptoms were worse with riding and driving. The Arbitrator notes that Dr. Young's intake forms reflected that Petitioner noted symptoms with writing and driving. However, it is unclear which of these histories Dr. Young initially was relying on. Again, the Arbitrator believes this adds to the finding that Dr. Sudekum's causation opinion was more persuasive.

While there is some questionability with regard to the evidence supporting that the Petitioner has carpal tunnel, the Arbitrator believes the Petitioner minimally has right sided carpal tunnel based on the EMG testing in August, 2013. The Arbitrator does not agree, however, that the Petitioner has proven that this condition was caused or aggravated by his employment with the Respondent. There are simply too many questions out there that are not answered. The Petitioner has the burden of proving the elements of his claim, and the Arbitrator believes he did not do so here by a preponderance of the evidence.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator as determined that the Petitioner has failed to prove that he sustained accidental injuries arising out of and in the course of his employment with the Respondent. As he has failed to prove accident, the issue of notice 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 determination that the Petitioner has failed to prove that he sustained accidental injuries arising out of and in the course of his employment with the Respondent, and has failed to prove his current condition is causally related to his employment, 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 determination that the Petitioner has failed to prove that he sustained accidental injuries arising out of and in the course of his employment with the Respondent, and has failed to prove his current condition is causally related to his employment, this issue is moot.

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

Jack Crippen,
Petitioner,
vs.

NO: 14WC018020

Osman Produce,
Respondent,

17IWCC0062

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, 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 4, 2016, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4800.00. 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: FEB 2 - 2017
MJB/bm
o-1/24/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CRIPPEN, JACK
Employee/Petitioner

Case# **14WC018020**

OSMAN PRODUCE
Employer/Respondent

17IWCC0062

On 4/4/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

5404 LAW OFFICES OF FOLEY & DENNY
TIMOTHY D DENNY
PO BOX 685
ANNA, IL 62906

2674 BRADY CONNOLLY & MASUDA PC
NOAH P HAMANN
211 LANDMARK DR SUITE C2
NORMAL, IL 61761

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

Jack Crippen
Employee/Petitioner

v.

Osman Produce
Employer/Respondent

Case # 14 WC 18020

Consolidated cases: n/a

17IWCC0062

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **February 10, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **May 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 scalp contusion and scalp laceration *are* causally related to the accident, but the cervical spine condition *is not* causally related to the accident.

In the year preceding the injury, Petitioner earned **$39,750.36**; the average weekly wage was **$764.43**.

On the date of accident, Petitioner was **72** years of age, *married* with **0** dependent children.

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

ORDER

Respondent shall pay for medical services **for the dates of service of May 22, 2012 at Union County Hospital and May 31, 2012 at Goreville Family Practice** 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 **solely as it pertains to the dates of service of May 22, 2012 at Union County Hospital and May 31, 2012 at Goreville Family Practice**. Respondent is to pay unpaid balances with regard to said medical expenses **solely as it pertains to the dates of service of May 22, 2012 at Union County Hospital and May 31, 2012 at Goreville Family Practice** directly to Petitioner. Respondent shall pay any unpaid, related medical expenses **solely as it pertains to the dates of service of May 22, 2012 at Union County Hospital and May 31, 2012 at Goreville Family Practice** according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner.

Respondent shall pay Petitioner the sum of **$458.66/week** for a further period of **10 weeks**, as provided in **Section 8(d)2** of the Act, because the injuries sustained caused **2% loss of use of the person-as-a-whole.**

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

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

Melinda M. Gore-Sullivan

Signature of Arbitrator

3/31/16

Date

APR 4 - 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jack Crippen
Employee/Petitioner

Case # **14** WC **18020**

v.

Consolidated cases: **N/A**

Osman Produce
Employer/Respondent

17IWCC0062

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified at the time of arbitration that he is currently seventy-six years of age and that in 2012 he was employed by Respondent. He testified that he began working for Respondent in 1994. He testified that he was a machinist and a welder, that he painted trucks and built truck bodies and that he was the shop foreman. He testified that he had an accident at work on May 22, 2012. He denied having any problems or injuries to his neck, and he further denied having anything wrong with his neck that kept him from working on a regular basis prior to the accident. He also denied being under the care of a physician for any ongoing issues with his neck.

Petitioner testified that on May 22, 2012, there was a John Deere tractor that had not been started for approximately two years. He testified that the engine did not break loose, so he picked up a 48-inch pipe wrench and placed it on the crank pulley. He testified that he put a piece of square tubing that weighed approximately 30 pounds over the handle of the wrench to make it longer and still could not move it, so he asked Don Duckworth to help him pull. He testified that the wrench lost its grip and came down, hitting him on the top of his head. He testified that he was struck from the area of his right eye to the top of his head, and that seven staples were used to close the wound. He testified that Petitioner's Exhibit 9 contained a picture of the wrench that he was using at the time of the accident, and that the wrench was made of steel and weighed approximately 50 pounds. He testified that the wrench and 3 by 3 piece of tubing weighed 40-50 pounds, in addition to his weight and Don Duckworth's.

Petitioner testified that after he was hit in the head he did not fall down and did not believe he lost consciousness. He testified that he took a break and sat down, and then went into the office to get a bottle of cold water and sat down again. He testified that he looked up at the calendar, and he saw two. He testified that "things started in [his] neck" about 30 minutes later.

Petitioner testified that after he was cut, there was blood running in his eyes so he got a handful of paper towels and put them underneath his hat to soak up the blood. He testified that he then started getting a little nauseous, and stated that he had better go to the emergency room. He testified that Don drove him to Union County Hospital. He testified that he told the hospital personnel what happened, as well as describing the laceration to his head. He testified that he also told them that he had neck pain at that time as well. He testified that he was told he had a concussion and was given pain medications. He testified that he went to work the next day.

Petitioner testified that over the next few months, his neck pain steadily got worse. He testified that he had had lower back pain for a while, but his neck pain overtook that within approximately one year. He testified that he finally went to see Dr. Aaron Kuntz, a neurologist, who then referred him to Dr. Tolentino. He testified that Dr. Tolentino recommended surgery, which he underwent on two occasions. He testified that he worked up until the surgeries were performed, but has not worked since.

Petitioner testified that his symptoms prior to undergoing surgery included increasing pain that kept getting worse, and that he also kept losing the ability to turn his head. He denied that surgery helped to resolve some of his problems. He testified that he cannot raise his head high enough to comb his hair or see in the mirror, and that he has to lean back to swallow. He testified that he takes four pain pills pretty much daily, and that he has had a cortisone injection in his neck by Dr. Reis. He also testified that Dr. Reis also injected his lower back and left hip.

Petitioner testified that he cannot work with how his neck feels now. He testified that he has problems with grip strength, has carpal tunnel syndrome and has numbness and tingling in three fingers that was not present prior to the accident in May of 2012.

On cross-examination, Petitioner denied having neck pain prior to the May 2012 accident. When shown the October 21, 2013 note as contained in Respondent's Exhibit 3, Petitioner noted that the record was dated 2013 and that he was hit in the head in 2012.

On cross-examination, Petitioner testified that may have taken the next day after the accident off but doubted it. He testified that he kept working until March 13, 2014, and agreed that he worked full duty for the timeframe of May 23, 2012 through March 13, 2014. He testified that his job duties on a daily basis typically included going to work at 8:00, laying down on the creeper and rolling under a truck, giving serial number information to someone in the office to order a part, climbing up a ladder and looking inside an aluminum truck bed, putting in a new floor and doing machine work. He also testified that some days he welded or did machine work all day long. He testified that he had to quit doing most of the painting during the last three years that he worked for Respondent.

On cross-examination, Petitioner confirmed that welding involved turning his neck, and further indicated that while working as a machinist he stood bent over with his head down most of the time. He testified that he typically welded about two hours per day. He confirmed that his job involved lifting, and that he would lift up to 50 pounds by himself but if there was something heavier he would have one of the younger guys help or he would use his small crane. He confirmed that these were duties that he was performing after the accident but before his surgery. He also confirmed that he did not ask for any special accommodations or time off.

On cross-examination, Petitioner agreed that he went to the emergency room at Union County Hospital on the date of the accident, and that he then went to see his family physician at Goreville Family Practice approximately one week later on May 31st. He confirmed that when he went to his family physician on that date, the staples were removed from his head. He testified that the physician's assistant did not recommend any treatment for his neck at that time. He agreed that after the staples were removed in May, he did not go to another doctor until July of 2013. He agreed that on July 11, 2013 he went to the emergency room at Union County Hospital because he fainted for some unknown reason, but believed it was due to dehydration. When asked if he remembered anything about his fall such as how he fell or landed, Petitioner responded that his nephew was there and stated that he lost consciousness for 5 or 10 minutes. He testified that by the time the ambulance arrived, he was sitting in his chair and felt fine.

On cross-examination, Petitioner agreed that he was not alleging that he hurt his low back or hip during the accident. He testified that he did not know whether his carpal tunnel syndrome was related to

the accident but would defer to the physicians on that issue. He agreed that he was not placed under any specific work restrictions from a physician for his neck. He testified that he has not been able to stand up for more than five minutes for two years, so he did not ask for any restrictions.

On redirect examination, Petitioner testified that after the accident there were a lot of days where he had to leave work early because he was having pain in his neck. He testified that it usually would be around 4:00 in the afternoon, but sometimes he would make it to 5:00. He testified that when it got bad enough and his double vision would start, he would call his wife to get him. He testified that when he welded, he was not typically welding something that was in a fixed position.

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 was noted to be May 22, 2012, at which time Petitioner alleged he was hit in the head with a wrench. Petitioner alleged that he sustained injury to his head, neck, and body as a whole as a result thereof. Petitioner signed the Application on May 16, 2014. (AX1).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 1.

The medical records of Union County Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. Petitioner was seen on May 22, 2012, at which time it was noted that the chief complaint was that of a head injury. The onset of symptoms was noted to have been three hours prior, and that the injury occurred at work. Petitioner complained of a steel beam falling on his head which knocked him to the ground. Petitioner complained of double vision, nausea and neck pain, and a small laceration was noted to the top of the head. Petitioner did not sustain loss of consciousness. A 1 cm long laceration was noted on Petitioner's head. No cervical spine tenderness was noted on palpation, and there was full range of motion without pain. There was no significant musculature spasm or paracervical tenderness. The Nurse Documentation noted that Petitioner rated his pain as 8/10, and that the pain was located in the head and neck. The clinical impression was noted to be that of (1) concussion without loss of consciousness; (2) laceration of the scalp. Petitioner was discharged to home, and was given a work slip indicating no working or anything strenuous for three days, and that he must see his physician to be cleared to return to work. (PX2).

The records of Union County Hospital reflect that Petitioner underwent a CT of the cervical spine on May 22, 2012, which was interpreted as revealing (1) no evidence of an acute fracture; (2) marked multilevel degenerative joint and disc disease with central canal stenosis which is severe at C5/C6 as well as moderate to marked foraminal narrowing at multiple levels; (3) straightening of the cervical spine; there is fusion of the facet joints on the left at C3/C4 and C4/C5 with partial osseous fusion involving the intervertebral disc space at C3/C4 with anterior osteophytes with changes which could be seen with ankylosing spondylitis; minimal anterolisthesis at C4/C5 as well as minimal retrolisthesis at C5/C6 and C6/C7 which is likely degenerative in nature. The records also reflect that Petitioner underwent a CT of the head on May 22, 2012, which was interpreted as revealing (1) mild cortical volume loss most pronounced involving the frontal lobes; (2) no evidence of acute intracranial hemorrhage; (3) mild soft tissue swelling along the scalp which may represent contusion; no displaced calvarial fracture. (PX2).

The records of Union County Hospital reflect that Petitioner was seen on July 11, 2013 with a chief complaint of syncope. The History and Physical related to Petitioner's inpatient admission noted that Petitioner presented to the hospital after having a syncopal episode, and that he ran out of his diabetic medication approximately one week ago. It was noted that his provider was on vacation and he did not have a way to get it filled. It was noted that his family witnessed him to have a syncopal episode the night prior, but he could not remember it. It was noted that he had had a couple of other syncopal episodes in

the past 3-4 years, and that each time it was due to low blood sugar. The assessment was noted to be that of (1) urinary tract infection, recurrent, due to urostomy; (2) history of bladder cancer with urostomy on the right side, resulting in frequent urinary tract infections; (3) acute kidney injury, superimposed on chronic kidney disease likely due to dehydration from his urinary tract infection and hyperglycemia; (4) hyperglycemia with some increased osmolality; (5) syncope which was likely due to volume depletion. (PX2).

The records of Union County Hospital reflect that Petitioner underwent a CT of the head on July 11, 2013, which was interpreted as revealing (1) no acute infarct, hemorrhage, neoplasm or hydrocephalus; (2) minimal bilateral frontal lobe atrophy; (3) marked upper cervical spine arthritis. (PX2).

The records of Union County Hospital reflect that Petitioner was seen on February 7, 2014 for various bloodwork. The records further reflect that Petitioner was seen on May 13, 2014 for a Physical Therapy Evaluation. Petitioner complained of his bilateral arms not working well and having difficulty pushing greater than pulling, as well as very mild walking and balance problems. It was noted that he underwent cervical surgery on March 14, 2014 with complications four days later with an emergency procedure. It was further noted that Petitioner was in inpatient rehabilitation for approximately one month and then received home health services. (PX2).

The physical therapy records reflect that Petitioner was seen on June 4, 2014, at which time it was noted he was still having pain in the neck, knees and ankle and that he was "about the same as always." At the time of the June 11, 2014 visit, it was noted that Petitioner felt his blood pressure issues were getting worse, and that he hated feeling like he was going to pass out all the time. The Outpatient Recertification dated May 13, 2014 noted a medical diagnosis of quadriparesis and an onset date of March 14, 2014. It was noted that Petitioner underwent a cervical fusion on March 14, 2014, and approximately four days later he was found unresponsive and had to undergo a second cervical surgery. At the time of the May 21, 2014 visit, it was noted that Petitioner did not hurt except sometimes in his left hip. At the time of the May 23, 2014 visit, Petitioner reported that his neck and hip always hurt but "it's part of the golden years." (PX2).

Included within the medical records of Union County Hospital was the interpretive report for an MRI of the lumbar spine performed on February 5, 2015, which was interpreted as revealing (1) moderate lumbar degenerative spondylosis which produces moderately severe L2-3, moderate L3-4 and mild L4-5 spinal stenosis; (2) moderate central disc extrusion L2-3, small central disc protrusion L3-4, small broad-based right posterior lateral disc protrusion L4-5 and broad-based central disc protrusion L5-S1; these disc herniations are partially calcified or ossified; (3) marked left hydronephrosis and marked thinning of the parenchyma in the left kidney with mild atrophy, no change compared to December 20, 2013. (PX2).

The medical records of Dr. Randy Doty/Goreville Family Practice were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. At the time of the May 26, 2010 visit, it was noted that Petitioner complained of constant pain over the right back. At the time of the August 27, 2010 visit, it was noted that Petitioner had chronic back pain. At the time of the December 15, 2010 visit, it was noted that Petitioner was doing fairly well and had constant pain in his lower back with a history of kidney stones. At the time of the January 12, 2011 visit, it was noted that Petitioner complained of pain in his back. At the time of the February 18, 2011 visit, it was noted that Petitioner had chronic low back pain, and that his ambulation was steady. (PX3).

The Goreville Family Practice records reflect that at the time of the March 25, 2011 visit, it was noted that Petitioner was seen for follow-up for a bowel obstruction. At the time of the May 6, 2011 visit, it was noted that Petitioner was recently hospitalized for a small bowel obstruction. At the time of the

June 3, 2011 visit, it was noted Petitioner had chronic kidney stones on the right side, and that he had a non-functioning left kidney. At the time of the August 11, 2011 visit, Petitioner presented with complaints related to a urinary tract infection. At the time of the September 9, 2011 visit, it was noted that Petitioner had degenerative disc disease of the lumbar spine as well as chronic kidney stones. At the time of the November 4, 2011 visit, it was noted that Petitioner presented for evaluation of his hypertension, diabetes mellitus, degenerative disc disease and kidney stones. (PX3).

The Goreville Family Practice records reflect that at the time of the January 13, 2012 visit, it was noted that Petitioner had a history of kidney disease, osteoarthritis and hypertension. At the time of the March 23, 2012 visit, it was noted that Petitioner was seen for diabetes mellitus, hypertension, and severe arthritis. At the time of the April 30, 2012 visit, Petitioner complained of right kidney and flank pain. At the time of the May 31, 2012 visit, Petitioner presented with 4 staples in his scalp due to a pipe falling on his head. It was noted that there was a 2-inch well-healed laceration with 4 staples, and that Petitioner's left eye was infected. At the time of the July 9, 2012 visit, it was noted that Petitioner had hypertension, diabetes mellitus and chronic kidney stones. At the time of the January 13, 2014 visit, Petitioner underwent pre-operative surgical clearance for cervical spondylosis. It was noted at that time that Petitioner had both neck and lumbar back pain. It was noted that Petitioner was cleared for a cervical fusion if he was also cleared by his endocrinologist and nephrologist. (PX3).

The medical records of Regional Brain & Spine were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. Petitioner was seen on October 21, 2013 at which time he described double vision and a syncopal event which he related to being struck on top of the head by a 48-inch pipe wrench while at work. Petitioner described episodic left-sided double vision and a syncopal episode approximately 3 months ago, and that in mid-July he had an episode of left arm weakness. It was noted that an MRI of the brain demonstrated evidence of previous small strokes. It was further noted that there was noted some internal carotid involvement, and that Petitioner had recently undergone a right-sided carotid endarterectomy. Petitioner reported a multi-year history of occasional cervical discomfort that did not radiate into the upper extremities, which had been well controlled with over-the-counter anti-inflammatory medications for the last several years. He described an aching discomfort exacerbated by range of motion and strenuous activity, and he described no upper or lower extremity muscle weakness or numbness. The impression was that of multi-level cervical spondylosis most notable at the C5-6 and C6-7 level where there was central canal stenosis. It was noted that Petitioner described a multi-year history of occasional cervical discomfort, which increased in severity last August when he was hit in the head with a wrench. It was noted that he had been seeing neurology on a regular basis for a complaint of double vision and a syncopal event. Although surgical intervention was discussed, it was noted that Petitioner did not wish to pursue surgery at that time, but it was noted he was scheduled to return in 6-8 weeks to discuss surgery. (PX4).

The Regional Brain & Spine records reflect that Petitioner was seen on December 2, 2013, at which time Petitioner continued to describe a multi-year history of episodic posterior cervical discomfort that he described as an aching-type sensation. He denied any radicular or paresthesia-type symptoms involving the upper extremities bilaterally, but he noted a significant limitation with range of motion of the cervical spine. It was noted that Petitioner had previously been struck on the top of his head by a "48-type branch" while at work, resulting in a syncopal event. The impression was that of (1) cervical spondylosis with stenosis at C5-6 and C6-7; C3-4 with C4-5 foraminal narrowing; (2) history of right lacunar infarct and right carotid endarterectomy by Dr. Robison on September 12, 2013. It was noted that both surgical and non-surgical options had been discussed, and that Petitioner had elected to proceed with neurosurgical intervention. Petitioner would undergo a CT scan of the cervical spine for surgical planning, and he was to obtain medical clearance from his primary care physician. (PX4).

The Regional Brain & Spine records reflect the Petitioner was seen on March 6, 2014, at which time the inferior C5 to superior C7 laminectomy with a C4-C7 instrumented posterolateral arthrodesis was discussed. Petitioner described a multi-year history of cervical discomfort that did not routinely radiate into the upper extremities. Medical clearance for the procedure had been obtained. Petitioner described no change in his symptoms on that date, but did describe an aching and stabbing pain of the posterior cervical region which was exacerbated by range of motion and strenuous activities. The impression was that of (1) cervical spondylosis with stenosis at C5-6 and C6-7; C3-4 autofusion with C4-5 foraminal narrowing; (2) history of right lacunar infarct and right carotid endarterectomy by Dr. Robison on September 12, 2013. The procedure was discussed in detail, and his post-operative course was outlined. (PX4).

The Regional Brain & Spine records reflect that Petitioner was seen on May 1, 2014, at which time it was noted he had progressed since being discharged from Southeast Hospital inpatient rehabilitation. Petitioner continued to report bilateral triceps weakness, but continued with home health physical therapy at the direction of Dr. Karshner. He described minimal posterior cervical discomfort and reported taking occasional pain medication. It was noted that he continued to exhibit symptoms of orthostatic hypotension and was being cared for by a cardiologist. The impression was that of (1) status post inferior C5 to superior C7 posterior cervical decompression and C4, C5, C6 and C7 lateral mass screw with onlay fusion performed on March 14, 2014; (2) status post C5-6, C6-7 ACDF performed March 18, 2014; (3) persistent triceps weakness. (PX4).

The Regional Brain & Spine records reflect that Petitioner was seen on June 25, 2014, at which time it was noted that since his last visit he had undergone an MRI and x-rays of the cervical spine. Petitioner reported an occasional aching-type sensation in the posterior cervical region, and he further reported taking pain medication prior to bedtime which provided some relief. Petitioner reported a numbness-type sensation extending from his elbows and his forearms and into the third, fourth and fifth digits bilaterally, right greater than left. He described some increased upper extremity strength but continued to note bilateral triceps weakness. Petitioner was recommended to undergo an EMG/NCV study of the bilateral upper extremities for further evaluation. It was noted that Petitioner was not able to return to work at that time, and he was advised against any repetitive neck movement or overhead work. A work slip was issued on that date, indicating that Petitioner was not cleared from a neurosurgical standpoint to return to work. (PX4).

The Regional Brain & Spine records reflect that Petitioner was seen on January 19, 2015, at which time it was noted Petitioner continued to describe an aching-type sensation in the posterior cervical region with numbness extending from his elbows into his forearms and into the third, fourth and fifth digits bilaterally, right greater than left. Petitioner reported marginal improvement in his bilateral triceps strength and upper extremity numbness since he was last seen. He continued to describe symptomatic postural hypotension, and it was noted he was currently ambulating with the assistance of a cane. Petitioner reported muscle weakness, numbness and loss of coordination. It was recommended that he undergo an MRI and CT scan of the cervical spine for further evaluation of his neck pain and cervical fusion, and that he undergo an EMG/NCV study of the bilateral upper extremities to evaluate for a cervical radiculopathy and/or peripheral entrapment. (PX4).

Included within the records of Regional Brain & Spine was an interpretive report for an MRI of the cervical spine dated January 27, 2015 which was interpreted as revealing (1) hyperintense T2 signal myelomalacia is present in the right paracentral and central cervical cord beginning at C3-4 that extends down to C4 where there is more focal bright STIR signal in the right paramidline cervical cord; there is also hyperintense T2 signal myelomalacia in the cervical cord from C5-6 to C6-7; (2) ankylosis bilateral occipital condyles and lateral masses of C1, ankylosis C3-4 and C4-5 vertebral bodies and left C3-4 and C4-5 facets; (3) post-operative changes of the anterior interbody fusions at C5-6 and C6-7, bilateral

laminectomies at C5-6 and partial bilateral laminectomies at C6-7 and posterior spinal fusion from C4-C7; (4) mild cervical degenerative spondylosis which produces mild spinal stenosis at C3-4; (5) severe left C2-3 and C3-4 neural foraminal stenosis. The interpretive report for a CT of the cervical spine also performed on January 27, 2015 was noted to reveal subtle dextroscoliosis; straightening of the usual cervical lordosis; posterior fixation hardware involving C4-C7 and anterior fixation hardware involving C5-C7; no hardware fracture or loosening; no acute fracture or listhesis; multi-level degenerative disease with mild central spinal canal stenosis to 10 mm at C2-3, C3-4 and C4-5; multilevel neural foraminal stenosis, moderate to severe on the left at C2-3 and C3-4; multi-nodular thyroid gland. (PX4).

The Regional Brain & Spine records reflect that Petitioner was seen on February 3, 2015 at which time it was noted he continued to have neck pain with radiation into his arms as well as numbness. Petitioner felt some generalized weakness of his upper extremities, and he also complained of low back pain which he described as aching and made worse with activity. A cervical epidural steroid injection was recommended, and Petitioner was also recommended to take Neurontin for his increasing arm pain and numbness. Additionally, a lumbar spine MRI was recommended due to increasing back pain, and it was noted Petitioner may be a candidate for a lumbar epidural steroid injection as well. (PX4).

Included within the Regional Brain & Spine records was an interpretive report for an MRI of the lumbar spine performed on February 5, 2015, which was interpreted as revealing (1) moderate lumbar degenerative spondylosis which produces moderately severe L2-3, moderate L3-4 and mild L4-5 spinal stenosis ; (2) moderate central disc extrusion L2-3, small central disc protrusion L3-4, small broad-based right posterolateral disc protrusion L4-5 and broad-based central disc protrusion L5-S1, all of which are partially calcified or ossified; (3) marked left hydronephrosis and marked thinning of the parenchyma in the left kidney with mild atrophy; no change compared to December 20, 2013. (PX4).

The Regional Brain & Spine records reflect that Petitioner was seen on February 18, 2015, at which time he underwent a cervical epidural steroid injection. Petitioner was also seen on March 31, 2015, at which time he stated the injection significantly improved his neck and arm pain. Petitioner was very pleased with his response. He stated that since his last visit his back pain with radiation into his hips had increased, and he described it as aching and made worse with all activity. Petitioner was not interested in surgery regarding his lumbar spine, but he could proceed with a lumbar epidural steroid injection. (PX4).

Included within the Regional Brain & Spine records was a Clinical Electromyography Report dated March 31, 2015 which noted that Petitioner was to be evaluated for cervical radiculopathy, brachial plexopathy or entrapment neuropathy. The study was interpreted as revealing electrodiagnostic evidence for widespread active and very chronic denervation in both upper extremities involving multiple cervical levels; preservation of the sensory potentials argues against brachial plexopathy and the most likely etiology is either anterior horn cell or multilevel radiculopathy; the denervation seen in the more distal muscles may be related to co-existent entrapment neuropathy, as there is evidence for bilateral carpal tunnel syndrome and bilateral ulnar neuropathies localized to the elbow segments. (PX4).

The Regional Brain & Spine records reflect that Petitioner was seen on April 6, 2015 at which time he reported that his posterior cervical discomfort had significantly improved following the cervical epidural steroid injection. Petitioner denied any significant neck pain, but he did continue to describe a numbness-type sensation extending from his elbows into the third, fourth and fifth digits bilaterally, right greater than left. He denied any pain associated with his upper extremity symptoms but felt it was more of an annoyance. He continued to describe bilateral upper extremity weakness and continued to perform daily exercises. He also described diffuse low back pain and right knee discomfort. The records reflect the Petitioner was to undergo a neurology consultation for further evaluation of the upper extremity weakness

and orthostatic hypotension. Petitioner apparently underwent a lumbar epidural steroid injection on April 8, 2015. (PX4).

The Regional Brain & Spine records reflect the Petitioner was seen on April 30, 2015 at which time he underwent a pain management evaluation. Petitioner had improvement of his back and leg pain following the injection, but continued to have neck pain which was chronic following multiple cervical surgeries. Petitioner was not interested in surgery at that time, and he had improvement of his pain with a max of four Hydrocodone tablets per day. (PX4).

Included within the Regional Brain & Spine medical records was a History and Physical Examination report from Neurologic Associates of Cape Girardeau/Dr. Robert Gardner dated May 26, 2015. Dr. Gardner suspected that Petitioner had a diabetic autonomic neuropathy as the cause of his severe orthostatic hypotension. Dr. Gardner did not think that Petitioner had primary autonomic failure or multiple systems atrophy, and he did not find any extrapyramidal affects. It was noted that Petitioner's paresthesias in the upper extremities was probably related to the carpal tunnel syndrome and ulnar neuropathy, and that the denervation seen in the proximal muscles on the EMG was probably related to the myelomalacia rather than motor neuron disease given the fact that he reported slow improvement. An electrodiagnostic study of the lower extremities was recommended in order to characterize his neuropathy further and to exclude more widespread denervation than in the cervical spine. (PX4).

The Regional Brain & Spine records reflect that Petitioner was seen on May 28, 2015 for follow-up regarding the epidural steroid injection and for monthly medication management of Hydrocodone for ongoing radiating low back pain for the last several years. It was noted that the pain was relieved by the injection somewhat and that the medication helped keep his pain somewhat tolerable. The impression was that of (1) lumbar stenosis; (2) lumbago. It was noted that Petitioner had a failed response to the most recent lumbar epidural steroid injection, but his pain was reasonably controlled with a limited amount of Hydrocodone. (PX4).

Included within the Regional Brain & Spine medical records was a Clinical Electromyography Report from Dr. Gardner dated June 2, 2015. The studies were interpreted as revealing no convincing evidence for multi-segment active denervation to support widespread anterior horn cell disease; there is evidence for an axonal sensorimotor polyneuropathy based on distal denervation on EMG; small sural SNAP amplitudes and borderline slowing of conduction velocities which fall within the axonal range. (PX4).

The Regional Brain & Spine records reflect the Petitioner was seen on June 29, 2015 for follow-up regarding his continued back pain. Petitioner continued to have neck pain which was chronic following multiple cervical surgeries as well. It was noted that Petitioner was taking a maximum of four Hydrocodone pills per day with good improvement of his pain. He denied any changes since his last visit and denied any side effects to his medications. It was noted that Petitioner may benefit from additional injections in the future for his back. (PX4).

The Regional Brain & Spine records reflect that Petitioner was seen on July 28, 2015 for follow-up regarding his continued back pain. It was noted that he continued to have neck pain which was chronic following multiple cervical surgeries as well. Petitioner felt his back pain had been worsening with radiation to his hips bilaterally, and it was noted that he had moderate to severe stenosis of the lumbar spine. It was noted that Petitioner would like to repeat lumbar injections as they were beneficial in the past. An additional lumbar epidural steroid injection was recommended. (PX4).

Included within the Regional Brain & Spine records were records related to a cardiovascular consultation performed on July 28, 2015 at Cardiovascular Consultants. It was noted that Petitioner was

being seen for a six-month follow-up after his cervical myopathy when he had syncope and developed severe orthostatic hypotension. The impression was that of (1) symptomatic orthostatic hypotension; (2) cervical myopathy, status post decompressive laminectomy. Petitioner was recommended to continue his usual follow-up through Dr. Gardner. (PX4).

The Regional Brain & Spine records reflect that Petitioner was seen on August 5, 2015 at which time he underwent a lumbar epidural steroid injection. Petitioner was also seen on August 27, 2015, at which time he was seen for follow-up regarding his continued back pain, and it was also noted that he continued to have neck pain which was chronic following multiple cervical surgeries. It was noted that his back and hip pain had been worsening, but he did have some improvement with the injections. Petitioner's Hydrocodone was increased, and he was instructed to continue to follow-up with neurology and cardiology regarding his orthostatic hypotension. (PX4).

The Regional Brain & Spine records reflect the Petitioner was seen on September 24, 2015 at which time it was noted he continued to struggle with orthostatic hypotension, tachycardia and fatigue. Petitioner did not feel well on that date, he was pale and stated that he felt dehydrated. Petitioner was wheeled to the emergency room for evaluation. Petitioner was next seen on October 13, 2015, at which time he described an aching-type sensation in the posterior cervical region, as well as bilateral upper extremity numbness and weakness. Petitioner reported low back pain that he described as a diffuse aching-type sensation, exacerbated with activity. He also reported left hip pain with a prior left hip replacement and right knee pain. Petitioner continued to be under the care of pain management and had undergone lumbar epidural steroid injections. Petitioner did not wish to consider surgery, and he wanted to continue with pain management. It was noted that no further intervention was warranted concerning the cervical spine. (PX4).

Included within the Regional Brain & Spine medical records was an interpretive report for x-rays of the lumbar spine performed at Southeast Health on October 13, 2015. The x-rays were interpreted as revealing no abnormal motion with flexion and extension imaging; multi-level moderate to severe degenerative disc and facet arthropathy with no compression fracture in the lumbar spine. (PX4).

The Regional Brain & Spine records reflect that Petitioner was seen on October 26, 2015 for a pain management evaluation. Petitioner was being seen for follow-up regarding his continued chronic neck pain. Petitioner denied any changes since his last visit, but stated he had improved medically. Petitioner was next seen on November 24, 2015 for a pain management evaluation. It was noted that since his last visit he had been instructed to alter his blood pressure medication, which had helped his symptoms somewhat. Petitioner continued to have chronic neck and back pain without any new radicular or myelopathic complaints. (PX4).

The Regional Brain & Spine records reflect the Petitioner was seen on December 22, 2015, at which time he returned for follow-up regarding his continued chronic neck and back pain. He denied any new radicular or myelopathic complaints. Petitioner continued to admit to good pain control with current doses of opioid-based medication. The records reflect that Petitioner was also seen on January 21, 2016, at which time he reported since his last visit he had had increasing pain in his left hip. He stated he felt that he stretched it when he put his clothes on the week prior, and it was noted he had been evaluated by orthopedics who had offered him additional surgery on the left hip. It was noted that Petitioner wanted to undergo a left trigger point injection over the left hip where he was tender. (PX4).

The medical records of Regional Primary Care were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. Petitioner was seen on April 25, 2014 in follow-up for a hospitalization. It was noted that Petitioner went into the hospital for a spinal fusion of his neck and that he was doing well with surgery, but that he had an episode of passing out where he lost consciousness but

did not cease breathing. It was noted that x-rays showed two vertebrae had collapsed on top of each other off-center, so Petitioner had to go back into surgery for spacers and a steel plate. It was noted Petitioner was having mobility issues. The assessment was that of orthostatic hypotension, fatigue and diabetes mellitus. (PX5).

The Regional Primary Care records reflect that Petitioner was seen on May 2, 2014, at which time it was noted that he was having issues with his diabetes as well as moderate weakness. Petitioner was seen on May 30, 2014, at which time he presented with fatigue, orthostatic hypotension and diabetes. It was noted that Petitioner was not taking his insulin due to the cost. Petitioner was also seen on July 30, 2014, at which time he presented with diabetes, orthostatic hypotension and neck pain. It was noted that the severity of Petitioner's neck pain was moderate, and that laying down at night resulted in severe neck pain that kept him awake. Petitioner was also seen on October 30, 2015, at which time he presented with diabetes, neck pain and orthostatic vertigo. It was noted that the location of Petitioner's pain was bilateral posterior neck, and that there was radiation of pain to the right upper arm and right forearm. (PX5).

The medical records of Southeast Health were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records included an operative report dated March 14, 2014 which noted a post-operative diagnosis of C4-C5 spondylosis with foraminal stenosis, C5-C6 and C6-C7 spondylosis with central stenosis and foraminal stenosis, C3-C4 autofusion. The procedures performed were that of: (1) inferior C5, C6, superior C7 laminectomy for decompression; (2) C4-C5, C5-C6, and C6-C7 posterior lateral arthrodesis with local autograft MagniFuse allograft and bone morphogenic protein; (3) C4, C5, C6, C7 lateral mass screw instrumentation. The records reflect that various consultations were performed related to orthostatic hypotension. (PX6).

The Southeast Health records reflect that Petitioner underwent a right carotid endarterectomy on September 20, 2013. The pre-and post-operative diagnosis was noted to be that of right carotid artery stenosis. An interpretive report for a CT of the cervical spine performed on March 5, 2014 was interpreted as revealing slight left torticollis; 2 mm anterior spondylolisthesis C4 with respect to C5 and C6 with respect to C7; some bridging bone fusion across the C1 occipital condyle articulation; bridging bone fusion seen across the C3-C4 intervertebral disc space as well as across the C4-C5 intervertebral disc space anteriorly; bridging bone fusion across the left C3-C4 and C4-C5 facet joints; overall osteopenia; degenerative arthrosis/osteoarthritis C1-C2 anteriorly; generalized bony spinal canal stenosis which may be congenital; focal central canal stenosis persists C5-C7; diffuse discogenic and degenerative joint disease cervical spine with associated levels of bony foraminal stenosis. (PX6).

The Southeast Health records reflect that on March 18, 2014 Petitioner underwent a second surgical procedure, which consisted of (1) C5-6 and C6-7 anterior cervical microdiscectomy and interbody arthrodesis; (2) C5, C6, C7 anterior cervical plate. The Operative Report noted that on the morning of March 18, 2014, Petitioner had normal strength and sensation in the bilateral upper and lower extremities, but later that day developed a new onset of bilateral triceps weakness. Thereafter, Petitioner elected to proceed with an anterior decompression and arthrodesis. (PX6).

Included within the Southeast Health records was a History and Physical Exam form dated March 21, 2014 pertaining to Petitioner's admission for occupational and physical therapies and rehabilitation nursing services. The records reflect that Petitioner suffered a stroke in July 2013, which was a lacunar stroke. It was noted that afterwards he started noting deficits in his arms and hands, and came to the attention of Dr. Tolentino and was found to have neuroforaminal narrowing at C4-C5 with degenerative disc disease of C5-C6 and C6-C7. It was noted that on March 14, 2014 Petitioner was admitted and had a laminectomy and arthrodesis at the appropriate levels, and that his hand strength improved. Petitioner had normal strength on the morning of March 18th, but by the afternoon he had weakness of the bilateral triceps and his grip strength was decreased. It was noted that Petitioner was seen urgently by Dr.

Tolentino and taken back to the operating room that night for C5-C6 and C6-C7 ACDF. Petitioner had significant problems with orthostatic hypotension. Therapies evaluated Petitioner and found deficits in activities of daily living, self-care and mobility. It was determined that Petitioner would require inpatient rehabilitation therapies and was admitted on March 21, 2014. The impression was that of patient with cervical stenosis with myelopathy, status post decompression, with apparent repeat neurogenic compromise requiring anterior cervical fusion, with residual neurogenic neurological deficits with activities of daily living, self-care and mobility, with medical issues. The Discharge Summary dated April 11, 2014 noted discharge diagnoses of (1) rehabilitation ambulatory dysfunction secondary to cervical spine stenosis with myelopathy status post decompression with apparent repeat neurogenic compromise requiring anterior cervical fusion with improving strength; (2) labile diabetes mellitus being followed by Dr. Wen, improved; (3) dysphagia, improved; (4) orthostatic hypotension, improved with medication; (5) history of stroke; (6) history of bladder cancer status post ileostomy; (7) chronic renal insufficiency with a creatinine of 1.745; (8) urinary tract infection on Levaquin. (PX6).

Included within the Southeast Health records was an interpretive report for an MRI of the cervical spine performed on May 1, 2014 which was interpreted as revealing (1) status post anterior longitudinal interbody fusion from C5-C7; (2) bilateral decompressive hemilaminectomies C5-6 and partial bilateral hemilaminectomies C6-7; a posterior longitudinal interbody fusion is present from C4-C7; there is no central canal stenosis; (3) bridging ankylosis is present between the occipital condyles and lateral masses of C1 bilaterally, the C3-4 and C4-5 vertebral bodies and the left C3-4 and C4-5 facet joints; (4) severe left C2-3 and C3-4 neuroforaminal stenosis; (5) upper thoracic facet arthropathy is present which produces bilateral foraminal stenosis from T1-2 through T3-4. The interpretive report for x-rays of the cervical spine performed on the same date revealed post-surgical changes of a C5-C7 ACDF and C4-C7 posterior fusion with multilevel laminectomies; no hardware failure or acute fracture; straightening of the lordotic curvature; no spondylolisthesis. (PX6)

The medical records of Southeast Neurology were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. Petitioner was seen for a consultation on August 15, 2013, at which time he presented with syncope, diplopia, neck pain and numbness. The onset was one month ago, it occurred episodically and was resolved, and the initial symptoms included loss of consciousness. It was noted that the month prior, Petitioner was sitting in his home and his nephew came to his house to pay a visit. Petitioner stated he was not feeling well at the time. Petitioner stood up from his chair and walked to the thermostat, and apparently lost consciousness and fell to the floor without preictal warning symptoms. His nephew heard a "thud" and came to Petitioner's aid, and he noted that Petitioner had fallen to the floor and was unconscious. Petitioner stated that the next thing he remembered was sitting up in his chair again and seeing that the ambulance had arrived. Petitioner also reported symptoms of diplopia that began six months ago and generally lasted three hours. Petitioner associated this with left upper extremity tingling and clumsiness. The assessment was that of consciousness loss, transient; hemiparesis; hypethesia; and neck pain. It was noted that with hemiparesis and sensory loss, Dr. Koonce could not rule out a cervical myelopathy. (PX7).

The Southeast Neurology records reflect the Petitioner was seen on August 29, 2013 for follow-up of diplopia, neck pain and tremor. It was noted that the brain MRI did not show a brain stem stroke but an acute lacunar infarct in the right caudate nucleus and other old scattered small right hemispheric cortical infarcts. It was further noted that the MRI of the C-spine showed moderately severe central stenosis of C5-6 and C6-7 from degenerative changes, no myelomalacia noted on images. Petitioner denied left hand numbness at that time. It was noted that Petitioner was referred to Dr. Tolentino for evaluation regarding the degenerative cervical spinal stenosis. (PX7).

Included within the Southeast Neurology records was an interpretive report for an MRI of the brain performed on August 26, 2013 which was interpreted as revealing (1) acute 3 mm lacunar infarct

right caudate nucleus; (2) old small peripheral branch infarcts right frontal lobe, right parietal lobe, right temporal lobe and subcortical white matter; this asymmetric distribution in the right hemisphere raises the possibility of a right internal carotid artery disease in the neck; (3) mild chronic ischemic small vessel disease which is asymmetrically greater in the right cerebral hemisphere. Also included was an interpretive report for an MRI of the cervical spine performed on August 26, 2013 which was interpreted as revealing (1) ankylosis C3-4 vertebral bodies and bridging ankylosis from the left C3 to the left C5 facets which are hypertrophied; this produces severe left C3-4 and moderate left C4-5 neural foraminal stenosis; (2) C5-6 posterior disc osteophyte complex with superimposed central and right paracentral disc protrusion that produces moderate spinal stenosis and severe bilateral foraminal stenosis; (3) posterior disc osteophyte complex C6-7 with mild bright STIR signal edema along the endplates and in the intervertebral disc, which may represent increased motion at this level; (4) multi-level neural foraminal stenosis. (PX7).

The transcript of the evidence deposition of Dr. Tolentino was entered into evidence at the time of arbitration as Petitioner's Exhibit 8. Dr. Tolentino testified that he is a neurosurgeon and has been in private practice for 10 years. He testified that he performed approximately 300 spine surgeries in the past year. He further testified that he is board-certified by the American Board of Neurologic Surgeons. (PX8).

Dr. Tolentino testified that he first saw Petitioner at his clinic on October 21, 2013. He testified that Petitioner reported that he had suffered an injury at work, and he relayed that he thought it occurred in August of 2012. He testified that Petitioner stated he was struck on the top of his head by a 48-inch pipe, and that he suffered with double vision and an episode of syncope sometime after that. He testified that Petitioner also had some left arm weakness, and was seen by neurology. He testified that Petitioner was found to have a stroke and underwent a carotid endarterectomy by a vascular surgeon. He testified that Petitioner had persistent headaches and neck pain on and off. He testified that Petitioner had some before the injury, but it was usually treated with over-the-counter medications only and this was more bothersome than it had been previously. He agreed when asked to assume that the event actually occurred on May 22, 2012. (PX8).

Dr. Tolentino testified that on examination, the only salient finding that Petitioner had was that he had some grip weakness and a little loss of dexterity in the left hand. He testified that he reviewed a cervical spine MRI from August 26, 2013, as well as a brain MRI performed on the same date. He testified that he diagnosed Petitioner with cervical spondylosis with stenosis at C5-6 and C6-7 with evidence of autofusion of the joints at C3-4 and C4-5. He testified that he had no specific knowledge as to what caused the autofusion. He testified that Petitioner was cautioned to avoid any traumatic or extensive activities to his head or neck, and that he was scheduled for follow-up in six weeks. He agreed that he understood Petitioner had surgery for the carotid artery between the accident and when Petitioner came to see him, and he confirmed that he did not provide any of that treatment. (PX8).

Dr. Tolentino testified that Petitioner was seen in follow-up on December 2, 2013, at which time he continued to report 7/10 pain. He testified that Petitioner described neck discomfort, less significant headache with posterior cervical discomfort as well as limited ability to move his neck in terms of range of motion. He testified that a discussion was had at that time regarding Petitioner's risks of potential injury given the stenosis at C5-6. He testified that Petitioner elected to proceed with a posterior cervical decompression, which was performed on March 14, 2014. He testified that he performed an inferior C5 to superior C7 laminectomy with a posterior lateral fusion from C4 to C7 with lateral mass screws. He testified that initially Petitioner did well, but that after three days he developed some orthostatic hypotension and weakness of his triceps. He testified that the decision was made on March 18th to do an anterior decompression to supplement the posterior decompression. (PX8).

Dr. Tolentino testified that after the second surgery, Petitioner remained neurologically stable. He testified that Petitioner developed and got some return of his strength in his upper extremities. He testified that he had Petitioner see his cardiologist for his blood pressure, which still remained unstable with position. He noted that Petitioner went to inpatient rehabilitation before going home, and that this was performed at Southeast Missouri Hospital. (PX8).

Dr. Tolentino testified that at Petitioner's follow-up appointment on May 1, 2014, his nurse practitioner saw Petitioner on that date. He testified that Petitioner reported that he continued to have the orthostatic hypotension, which was managed by his cardiologist. He testified that Petitioner had no numbness in his upper or lower extremities, and that he had some improving triceps strength but still had some weakness. He testified that Petitioner rated his pain at 5/10 at that point in time. He testified that he next saw Petitioner with his physician's assistant on June 25, 2014, at which time Petitioner had to take some pain medication. He testified that Petitioner started to develop some numbness in a delayed fashion from the elbows to his forearms at the third, fourth and fifth digits. He testified that Petitioner was still weak in the bilateral triceps but it was improving, and that Petitioner rated his pain at 7/10. (PX8).

Dr. Tolentino testified that Petitioner would not be considered at maximum medical improvement for the surgery he performed, and that he would usually determine maximum medical improvement between nine months and one year post-surgery at which point he would get CT imaging of the neck to ensure that the arthrodesis was stable and that the fusion was intact. When asked if he had an opinion as to whether the event of May 22, 2012 caused or aggravated the cervical spine condition that he treated, Dr. Tolentino responded that what he saw was primarily arthritic so he did not believe that the pipe wrench injury caused the neurologic changes that necessitated the surgical interventions and treatment. He testified that he did not know how hard Petitioner was hit other than he had the laceration. He testified that with a sufficient blow, the injury could have aggravated the condition. He testified that if Petitioner had pre-existing stenosis due to arthritic changes and arthritis and was hit sufficiently that it caused enough pressure on the spinal cord and the disc herniation pushing in on it that it made it persistently symptomatic, it could have aggravated his pre-existing arthritis. When asked to assume he was not shown evidence or that there was no evidence Petitioner's cervical spine was not symptomatic beyond what could be treated with over-the-counter medications and that as a result of that blow his pain became bad enough for him to seek medical treatment and whether the blow would at least be a part of the reason he needed to perform surgery, Dr. Tolentino responded affirmatively. (PX8).

Dr. Tolentino testified that as of his last examination, he did not think Petitioner could have worked as a mechanic from the time that he saw him up until the time of the deposition. When asked if he had been asked to give Petitioner off-work slips from the time that he came to see him until the last time Petitioner was seen, he testified that he thought Petitioner would have needed to be off work because of the condition he was treating. He testified that his bills were reasonable within his geographic region, and that all of the treatment he had provided had been reasonable and necessary to cure the effects of the cervical spine condition. (PX8).

On cross-examination, Dr. Tolentino admitted that he did not have opportunity to review the initial emergency room records. He testified that it was not a worker's compensation issue at that time, and he only took Petitioner's history. He agreed that he was not aware of the specific details of the accident other than what Petitioner stated regarding the 48-inch pipe wrench. He agreed that he did not know how hard Petitioner hit himself in the head, and he agreed that that information would be pertinent to his causation analysis. (PX8).

On cross-examination, Dr. Tolentino agreed that he has not reviewed any x-rays or diagnostic images from the initial emergency room visit, but indicated that he did not think that information would be pertinent to his analysis. He admitted, however, that a CT scan might be. He agreed that Petitioner

was referred to him by Dr. Koonce, and that he reviewed Petitioner's chart from Dr. Koonce. When asked if he was aware of Petitioner's treatment history between the May 22, 2012 accident and when he first saw Dr. Koonce in August 2013, he responded that he knew about the syncope, the double vision, the stroke and the carotid endarterectomy, but beyond that had no further information. When asked to assume that during that time, which was roughly a year and three months after the date of accident, if it could be shown that Petitioner was not treating for neck pain during that time and whether it would be relevant to his causation analysis, he agreed that it would be. He agreed that it would tend to show that potentially an aggravation did not occur. He further agreed that if it could be shown during that time that Petitioner was working as a mechanic for a year and three months and whether that information would alter his causation opinion, he agreed that it would. (PX8).

On cross-examination, when asked how quickly someone would typically seek medical treatment if they aggravated a pre-existing cervical spine condition, Dr. Tolentino responded that it was usually within a week or two or at least reported to their family physician fairly usually quickly. When asked if an individual fainted and fell, Dr. Tolentino agreed that depending on how they fell on it could aggravate spondylosis. He testified that Petitioner's syncopal events were probably not related to the cervical spine disease but may be related to the carotid disease. He testified that the left hand numbness could be related to both the stroke and the cord compression. He agreed that the double vision was not related to the cord compression, however. With respect to the August 26, 2013 MRI of the cervical spine, Dr. Tolentino testified that the findings were all degenerative in nature. (PX8).

On cross-examination, Dr. Tolentino agreed that none of his treatment records had any opinions or statements regarding causation of the worker's compensation injury. He agreed that to his knowledge, Petitioner's treatment was billed through Medicare. (PX8).

On cross-examination, Dr. Tolentino agreed that he testified that it was his opinion that the surgery was done to protect Petitioner from further injuring himself in a car accident or some kind of traumatic event. When asked if it was fair to classify the surgery as preventing future injury rather than eliminating some kind of condition of ill-being that existed, Dr. Tolentino responded that the primary reason for the surgery was to protect Petitioner from further injury but the hope was that in doing so and in stabilizing the segments, it would help his neck pain. He agreed that the surgery performed was not meant to address resolving Petitioner's left upper extremity symptoms. (PX8).

On cross-examination, Dr. Tolentino agreed that he has not seen Petitioner since June of 2014. He agreed that he would need to see Petitioner again in order to comment on his work abilities. He noted that at the time of Petitioner's last appointment he had recommended additional treatment including an EMG as well as x-rays, and that Petitioner was supposed to follow-up with him but had not returned. (PX8).

On redirect examination, Dr. Tolentino agreed that it would be reasonable to see a patient delay spine surgery to address an issue such as a problem with the carotid artery. He agreed that one would treat a stroke before one would treat arthritis in the neck. He agreed that if someone fainted or lost consciousness, it could be attributable to post-concussion symptoms. (PX8).

On redirect examination, Dr. Tolentino testified that less than 5% of his practice was worker's compensation, and he agreed that it was fair to say that his office staff did not deal with a high volume of Illinois or Missouri worker's compensation-related issues. When asked to assume if Petitioner came to see him two days before his work accident and his spinal condition was the same but Petitioner stated he was able to deal with the pain with over-the-counter medications, he responded that he would not have performed surgery. (PX8).

On further cross-examination, Dr. Tolentino testified that he would expect [illegible] to a concussion within six months. He testified that prior to the deposition he met with Petitioner's counsel, and the discussion was had regarding whether the injury necessitated the treatment rendered. He testified that the meeting was approximately 10-15 minutes long. (PX8).

The photograph of a pipe wrench was entered into evidence at the time of arbitration as Petitioner's Exhibit 9.

The Records Review Reports dated October 10, 2014 of Dr. David Lange was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The report indicated Dr. Lange opined that that Petitioner's diagnoses related to the May 22, 2012 incident were that of (1) scalp contusion by blunt instrument (a large wrench); (2) scalp laceration. Dr. Lange noted that although the emergency room note suggested a "concussion," there was no loss of consciousness, the neurologic examination was normal and there were no medical records to suggest any post-concussive symptoms and/or signs. It was noted that Petitioner's 2013 neurologic symptoms were readily explained by a stroke, namely a lacunar infarct secondary to right carotid artery disease. Dr. Lange indicated that as a result, Petitioner's neurologic symptoms were and are unrelated to the May 22, 2012 incident. Dr. Lange further indicated that Petitioner's need for surgery was due to his pre-existing multi-level degenerative changes with spinal stenosis, and that the surgery was performed in a prophylactic fashion due to his significant stenosis and the possibility of future spinal cord injury with significant trauma. He indicated that as a result, the surgical procedure was not associated with the May 22, 2012 incident. (RX1).

The report noted that Dr. Lange believed that there was no reason not to believe that Petitioner had a contusion to the scalp with laceration, but beyond that there were no medical records to suggest any other diagnosis, including an unsubstantiated "aggravation" of his pre-existing multi-level degenerative changes and stenosis. Dr. Lange indicated that the surgery with a posterior decompression and fusion was to address spinal stenosis, obviously a degenerative condition. Dr. Lange noted that the surgery was performed in a prophylactic fashion to prevent future spinal cord injury with the traumatic event such as a motor vehicle accident, and that the procedure was not to address neck pain. Dr. Lange indicated that furthermore, it was not to address Petitioner's left upper extremity symptoms which were due to his stroke. Dr. Lange noted that Petitioner had one of the acknowledged complications associated with posterior decompressions for stenosis, namely new onset radiculopathy. Dr. Lange noted that Petitioner's triceps weakness necessitating the second surgical procedure was simply a complication of the first procedure and, similar to the first procedure, was unrelated to his work-related event in May 2012. (RX1).

The report indicated that Dr. Lange was of the position that maximum medical improvement would have occurred when the scalp wound had healed and the staples were removed. Dr. Lange further opined that Petitioner would have reached a treatment plateau at the time the scalp wound was healed and the staples had been removed, and that no other treatment was indicated concurrent with the May 2012 incident or subsequent to that time. Dr. Lange further indicated that there was not enough information in the medical records to address Petitioner's work capabilities, but indicated there would be no reason for Petitioner not to have been working his usual full duty occupation subsequent to the scalp wound healing and staple removal. Dr. Lange also indicated that any potential work restrictions would be due to other issues (such as his year 2013 stroke and his post-operative complication in 2014) as opposed to the work-related incident of May 22, 2012. (RX1).

The transcript of the evidence deposition of Dr. David Lange was entered into evidence the time of arbitration as Respondent's Exhibit 2. Dr. Lange testified that his specialty is orthopedic surgery, and that he subspecialized in treatment of the spine. He testified that he has been board-certified since 1979.

He testified at the time of the deposition that he was in the process of retiring, and that over the course of his career he performed thousands of spinal surgeries. (RX2).

Dr. Lange confirmed that he performed a records review pertaining to Petitioner on October 10, 2014. He testified that his understanding from the review of the records was that while working in May 2012 Petitioner was hit in the head with a large wrench. He testified that his understanding of Petitioner's complaints following that accident included head pain, a laceration to the scalp, and, conceding that he missed it during the performance of the record review, also neck complaints while in the emergency room. He testified that the Emergency Room diagnosed a laceration, and that the additional diagnosis was concussion without loss of consciousness which he thought was somewhat of an overstatement. He testified that there appeared to be a gap of approximately 14 months before there were any additional relevant medical records, and that those appeared to be related to Petitioner's stroke. (RX2).

Dr. Lange testified that there were neurology and neurosurgical consultations reviewed, and that a neurology consultation took place on August 15, 2013 which suggested that the symptoms at that time of syncope and double vision were concurrent with August 2013 rather than the May 22, 2012 work-related incident. He testified that there was no discussion that the neck pain was related to the wrench incident that had occurred 15 months prior. He noted that Petitioner was found to have had a stroke likely due to carotid disease in August of 2013 which resulted in a neurologic deficit to the left arm. He noted that ultimately Petitioner was seen by a neurosurgeon some 17 months after the work-related incident, who noted a multi-year history of occasional cervical discomfort that did not radiate into the upper extremities. Dr. Lange testified that he thought this was important because Petitioner, subsequent to the stroke, did have left upper extremity issues and after surgery had bilateral upper extremity symptoms, but when the neurosurgeon first saw him on October 21, 2013 there were no such symptoms noted to suggest cervical radiculopathy. (RX2).

Dr. Lange testified that Petitioner ultimately did have surgery on his neck, and it was noted that in the process of "working up" his neurologic deficit he had been found to have significant spinal stenosis. He testified that the surgery was not to address current symptoms since Petitioner did not have any radicular symptoms, but that Petitioner also did not have myelopathy which referred to symptoms from spinal cord compression. He testified that the surgery was offered for the radiographic appearance of a very degenerative neck with a small spinal canal to prevent something that might occur in the future with something like an automobile accident. He testified that there was a complication where after the surgery Petitioner developed weakness in both arms, which was a known potential complication of laminectomies or laminoplasties. He testified that there was no reason to think that Petitioner did not get hit in the head and had a laceration and probably a contusion to the scalp, but there were no records for more than a year afterwards to suggest any lingering symptoms. He testified that Petitioner obviously had prior neck complaints, and that the two cervical surgeries were performed to address other issues than the May 22, 2012 injury. (RX2).

Dr. Lange testified that he reviewed the interpretive reports but did not have the diagnostic images. He testified that the reports were consistent, and that the MRI report of August 26, 2013 (which was some 13 months after the work-related wrench incident) simply suggested spinal canal stenosis on the basis of his degenerative changes. He testified that no acute phenomenon was noted, such as a disc herniation or fracture, that had not been treated. When asked how the interpretive reports for the May 2013 CT and the August 2013 MRI reports compared to the operative findings, Dr. Lange responded that they were consistent with the post-operative diagnoses showing multi-level degenerative changes. He testified that he had no reason to dispute the diagnostic imaging reports. He further noted that there was nothing acute in either the CT of May 22, 2012 or the August 26, 2013 MRI reports. (RX2).

Dr. Lange agreed that the diagnoses he found to be related to the work accident were that of the contusion to the scalp and a laceration on the scalp, but he did not necessarily agree with the additional diagnosis of concussion with no loss of consciousness as documented in the Emergency Room records. He testified that it would not be unreasonable to think that someone who got hit in the head with a long, heavy wrench might have triggering of more symptoms, but to him that was different than to say that the May 22, 2012 incident produced something new or aggravated a pre-existing condition because there were no medical records after the emergency room visit suggesting that there were any kind of symptoms. He testified that it was his opinion that the cervical spine surgeries were unrelated to the work accident, and that they were not to address a traumatic condition but were rather to address spinal stenosis and a potential future traumatic event. Dr. Lange testified that the spinal cord did not tolerate an extreme amount of narrowing with things like repetitive activities, so some people would begin to develop symptoms slowly but surely just because they were alive. He testified that on the other hand, a certain percentage of individuals who had trivial traumatic events, such as slips and falls in the elderly, could produce essentially a paralytic condition if the spinal cord had chronic compression. He testified that they frequently offered enlargement of the spinal canal to avoid an unknown future event, so it was considered prophylactic. (RX2).

Dr. Lange testified that he believed Petitioner achieved maximum medical improvement from his accident at work when the staples were removed from his head. He testified that he had no records to suggest there was any reason Petitioner would not be working with respect to the May 22, 2012 incident with the proviso that at some point he had to have the staples taken out of the scalp. He testified that he had no reason to believe that a physical examination of Petitioner would change his opinion with regards to causation. He testified that if there were issues related to permanency or future medical treatment, then face-to-face was mandatory with an examination. (RX2).

On cross-examination, Dr. Lange testified that it was not unreasonable to think that Petitioner might have triggered more symptoms related to neck pain than perhaps he had before May 22, 2012 at least on a temporary basis. When asked whether the medical definition of a concussion delineated between someone who lost consciousness and someone who did not lose consciousness, Dr. Lange responded that it did not. He testified that a "lick" to the head without any signs or symptoms, by definition, was not a concussion. He testified that if Petitioner had a history of losing consciousness, then that was a neurologic symptom and would imply that he did have a concussion. He agreed that people who had concussions sometimes did not recall whether or not they lost consciousness. He further agreed that one of the side effects of concussions was that there could be memory loss associated with the event and what happened afterwards. (RX2).

On cross-examination, when asked about the gap between the actual trauma and when Petitioner began to seek neurosurgical treatment for his cervical spine, Dr. Lange testified that he understood that Petitioner was treating for the problems with the carotid artery in June or July of 2013. He agreed that he had patients that needed intervention of the spine but such intervention was delayed due to other problems such as a vascular issue. When asked which doctor definitively diagnosed Petitioner with having a stroke, Dr. Lange responded that he believed it was the neurologist who saw Petitioner in 2013. (RX2).

On cross-examination, Dr. Lange agreed that he felt that the surgery was performed simply to prevent future injury. He noted that any actual localized narrowing related to nerve roots was seen to be on the opposite right side as opposed to Petitioner's left arm symptoms, and if one looked at the notes of the neurosurgeon he was operating for stenosis in a prophylactic way. He was not, however, critical of the neurosurgeon's approach. He testified that when it came to prophylactic surgery, it was being offered irrespective of the complaints of the patient. He testified that as was frequent and was the case here, the patient actually had neither radicular nor myelopathic complaints. He testified that Petitioner had a

finding that was alarming for the potential for a future catastrophic neurologic event. He agreed that this was a procedure he would perform even if there were no pain complaints related by Petitioner. (RX2).

On cross-examination, when asked to assume that Petitioner testified that he did have neck pain starting at the time of the accident up through the time of surgery and whether that changed his analysis, Dr. Lange responded that he did not think so. He testified that simply because Petitioner was hit in the head by the wrench would not mean that miraculously any pain that he had before would go away, that people could develop more neck symptoms simply because they were aging and that the surgery was not performed for neck pain in this case. When asked whether what it would be reasonable for Petitioner to seek consultation with the spine surgeon in association with the incident assuming Petitioner had tolerable neck pain that he was managing with over-the-counter medications and that after being hit with the pipe wrench his pain became more significant, Dr. Lange responded that it was not in association with the incident but for his symptoms. He testified that chronologically there were "a lot of hoops one would have to jump through" just to suggest that his consultation with the neurosurgeon was related to his neck pain. He testified that it was not noted by the neurosurgeon in the first couple of his sentences in his consultation note, and even if one looked at the note of the neurologist in August 2013, he suggested Petitioner's neck pain had actually increased over a period of six months which would be approximately February 2013 instead of nine months before. (RX2).

The medical records of Regional Brain & Spine were entered into evidence at the time of arbitration as Respondent's Exhibit 3. The records appeared to be nearly identical to the vast majority of those records as contained in Petitioner's Exhibit 4 with exception of an internal e-mail exchange dated October 22, 2013 and October 23, 2013 between Ceretha Rucker, BSN, RN and Jacob L. Muckerman, FNP, BC. In Ms. Rucker's e-mail of October 22, 2013, she inquired whether Petitioner's condition was related to his reported work injury or a separate condition billable through Medicare. In Mr. Muckerman's response dated October 23, 23, he indicated that it was a separate billable condition, that he (*i.e.*, Petitioner) was struck on the head and saw [Dr.] Koonce for "HA and dizziness," that in the work-up [Dr.] Koonce found significant arthritis/degenerative spondylosis of the C-spine, and that he would say it is a separate condition related to arthritic changes and not a blow to the head. (RX3).

CONCLUSIONS OF LAW

With respect to disputed issue (F) pertaining to causal connection, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that his scalp contusion and scalp laceration are causally related to the work accident of May 22, 2012, but has failed to prove that this cervical condition is causally related to the work accident of May 22, 2012.

The Arbitrator places great weight on the admissions made by Dr. Tolentino during the course of his cross-examination with respect to the issue of causation of the cervical condition, and also places significant weight on the opinions rendered by Dr. Lange as to the issue of causation. The Arbitrator notes that Dr. Tolentino in his evidence deposition made several significant admissions on cross-examination, including the fact that he did not know how hard Petitioner hit himself in the head which he agreed would be pertinent to his causation analysis; that it was his opinion that the surgery was done to protect Petitioner from further injuring himself in a car accident or some kind of traumatic event; that his causation opinion would be altered if it were shown that Petitioner was working as a mechanic for a year and three months between the time of the accident at the time of surgery; and that his causation opinion would be altered if it were shown that Petitioner was not treating for neck pain between the time of the accident and his initial presentation to his office, which he conceded would tend to show that an aggravation to any pre-existing cervical spine condition did not occur. (PX8).

Furthermore, the Arbitrator finds to be significant Dr. Lange's testimony that during the course of the performance of his records review, he reviewed neurology and neurosurgical consultations and noted that a neurology consultation took place on August 15, 2013 which suggested that the symptoms at that time of syncope and double vision were concurrent with August 2013 rather than the May 22, 2012 work-related incident. The Arbitrator notes that Dr. Lange testified that the surgery was offered for the radiographic appearance of a very degenerative neck with a small spinal canal to prevent something that might occur in the future with something like an automobile accident, and that there was no reason to think that Petitioner did not get hit in the head and had a laceration and probably a contusion to the scalp, but there were no records for more than a year afterwards to suggest any lingering symptoms. The Arbitrator places greater reliance upon Dr. Lange's opinion that Petitioner's two cervical surgeries were performed to address other issues than the May 22, 2012 injury, particularly in light of the admissions made by Dr. Tolentino during the course of his cross-examination. (RX2).

Based upon the foregoing, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that his scalp contusion and scalp laceration are causally related to the work accident of May 22, 2012, but has failed to prove that this cervical condition is causally related to the work accident of May 22, 2012.

With respect to disputed issue (J) pertaining to necessary medical services, the Arbitrator finds that Respondent is liable for payment only for the Emergency Room treatment rendered at Union County Hospital for the date of service of May 22, 2012 as well as the visit at Goreville Family Practice for the date of service of May 31, 2012, as this treatment is related to the scalp contusion and scalp laceration causally related to the underlying accident. The Arbitrator finds that Respondent is not responsible for payment of the treatment rendered for Petitioner's cervical condition in light of the Arbitrator's finding as to the issue of causation.

With respect to disputed issue (K) pertaining to temporary total disability benefits, the Arbitrator finds that no evidence was proffered suggesting that Petitioner was taken off work after the scalp contusion and scalp laceration, and further finds that Petitioner himself admitted that he returned to work full duty for Respondent for the timeframe of May 23, 2012 through March 13, 2014. As such, the Arbitrator denies Petitioner's request for post-operative temporary total disability benefits for the timeframe of March 13, 2014 through April 6, 2015 as sought at the time of arbitration in light of the Arbitrator's finding as to the issue of causation.

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 provided by either party. As a result thereof, the Arbitrator gives no weight to this factor.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he did not return to work after his cervical surgeries were performed, but further notes that Petitioner admitted that he worked full duty for the timeframe of May 23, 2012 through March 13, 2014. As Petitioner is no longer working, the Arbitrator places lesser on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 72 years old on his date of accident. Given the advanced age of Petitioner, 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 continued to work full duty for Respondent, but did not return to work subsequent to his cervical surgeries. The Arbitrator notes that Dr. Tolentino testified that he did not believe that Petitioner could return to work as a machinist, but Dr. Lange testified that he believed there was no reason Petitioner could not return to work once the scalp laceration had healed and the staples were removed. 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 Petitioner testified that his symptoms prior to undergoing surgery included increasing pain that kept getting worse, and that he also kept losing the ability to turn his head. He denied that surgery helped to resolve some of his problems. He testified that he cannot raise his head high enough to comb his hair or see in the mirror, and that he has to lean back to swallow. At his final office visit with Dr. Tolentino on on December 22, 2015, Petitioner returned for follow-up regarding his continued chronic neck and back pain. He denied any new radicular or myelopathic complaints, and continued to admit to good pain control with current doses of opioid-based medication. 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 at the conclusion of his treatment with Dr. Tolentino as it pertains to the cervical condition, but notes that no evidence was proffered at the time of arbitration regarding ongoing issues with the scalp laceration. 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 2% loss of use of the person-as-a-whole as provided in Section 8(d)2 of the Act for the scalp contusion and scalp laceration.

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

Diana Powell,
Petitioner,

vs.

NO: 15WC028520

17IWCC0063

Galesburg Cusd #205,
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, 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 January 6, 2016, 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.

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: FEB 2 - 2017
MJB/bm
o-1/24/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

POWELL, DIANA
Employee/Petitioner

Case# **15WC028520**

15WC028633

GALESBURG CUSD#205
Employer/Respondent

17IWCC0063

On 1/6/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.50% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0000 WHITT LAW LLC
BRIAN P WOJCICKI
225 E COOK ST
SPRINGFIELD, IL 62704

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Diana Powell
Employee/Petitioner

v.

Galesburg CUSD#205
Employer/Respondent

Case # **15** WC **28520**

Consolidated cases: **15 WC 28633**

17IWCC0063

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Peoria**, on **November 16, 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. ☒ 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 4, 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 **$23,555.36**; the average weekly wage was **$603.98**.

On the date of accident, Petitioner was **68** years of age, ***single*** with **0** dependent children.

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

ORDER

Respondent shall pay the reasonable and necessary expenses associated with the medical care and treatment provided to her by Dr. Williams, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize and pay the reasonable and necessary expenses associated with the bi-lateral carpal tunnel surgeries prescribed for her by Dr. Williams, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Arbitrator Anthony C. Erbacci

December 31, 2015
Date

JAN 6 - 2016

FACTS:

17IWCC0063

On February 4, 2015 the Petitioner was employed by the Respondent as a bus driver, having been so employed for approximately seventeen years. The Petitioner described that she drove a diesel "mini-bus" approximately six to eight hours each work day and used a mechanical device with her right hand to open and close the bus door. The Petitioner described that the steering wheel of the bus vibrated and that it took a certain amount of force to open and close the bus door.

The Petitioner testified that on February 4, 2015 she was in her bus, returning some students to their school, when her bus was struck from behind by another vehicle. The Petitioner described that she was stopped at an intersection at the time and that the impact of the crash was significant. The Arbitrator notes that the pictures of the bus after the impact (PX5) demonstrate that the impact was significant enough to cause the rear bumper of the bus to be noticeably dented inward. The Petitioner also described that at the time of the accident she had both of her hands on the steering wheel and that she felt a jarring to her wrists and neck and felt a whiplash-type injury. The Petitioner testified that none of the children on the bus was injured.

The Petitioner testified that following the accident, she called her supervisor, Paulette Earp, and reported the accident and then completed her route. The Petitioner testified that when she arrived at the school to drop off the children, Jeff Houston, another employee of the Respondent came out to the bus and she advised Mr. Houston that she felt like she had sustained a whiplash-type injury as a result of the motor vehicle accident. The Petitioner testified that she also had a conversation with Karen Addis, another employee of the Respondent who has responsibility for insurance related matters, and described the accident and the soreness she was feeling. The Arbitrator notes that both Paulette Earp and Karen Addis confirmed that Petitioner's testimony that she advised them of the motor vehicle accident that had occurred on February 4, 2015. The Petitioner testified that she was then sent by the Respondent to be seen at OSF Occupational Health.

The records of OSF Occupational Health demonstrate that the Petitioner was seen there on February 4, 2015 and provided a history of the motor vehicle accident consistent with her testimony. It was noted that the Petitioner reported that she "snapped her head and she felt like she tightened up on the steering wheel." The Petitioner was diagnosed with a cervical strain, restricted from work the next day, and prescribed medication. On February 6, 2015 the Petitioner followed-up and was noted to report having some soreness but no pain. She was also noted to have no numbness in her hands, no coordination problems, and no pain shooting down her arms. The Petitioner was discharged and returned to regular work at that time.

The Petitioner testified that she returned to her regular work but the symptoms in her hands continued to worsen. The Petitioner testified that she complained about her symptoms but she continued to work her regular job.

On April 9, 2015 the Petitioner sought treatment for her hand complaints from Dr. James Williams at Midwest Orthopedic Center. Dr. Williams noted that the Petitioner had been driving a school bus with a vibratory steering wheel for the last 17 years and that she had mild numbness and tingling in her hands which became much worse after an accident in February of 2015. Dr. Williams' assessment was that the Petitioner had carpal tunnel syndrome and he ordered a nerve conduction

study.

On April 17, 2015 the Petitioner underwent nerve conduction studies of her bilateral upper extremities which were reported to demonstrate findings consistent with a moderate carpal tunnel syndrome on the left side and a mild carpal tunnel syndrome on the right side.

The Petitioner followed up with Dr. Williams on April 27, 2015. Dr. Williams noted that as a school bus driver the Petitioner used her right hand to open and close the door of the bus and she used her left hand constantly on the steering wheel. Dr. Williams also noted that the Petitioner's accident in February 2015 aggravated her mild numbness and tingling symptoms. After review of the EMG/NCV report, Dr. Williams concluded that the study showed moderate left and mild right carpal tunnel syndrome, and he opined that due to the vibration of the steering wheel and the number of years she worked as a bus driver the Petitioner's carpal tunnel was at least aggravated, if not caused, by her work duties. Dr. Williams recommended bi-lateral carpal tunnel release surgeries for the Petitioner.

The Petitioner testified that she discussed the surgical recommendation with Paulette Earp and that she also advised Ms. Earp of Dr. Williams causation opinion but she did not specify exactly when that discussion occurred. A time off record confirms that the Petitioner took time off work on April 17 and 27, 2015 for doctor appointments, but there is no specific indication as to the reason for those doctor appointments. Both the Petitioner and Ms. Earp testified that in May 2015, the Petitioner informed Ms. Earp that she would not be available to drive during the summer months because she wanted to undergo bilateral carpal tunnel surgery but Ms. Earp testified that the Petitioner did not indicate that the treatment was related to any work accident.

The Petitioner returned to her regular work after the summer of 2015 and, on August 31 2015, an accident report was completed by Karen Addis Frakes. The report indicates a date of accident of April 27, 2015 but also indicates that February 4 or 5, 2015 was the "date of accident". The report indicates that the nature of the injury was "whiplash", that the object responsible for the injury was "steering wheel" and that the accident occurred when "rear ended by vehicle". The Petitioner signed the report and wrote "Feb 4 2015" next to an "Additional Comment" written by Ms. Addis Frakes that "Diana feels there is a typo in paperwork as only one (1) accident date." (Rx 5)

Thereafter, the Petitioner continued to work full duty for the Respondent and she has missed no additional time from work as a result of her condition. The Petitioner testified that she currently continues to have some stiffness in her neck as well as numbness and tingling in both of her hands.

The October 29, 2015 evidence deposition testimony of Dr. James Williams was admitted into the record as Petitioner's Exhibit 4. Dr. Williams testified regarding his April 2015 treatment of the Petitioner, her causally related symptoms, and his surgery recommendations. Dr. Williams testified that Petitioner's co-morbidities made it more likely that the Petitioner could develop carpal tunnel conditions related to her bus driving activities and he opined that the February 4, 2015 motor vehicle accident aggravated the Petitioner's pre-existing carpal tunnel condition. Dr. Williams further opined that the Petitioner's work activities could also have caused or aggravated her bi-lateral carpal tunnel syndrome. Dr. Williams explained that constant gripping of the vibratory steering wheel with her left hand likely contributed to greater symptoms in her left wrist than her right hand, which is used

occasionally to pull open the passenger door with a lever. Dr. Williams testified that the Petitioner's current condition of ill-being was causally related to her work her work activities and that the Petitioner was a surgical candidate and needed bi-lateral carpal tunnel release surgeries.

No medical testimony or opinions from any other physicians was offered into the record.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds and concludes as follows:

The evidence presented clearly demonstrates that the Petitioner was involved in a motor vehicle accident while she was performing the regular duties of her employment with the Respondent on February 4, 2015. The Petitioner sought medical treatment immediately following the accident at OSF Occupational Health where she provided a history of the motor vehicle accident consistent with her testimony. It was noted that the Petitioner reported that she "snapped her head and she felt like she tightened up on the steering wheel." The Petitioner was diagnosed with a cervical strain, restricted from work the next day, and prescribed medication.

Based upon the foregoing, and having considered the totality of the evidence presented as well as the relevant statutory provisions and case law, the Arbitrator finds that on February 4, 2015, and accident did occur that arose out of and in the course of the Petitioner's employment by the Respondent.

In Support of the Arbitrator's Decision relating to (E.), Was timely notice of the accident given to Respondent, the Arbitrator finds and concludes as follows:

The Petitioner testified that she reported the accident to her supervisor, Paulette Earp, immediately after it occurred and to Karen Addis Frakes later that same day. The Petitioner's testimony in that regard was credible and was not contradicted or rebutted.

Based upon the foregoing, and having considered the totality of the evidence presented as well as the relevant statutory provisions and case law, the Arbitrator finds that timely notice of the accident was given to the Respondent.

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, (J.), Were 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:

Dr. Williams, the Petitioner's treating physician, opined that the February 4, 2015 motor vehicle accident aggravated the Petitioner's pre-existing carpal tunnel condition. Dr. Williams further opined that the Petitioner's work activities could also have caused or aggravated her bi-lateral carpal tunnel syndrome. Dr. Williams explained that constant gripping of the vibratory steering wheel with her left hand likely contributed to greater symptoms in her left wrist than her right hand, which is used occasionally to pull open the passenger door with a lever. Dr. Williams testified that the Petitioner's current condition of ill-being was causally related to her work her work activities and that the Petitioner was a surgical candidate and needed bi-lateral carpal tunnel release surgeries. No medical testimony or opinions from any other physicians was offered into the record.

The Arbitrator finds that the testimony and opinions of Dr. Williams were sufficiently credible, reliable, and persuasive to satisfy the Petitioner's burden of proof in the instant matter. No medical opinions or testimony which contradicted, rebutted, or challenged Dr. Williams' opinions was offered into the record.

Based upon the foregoing, and having considered the totality of the evidence presented as well as the relevant statutory provisions and case law, the Arbitrator finds that the Petitioner's current condition of ill-being is causally related to the work injury of February 4, 2015. The Arbitrator further finds that the medical care and treatment rendered to the Petitioner by Dr. Williams, as well as the surgical procedures recommended for the Petitioner by Dr. Williams, are reasonable, necessary, and causally related to the Petitioner's work injury of February 4, 2015.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Ewin,

Petitioner,

vs.

NO: 16 WC 1430

17IWCC0064

Cheapies Tires, TA,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 2, 2016, is hereby affirmed and adopted.

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

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

17IWCC0064

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.

FEB 2 - 2017

DATED:
TJT:yl
o 12/19/16
51

Michael J. Brennan

Kevin W. Lamborn

DISSENT

The facts of this case are not in dispute – Petitioner was using a floor jack and sitting cross-legged to change a customer's tire in Respondent's parking lot when he got up and felt a pop in his knee. The question is how to properly apply the law to this set of facts.

The Arbitrator found that "...Petitioner failed to proffer any evidence that he injured his left knee as a result of an employment-related risk and finds that Petitioner was not exposed to any greater risk than the general public when getting up from a seated position on the ground." (Arb.Dec. [Addendum], p.7). Thus, the Arbitrator appears to be applying a "neutral risk" analysis. I believe that such an analysis is unnecessary and not supported by the current case law.

In the recent case of *Steak 'N Shake v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150500WC, 2016 Ill. App. LEXIS 798 (11/17/16), the claimant was a waitress/trainer/manager who was injured while wiping down a table at work. The appellate court noted that the claimant's unrebutted testimony established her duties as a manager were to keep the flow of customers moving in an efficient manner and that she credibly testified she would on occasion clean and bus tables if necessary to keep the customer flow moving. As a result, the court found that the record established claimant was injured while engaged in an activity that the employer might reasonably have expected her to perform in the fulfillment of her job duties and thus resulted from a risk distinctly associated with her employment.

Likewise, in *Mytnik v. Illinois Workers' Compensation Commission*, 2016 IL App (1st) 152116WC, 2016 Ill. App. LEXIS 779 (11/10/16), the appellate court reversed the Commission and found that the act of bending down to pick up a bolt that had fallen on the assembly line was a risk distinctly associated with his job, given testimony to the effect that bolts had been dropped in the past and that failure to remove same could result in shutdown of the line.

In the present case, the activity that Petitioner was engaged in at the time of the injury (changing a tire) was similarly distinctive to his job – just like the waitress/manager wiping down a table in *Steak 'N Shake* or the assembly line worker picking up an errant bolt from the production line in *Mytnik*. In fact, all Petitioner did was change tires all day long, and he had to

do so using a standard floor jack – not the type of lift one typically sees in a full service garage. As a result, it would not be unreasonable to expect that Petitioner would have to stand on occasion from a seated position in order to fulfill his work-related duties, and that the risk of injury while performing such an activity was distinctively associated with his employment.

As a result, and in light of the fact that the parties stipulated to notice and causation (see Arb.Ex.#1), I would reverse the Arbitrator and find that Petitioner sustained accidental injuries arising out of and in the course of his employment on 12/4/15, and award compensation accordingly.

Thomas J. Tyrrell

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

EWIN, JAMES
Employee/Petitioner

Case# **16WC001430**

CHEAPIES TIRES TA
Employer/Respondent

17IWCC0064

On 3/2/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0487 SMITH ALLEN MENDENHALL ET AL
LAURA COLE
PO BOX 8248
ALTON, IL 62002

0358 QUINN JOHNSON
CHRISTOPHER CRAWFORD
227 N E JEFFERSON ST
PEORIA, IL 61602

17IWCC0064

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

James Ewin
Employee/Petitioner

v.

Cheapies Tires, TA
Employer/Respondent

Case # 16 WC 1430

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **February 10, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 4, 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.

On the date of accident, Petitioner was **33** years of age, ***married*** with **1** dependent child.

ORDER

Petitioner failed to prove that he sustained an accident that arose out of and in the course of his employment with Respondent and, as such, all benefits are denied. The remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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

2/29/16
Date

MAR 2 - 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

James Ewin
Employee/Petitioner

Case # **16** WC **1430**

v.

Consolidated cases: **N/A**

Cheapies Tires, TA
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he worked at Cheapies Tires in Alton from September 2015 until he was hurt in December of 2015. He testified that Respondent is a new and used tire shop, and that he changed tires. He testified that he jacked up cars, took the tires off and put new ones on. He testified that they used a floor jack, that a lift was not used and that they changed tires in the parking lot.

Petitioner testified that some days he worked he would be there for 4-6 hours, and that on other days he would work all day. He testified that he typically worked six days per week, but sometimes he worked seven days per week. He agreed that his hours varied. He testified that some days he was there from approximately 9:00 or 10:00 a.m. until close, and that they typically closed between 8:00 and 9:00 p.m. depending on how many cars were in the lot. He testified that he typically worked 36 hours per week, that he was paid $10.00 per hour and that he was paid in cash.

Petitioner testified that on December 4, 2015, he was on the ground changing a tire. He testified that he went to stand up and that his leg gave out. He testified that he heard it pop, and then he went and sat in the office until his wife came to pick him up. He testified that he was on the ground sitting "Indian style" to change a tire because he was using a floor jack and had to get down on the ground to use it.

Petitioner testified that he did not receive any medical treatment until the next day, and that he went to Jerseyville Community Hospital. He testified that he could not walk or put any pressure on his left knee. He testified that at the hospital x-rays were taken, he was told to ice it down and he was also told to follow-up with his family physician. He testified that he sought follow-up medical treatment after his visit to the emergency room at Dr. Lyons' office, but that he was seen by his physician's assistant, Victoria Hargrave, at Jersey Community Hospital Medical Group. He testified that they reviewed x-rays, said they were unable to do an MRI because of the swelling, had him come back for a follow-up visit and eventually had him undergo an MRI. He testified that he had his MRI at St. Anthony's in Alton. He testified that after he had the MRI, he was told that he needed to see an orthopedic doctor. He testified that he then saw Dr. Vest.

Petitioner testified that when he saw Dr. Vest his left knee was sore, he was unable to put any weight on it and it felt like it wanted to give out. He also testified that he was still having trouble walking. He testified that Dr. Vest put him in a brace and gave him crutches. He testified that Dr. Vest recommended that he undergo physical therapy, and then undergo ACL reconstruction surgery. He

testified that he has been off work since the date of accident, and that Dr. Vest currently has him off work. When asked if he had ever injured or had any problems with his left knee prior to the work accident on December 4, 2015, he responded that he did not.

On cross-examination, Petitioner confirmed that he saw physicians at Jersey Hospital as well as Ms. Hargrave and Dr. Vest following this incident. He confirmed that on each of those occasions, the physicians or nurses asked him how the accident happened and that he told them how the accident happened.

Respondent called Jeff Reppenhagen as a witness at the time of arbitration. He testified that he is a manager for Cheapies Tires, and has worked for Respondent for four years. He testified that he is the manager mainly at the Alton facility, but that he runs both shops. He testified that Respondent has three shops in total. He testified that he spends most of his time at the Alton location, and that this had been the case for the last four years. He indicated that he is now in Granite City and had been there for the three weeks prior to arbitration, but up until that time he was in Alton.

Mr. Reppenhagen testified that on December 4, 2015 he was in Alton, and that he is familiar with Petitioner. When asked if Petitioner was an employee of Respondent, he responded that Petitioner worked there on and off for the first couple of months but never really became a full-time employee. He testified that the last he knew, Petitioner left for another job. He agreed that Petitioner started working for Respondent in September and that he worked there through December. He testified that as manager he scheduled the employees for work, and that he was the one that told them to come in or when they had to go home if it was slow. He agreed that he was familiar with the hours that Petitioner worked.

Mr. Reppenhagen testified that Petitioner typically worked 15-20 hours per week on average towards the end, and that the first week or two Petitioner worked 25-30 hours per week on average. He testified that Petitioner was earning $10.00 per hour and that he was paid in cash. He testified that Respondent opened at 8:00 a.m. and closed when the cars stopped coming at night, which was usually around 8:00-9:00 p.m. He testified that Petitioner was a part-time employee. He denied having any wage records for Petitioner.

Mr. Reppenhagen confirmed that he has interaction with workers' compensation claims and testified that when something happens, he is the lot manager and usually the daily manager until one of the owners arrives and should be the person to whom any accidents are reported. He confirmed that he was at Respondent on December 4, 2015, but he was not made aware of any work injury that Petitioner suffered on that day. When asked if Petitioner was working on December 4, 2015, he responded that he could not say for sure and did not remember.

On cross-examination when asked what day of the week was December 4, 2015, Mr. Reppenhagen responded that he did not remember. He testified that he worked every day of the week, so he knew he was there. When asked what hours he worked on that day, he responded that he comes in and opens usually between 8:30-9:00 a.m., and that he is typically there until 6:00-7:00 p.m. at night. He testified that some days he goes home earlier if the opportunity arises, but that he works seven days a week.

On cross-examination, Mr. Reppenhagen agreed that he did not have any documentation of the hours worked by Petitioner when he was working at Respondent. He testified that he knew the hours that Petitioner worked for him, but he did not know where the documentation was or who had it. He further testified that he assumed there was no documentation because Petitioner was paid in cash.

Respondent called Kevin King as a witness at the time of arbitration. He testified that he lives in Granite City and works for Respondent. He testified that he has worked for Respondent for four years, that his position is a tire changer but that he is currently shredding tires. He testified that he mainly works at the Granite City location, but also works at the Alton location when needed.

Mr. King testified that he worked at the Alton location on December 4, 2015. He testified that he worked until 6:00 or 7:00 p.m. that evening, and that he was shuttling tires back and forth. When asked if he was familiar with Petitioner, he responded that he had only met him twice.

Mr. King testified that on December 4, 2015, he saw Petitioner when they were loading up tires in the back of the box truck. He testified that Petitioner kicked a tire, and it looked like he was limping out of the back of the box truck afterwards. He testified that he saw Petitioner earlier that day, that he smelled alcohol on his breath and that he continued to work. When asked what Petitioner was doing at the time, he responded that he was loading tires in the back of the box truck. He testified that he saw Petitioner kick one of the tires that rolled in, and that he overstepped and kicked it to stop it. He testified that he thought that Petitioner was "goofing around." He testified that he thought that Petitioner kicked the tire excessively, and that it looked like he hurt himself because he limped out of the box truck. He testified that this was the last time that he saw Petitioner. He testified that prior to kicking the tire, Petitioner seemed to be fine. He denied having worked with Petitioner on any previous occasions. He testified that he did not see where Petitioner went after he left the back of the box truck.

On cross-examination, Mr. King admitted that he did not know what day of the week was December 4, 2015. He testified that he remembered that on December 4, 2015, he was working in Alton loading a truck in the back because they were shuttling tires back and forth to get rid of them. He agreed that he did that task on other days, and that he might also have done it on either December 3rd or December 6th as well. He agreed that he testified that he saw Petitioner walk away from the truck that he was loading, but denied having seen his knee buckle or give away when he walked away from the truck.

On redirect, Mr. King agreed that he was taking away tires on December 4th, and that this could be part of his day on certain days depending on how many tires were in Alton.

On rebuttal, Petitioner testified that he was changing a tire at the specific time that he was injured because he was asked by either Julian or Jay to go out and help. He testified that it was after 8:00 p.m., and they were trying to get cars off the lot so they could close. He agreed that he testified that after he hurt his knee, he went into the office and sat down until his wife arrived to pick him up. He testified that when he went into the office, he told Julian and Jay that he hurt his knee. He testified that Julian was the owner's son, and that Jay was the owner. He also testified that the next day on December 5, 2015, he talked to Jessa in the office and told her that he could not come into work because his knee was injured.

On cross-examination when asked if Jeff was his manager, Petitioner responded that as far as he knew, Julian and Jay were the ones "running the show." When asked if Mr. Reppenhagen was the manager, Petitioner responded that he had worked with him in Granite City as a manager. He testified that Mr. Reppenhagen worked at the Alton location, but he was never made aware that he was a manager. He admitted that he knew he was a manager at Granite City.

On cross-examination, Petitioner denied working anywhere else after he worked for Respondent, and further denied working for Farm Service. He agreed that he had no wage records from Respondent, and he further agreed that he had no tax documents showing what his wages were while working for Respondent. He agreed that he was aware that Jay spent some of his time in Florida, and when asked if he recalled him being in Florida in December, he responded that Jay had not left yet.

The Application For Adjustment of Claim was entered into evidence at the time of arbitration as Arbitrator's Exhibit 2. The Application alleged that an accident occurred on December 4, 2015 when Petitioner was getting off the ground from mounting a tire. (AX2).

The medical records of Jersey Community Hospital Medical Group were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The records reflect that Petitioner was seen for emergency room follow-up on December 8, 2015. The "chief complaint" was noted to be that on Friday, Petitioner was standing and his left knee gave out and made a popping noise after which he went to the emergency room on Saturday. The history of present illness noted that on Friday night after work he was sitting Indian-style to put a tire on a vehicle and went to stand up and when he did this, his left knee gave out and made a popping noise. Petitioner denied any swelling. It was noted that his pain improved when sitting still and after taking Norco, and that his pain increased when walking and straightening out his knee. The assessment was that of arthralgia of the left knee/patella/tibia/fibula, and Petitioner was instructed to take his medication as directed, perform his exercises/stretching as directed, do Epsom salt soaks and to rest and elevate the leg when possible. It was noted that a discussion was had regarding not wearing the knee brace continuously and doing range of motion with the knee, and he was instructed to follow up in two weeks or sooner if the symptoms were worsening or not improving. (PX1).

The records reflect that Petitioner was seen on December 23, 2015, at which time Petitioner stated that his left knee was doing better than before but it was weak and liked to give out on him. He reported that when he did not have his brace on, it buckled and went in a "weird" direction. The history of present illness noted that Petitioner reported that his knee was not as painful and had better range of motion but still hurt. He reported that his knee would lock up, felt like it would hyperextend and felt like it wanted to give out. He also reported that he had an open area to the right inner thigh for the past week, and that he had an abscess in the past and history of MRSA. He was assessed with cellulitis and abscess of the thigh, as well as arthralgia of the left knee/patella/tibia/fibula. An MRI was ordered. (PX1).

The records reflect that Petitioner was seen on January 6, 2016 in order to discuss the MRI results. It was noted that the MRI of the left knee showed a complete tear of the ACL, subcortical fracture within the midportion of the lateral femoral condyle and possible meniscus tear. It was noted that Petitioner reported that the injury occurred at Cheapies Tires where he works, but it was after working hours but on the property of his employment. He originally reported that it was not worker's compensation and now was unsure after contacting a lawyer if he was even on the payroll. He reported that he clocked in and out and that the first few checks were in an envelope and then after that there was an envelope with cash in it so he did not know if he was on the payroll and therefore could not file a worker's compensation claim. He reported that his boss was "not being to [*sic*] nice" and would not let him return until given a note that his knee was okay and he could work so he called a lawyer. He had not filed a claim per his report and was waiting to get the official MRI results first. The assessment was that of a non-displaced fracture of lateral condyle of left femur, arthralgia of the left knee/patella/tibia/fibula and complete tear of the anterior cruciate ligament of the left knee. He was referred to an orthopedic physician. It was noted that this provider did not take worker's compensation, so he was provided with options of places to go. (PX1).

Included within the medical records was a letter dated January 14, 2016 directed to "To Whom It May Concern" indicating that Petitioner was unable to work from December 8, 2015 to February 3, 2016, and that he was being released to return to work on February 4, 2016. Another letter dated January 14, 2016 directed to "To Whom It May Concern" was included within the medical records, indicating that Petitioner was unable to work until seen and released by Dr. Vest. (PX1).

Included within the medical records was a notation for a phone call dated January 14, 2016, at which time Petitioner indicated he needed a work slip to be off from December 8th through February 3rd

for his lawyer on a worker's compensation case. The slip was requested to be faxed to Petitioner's attorney. (PX1).

Also included within the medical records was an interpretive report for an MRI of the left knee performed on January 2, 2016. The interpretive report noted a history of left knee pain, popping and buckling for three weeks, and that Petitioner was attempting to stand from a position where he was sitting with his legs crossed and heard a pop/felt pain. The impression of the interpreting radiologist was that of (1) complete tear of the ACL; (2) contusion surrounding the fracture within the lateral femoral condyle, contusion within the posterior aspect of the lateral tibial plateau; (3) blunting of the inferior and peripheral aspect of the medial meniscus within the periphery of the body contacting the inferior articular surface; appearance is equivocal for tearing of the meniscus versus the shape of the meniscus. (PX1).

The medical records of Jersey Community Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The Emergency Department records noted a patient arrival time of 18:47, and a triage form time of 18:21. The records reflect that Petitioner stated yesterday he went to stand up and his left knee gave out and that he felt it pop. He stated he could not fully straighten the leg out or bend the knee. He further stated that his toes felt a little numb, and it was noted that he was using a walker to get around. It was noted that he worked in a car garage so he was up and down all the time during his work day. He denied a prior history of problems with the knee. The records reflect that he was given a work slip taking him off work until December 8, 2015, and that he was assessed with an acute left knee sprain and instructed to follow-up with his primary care physician. The interpretive report for x-rays performed on the same date were interpreted as revealing no radiographic evidence of bone or joint disease. (PX2).

The medical records of Orthopedic & Sports Medicine Clinic were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that a Certificate for Return to School or Work dated February 3, 2016 was issued, indicating that Petitioner was not able to return to work until further notice. The records reflect that Petitioner was seen on February 3, 2016, at which time he was seen for an initial visit with complaints of pain in the left knee. The history noted that this was a worker's compensation case, and that Petitioner was injured on December 4, 2015 in the parking lot at his work. He reported that he was sitting cross-legged on the ground, helping a co-worker change a tire and stood up with his ankles still crossed and felt a severe pop in the left knee. Afterwards, Petitioner was able to limp to a chair, but was unable to put full weight on the left leg. He stated that he already clocked out of work at the time of the injury. It was noted that he went to Jerseyville emergency room the next day after the pain did not improve, and that he was given a hinged knee brace and an off work note. It was noted that Petitioner had been bearing intermittent weight on the left leg, but had been limping. He stated that his wife had a walker that she used after her back surgery a few years ago, which he had been using. He still noticed some swelling in the left knee, but had not noticed any bruising. He stated that the left knee felt very unstable and had given out three additional times since the original injury. The impression was that of (1) acute ACL tear, left knee; (2) non-displaced fracture, lateral femoral condyle, left knee; (3) probable medial meniscus tear, left knee. Petitioner was fitted with a long leg hinged knee brace, and was instructed to wear the brace when ambulating or transferring. He was fitted with crutches, and he was instructed to remain off work until further notice. The records reflect that a discussion was had with regards to ACL reconstruction of the left knee. (PX3).

The Addendum to Office Note dated February 3, 2016 noted that Dr. Vest had reviewed the case with his physician's assistant. It was noted that Dr. Vest wanted Petitioner to follow-up in the office the next week for him to be personally examined and to discuss further treatment options. It was noted that Petitioner may be a future candidate for arthroscopy of the left knee with ACL reconstruction and medial meniscus repair or partial meniscectomy. It was further noted that Petitioner had been off work and would continue to remain off work. (PX3).

The records reflect that Petitioner was seen on February 8, 2016, at which time he was seen for follow-up with complaints of pain in the left knee. In addition to the previous description of accident, it was noted that Petitioner stated that he had already clocked out of work at the time of the injury. The impression was that of (1) acute ACL tear, left knee; (2) bone contusions of the lateral femoral condyle and lateral tibial plateau of the left knee; (3) probable medial meniscus tear, left knee. It was noted that Petitioner was a candidate for arthroscopy of the left knee with probable ACL reconstruction and possible partial medial meniscectomy or meniscus repair under general anesthesia. It was noted that prior to surgery, he first needed physical therapy to restore his full range of motion of the left knee and allow further time for the bone contusions to heal. A script for physical therapy was issued at that time, and he was instructed to continue to use the crutches with 50% weight-bearing on the left leg and it was noted he was to continue to wear the hinged knee brace with ambulation for stability. It was noted that Petitioner was to be off work until further notice, and he was to follow-up in four weeks with x-rays of the left knee. A Certificate for Return to School or Work was issued on February 8, 2016, indicating that Petitioner was not able to return to work until further notice. (PX3).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 4.

CONCLUSIONS OF LAW

In regard to disputed issue (C), to obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he has suffered a disabling injury arising out of and in the course of his employment. 820 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1013 (1st Dist. 2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 57 (1989). However, the fact that an injury arose "in the course of" the employment is not sufficient to impose liability, for to be compensable, the injury must also "arise out of" the employment. *Id.* at 58.

The "in the course of" component refers to the time, place and circumstances under which the accident occurred. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483 (1989). If an injury occurs within the time period of employment, at a place where the employee can reasonably be expected to be in the performance of her duties, and while she is performing those duties or doing something incidental thereto, the injuries are deemed to have been received in the course of the employment. *Caterpillar Tractor Co.*, 129 Ill. 2d at 58. The "arising out of" component refers to an origin or cause of the injury that must be in some risk connected with or incident to the employment, so as to create a causal connection between the employment and the accidental injury. *Id.* There are three categories of risk to which an employee may be exposed: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks, which have no particular employment or personal characteristics. *Springfield Urban League v. Illinois Workers' Compensation Comm'n*, 2103 IL App (4th) 120219WC; *Young v. Illinois Workers' Compensation Comm'n*, 2014 IL App (4th) 130392WC. Injuries resulting from a neutral risk are not generally compensable and do not arise out of the employment unless the employee was exposed to the risk to a greater degree than the general public. *Id.*

With respect to disputed issue (C), the Arbitrator concludes that Petitioner failed to prove by a preponderance of the evidence that he sustained an injury on December 4, 2015 that arose out of his employment with Respondent. In so concluding, the Arbitrator finds that Petitioner failed to proffer any evidence that he injured his left knee as a result of an employment-related risk and finds that Petitioner was not exposed to any greater risk than the general public when getting up from a seated position on the

ground. The Arbitrator notes that Petitioner testified that he was on the ground changing a tire, that he went to stand up and that his leg gave out. He testified that he heard it pop, and then he went and sat in the office until his wife came to pick him up. He testified that he was on the ground sitting "Indian style" to change a tire because he was using a floor jack and had to get down on the ground to use it. The Arbitrator notes that Petitioner failed to identify any hazardous condition or defect that contributed to his sustaining injury when he went to stand up from a seated position, that he failed to testify as to his slipping, falling or otherwise losing his balance in the process of standing up from the ground and that he failed to testify that he was manipulating or holding any tools or equipment at the time that he got up from a seated position that may have affected his ability to do so. As a result of the foregoing, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that he sustained an injury on December 4, 2015 that arose out of his employment with Respondent.

In light of the Arbitrator's findings with disputed issue (C), the Arbitrator makes no findings with respect to disputed issues (G), (J) and (K), as those issues are rendered moot. The claim is denied.

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

Jacob Capps,

Petitioner,

vs.

NO: 13WC 07107

Lowe's Home Centers Inc,

Respondent,

17IWCC0065

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 6, 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.

17IWCC0065

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 6 - 2017

o020117
CJD/rlc
049

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

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

CAPPS, JACOB
Employee/Petitioner

Case# **13WC007107**

13WC032623

LOWE'S HOME CENTERS INC
Employer/Respondent

17IWCC0065

On 1/6/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.50% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0246 HANAGAN & McGOVERN PC
BRIAN T McGOVERN
123 S 10TH ST SUITE 601
MT VERNON, IL 62864

0000 INMAN & FITZGIBBONS LTD
MICHAEL BANTZ
201 W SPRINGFIELD AVE #1002
CHAMPAIGN, IL 61820

17IWCC0065

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)

JACOB CAPPS
Employee/Petitioner

v.

LOWE'S HOME CENTERS, INC.
Employer/Respondent

Case # 13 WC 007107

Consolidated cases: 13 WC 032623

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **November 4, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 _____

17IWCC0065

FINDINGS

On the date of accident, **09/15/2010**, 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 **$4,903.32**; the average weekly wage was **$196.13**.

On the date of accident, Petitioner was **20** years of age, ***single*** 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 **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$5,239.42** for medical benefits that have been paid, for a total credit of **$5,239.42**.

Respondent is entitled to a credit of **$0** for any medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 9 as provided in Sections 8(a) and 8.2 of the Act subject to the fee schedule. Respondent shall be given credit for the amounts it has paid as reflected in Respondent's Exhibit 1.

Respondent shall authorize and pay for the medical treatment, in the form of an L5-S1 lumbar fusion, as recommended by Dr. Matthew Gornet.

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

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

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

Signature of Arbitrator

January 2, 2016
Date

ICArbDec19(b)

JAN 6 - 2016

Findings of Fact and Conclusions of Law

Petitioner has two claims pending for injuries to his low back. One case is against Lowe's Home Centers, Inc. (the case herein) and alleges an accident date of September 15, 2010. The other claim is against Walgreens Family of Companies and alleges an accident date of March 28, 2011 (13 WC 32623). Both cases were consolidated for purposes of a hearing; however, the parties understood that separate decisions would be issued.

The Arbitrator finds:

On September 15, 2010, Petitioner, 20 years of age, was employed with Respondent as a receiver. Each morning, he would unload trucks, and on this day, while bending over and picking up a Christmas tree box, he suffered an injury to his low back. Respondent stipulated to accident.

The same day, Respondent sent Petitioner to Care First for medical treatment. (PX1, RX3.) Petitioner reported that he was picking up a Christmas tree box and felt sharp pain in his lower back that was radiating into both of his legs. Physical exam revealed bilateral tenderness with spasms in his low back at L5-S1. He was diagnosed with low back pain with an acute lumbosacral strain. He was prescribed a muscle relaxer and physical therapy. X-rays taken that day were negative for fracture, spondylolisthesis, or spondylolysis, and showed minimal degenerative change in his lower lumbar spine. (PX3.) He was released to light duty, which Respondent accommodated.

Petitioner underwent physical therapy at Synergy Therapy three times per week from September 22, 2010 to November 19, 2010. At the time of the initial evaluation, Petitioner was having trouble working, walking, climbing stairs, and driving. These records indicate Petitioner's pain was waxing and waning. For example, on September 24, 2010, Petitioner noted working on September 23, 2010 and then feeling sore. On September 27, 2010, he stated he was feeling better after not working over the weekend. (PX 2)

Petitioner's next visit with Care First was on October 1, 2010. He reported feeling ninety percent better with occasional discomfort and indicated physical therapy was helping. Petitioner's pain level was down to one out of ten from eight or nine out of ten, and down from six or seven out of ten when physical therapy started to zero or one out of ten at the end of physical therapy. He was released to full duty, ordered to continue physical therapy, and told to return if needed. Petitioner signed a form stating that "When I started therapy my pain was at a 8 or 9. Now it is at a 1. I had trouble walking and getting around and now I am fine." (PX1, RX3)

Petitioner attended physical therapy at Synergy on October 4, 2010, reporting increased tightness and soreness in his lower back after having resumed full duty work. (PX 2)

On October 11, 2010, Petitioner returned to Synergy Therapeutic Group reporting

increased low back symptoms over the past week. *Id.* Petitioner reported increased low back complaints when working on October 15, 2010 after unloading two trucks at work. *Id.* On October 29, 2010, Petitioner reported increased low back soreness, as well as pain in a specific point in his back after lifting heavy grills at work. *Id.*

On November 8, 2010, Petitioner started a new position with Select Remedy in the PWD ("People With Disabilities") Program with a goal of obtaining employment with Walgreens.

When seen at Synergy Therapy on November 10, 2010 Petitioner reported complaints of bilateral leg soreness after starting a new job that week. He had difficulty completing therapy exercises that day and was noted to be walking with an antalgic gait. Petitioner reported continued soreness on November 12, 2010. (PX 2)

Petitioner was discharged from therapy on November 19, 2010. He also signed a form in which he indicated that his pain had originally been a 6/7 about after 24 visits his pain had gone away to a "0" or an occasional "1." He could not sit or stand as long as he wanted. (RX 3)

Petitioner was hired and officially started a new position at Walgreens on March 8, 2011.

On March 23, 2011, Petitioner presented to Team Works Therapy with complaints of recurrent low back pain. Due to his dyslexia Petitioner had some assistance completing a Questionnaire. According to the initial evaluation from Team Works, Petitioner reported his complaints on March 22, 2011. Petitioner reported having injured himself while working for Respondent about five to ten months earlier and re-aggravating it with bending and twisting. Petitioner was having trouble sleeping due to pain. Petitioner was issued a back brace and advised/referred for work on strengthening and flexibility. (PX 4)

On March 28, 2011, Petitioner was evaluated by Nurse Practitioner Amanda McKee at the Orthopaedic Center of Southern Illinois. He completed a "New Complaint History Form" as part of the examination. In it, he indicated he had been referred by Dr. David DeLoso/Amorodo. His chief complaint was lower back pain extending down his left leg. As part of the history form, Petitioner reported that he is "always sore" but on the Tuesday of the previous week he started having pain radiating down his leg to his right thigh. It is further noted, "while at Lowe's pick[ed] up Christmas tree box and couldn't stand up. Now at Walgreens since 11/10 and pain has been increasing. Seeing trainer at Walgreens. Trainer says left foot is turned out." (PX 5)

When examined by N.P. McKee, Petitioner related a history of an eight-month history of chronic low back pain with radicular complaints including numbness and tingling into his left lower extremity. (PX 5) Petitioner was accompanied by his mother. Petitioner reported that on September 10, 2010, while working for Respondent, he picked up a Christmas tree weighing approximately 80 pounds and felt immediate pain in his back. According to the note, "He reports it is not a Workman's Compensation case." Petitioner further explained that he was now working for Walgreens and noticing increased back pain since doing more repetitive bending, stooping, lifting, and twisting. The note further indicates Petitioner's back pain was four out of ten and his leg pain a three out of ten. X-rays of Petitioner's lumbar spine taken during this visit failed to demonstrate any obvious fracture or dislocation. Nurse Practitioner McKee's impression was

that of chronic low back pain, left-sided sciatica, lumbar radiculopathy, left sacroilitis and bilateral pes planus. Petitioner was advised to hold off on the Doan's and Aleve and Nurse Practitioner McKee recommended a course of physical therapy for his low back, sacroiliac joint and sciatic regimens and custom orthotics for the treatment of his pes planus. She further recommended "good work shoes." He was given a prednisone taper and scripts for Relafen and Skelaxin. Petitioner declined an MRI or consultation at that time. Nurse Practitioner McKee noted that Petitioner requested no work restrictions but would continue to use a low profile back brace at work. (PX 5)

Petitioner was seen at Team Works/Mt. Vernon Wellness on April 5, 2011, at which time Petitioner reported minimal symptoms which he believed was from taking "LOW" recently. Treatment was provided. (PX 4)

Petitioner again presented to Team Works/Mt. Vernon Wellness on April 7, 2011 reporting reduced symptoms, even while working full days that week. Treatment was provided. (PX 4)

Petitioner returned to Team Works/Mt. Vernon Wellness (hereafter referred to as TM/MV) on April 12, 2011 reporting minimal symptoms. According to the note, Petitioner commented, "he feels like he did before re-injury." Treatment was provided. (PX 4)

When re-examined at TM/MV on April 14, 2011 Petitioner reported minimal symptoms in recent days. Treatment was provided. (PX 4)

As of April 21, 2011 Petitioner was advising TM/MV that his symptoms were manageable but ongoing. (PX 4)

In the TM/MV note of April 22, 2011 it was noted that physical therapy had shown consistent symptom relief throughout Petitioner's visits and as of that day Petitioner was reporting only sporadic, dull pain throughout with no radiating symptoms into his left leg. Petitioner tolerated all treatment and showed home exercise compliance; however, he "continues to have obvious postural deficits." Petitioner was to return after his nurse appointment on April 26, 2011. (PX 4)

Petitioner returned to the Orthopaedic Center of Southern Illinois and was again evaluated by Nurse Practitioner McKee on April 26, 2011. Petitioner reported minimal low back and SI joint pain and denied any left lower extremity numbness, tingling, or radicular complaints. Petitioner had finished the prednisone and was taking the Relafen and Norflex but not the Skelaxin. Physical therapy at work was reportedly helping. Nurse Practitioner McKee's assessment was that of resolving chronic low back pain, left sciatica with radiculopathy, left-sided sacroilitis, and bilateral pes planus. Nurse Practitioner McKee recommended continued physical therapy, noting Petitioner "deferred" any type of consultation, MRI, or injection at that time. (PX 5)

Petitioner returned to TM/MV on May 5, 2011 reporting that he had been referred for continued therapy exercises. It was noted that Petitioner was continuing to have a decrease in

symptoms but after stopping his steroid treatment, his symptoms started increasing again. (PX 4) As of May 10, 2011 Petitioner was reporting manageable symptoms but frustration with constant symptoms in his low back and was considering an injection. When he returned the next day, it was noted that he was in obvious pain when walking into the facility and reported having significantly increased symptoms after waking up that morning. He couldn't attribute anything to it. Petitioner's symptoms were described as "significant" when he returned on May 12, 2011 and Petitioner reported having to "take a point" the previous night because of them. Petitioner reported minimal symptom reduction and obvious difficulty walking and moving around the treatment table. (PX 4)

TM/MV therapy notes from May 17, 2011 indicate Petitioner reported no improvement. His "FM" was allowing him to clean, but Petitioner believed his symptoms eventually were just as bad due to stairs and bags of garbage. (PX 4)

On May 19, 2011, Petitioner presented to Dr. Ahmed at the Mt. Vernon Wellness Center with the chief complaint of hip and back pain, "goes to orthopedic center." Petitioner, who was noted to be 21 years old, gave a history of lumbar pain which was had begun one year earlier and was moderate in severity and radiating into his left hip. The onset of the back pain was noted to be "gradual" and precipitated by exercise. Lying down was helpful but he was having trouble sleeping. Petitioner explained that after lifting a Christmas tree at work his back "just gave out." He had undergone physical therapy for about a month and it helped for a "short time." Petitioner had been working for Walgreens six months "full case pick" and had undergone a "few x-rays." Petitioner explained that he did stretches in the morning; otherwise, he couldn't get out of bed. Petitioner was diagnosed with a backache and prescribed medications. He was to return in one week or call if his symptoms worsened or persisted. (PX 4)

On May 26, 2011, Petitioner followed up with Nurse Practitioner McKee complaining of significant low back and left leg pain since last being seen. He had been working "essentially full duty which is causing pain." Rather than take Relafen, Petitioner was on Mobic. The prednisone was reportedly the only thing that had really helped. He was still undergoing physical therapy at work. (PX 5) Nurse Practitioner McKee recommended Petitioner continue physical therapy, and ordered an MRI of Petitioner's lumbosacral spine to further address his complaints. *Id.* Nurse Practitioner McKee also placed Petitioner under work restrictions of no repetitive bending, stooping, lifting, twisting, or lifting more than 50 pounds. Medications were adjusted. *Id.*

An MRI of Petitioner's lumbosacral spine was taken on June 2, 2011 showing degenerative disc disease at L5-S1 with a mild diffuse disc bulge which impinged on the traversing nerve root bilaterally. *Id.*

On June 10, 2011, Petitioner followed up with Nurse Practitioner McKee with continued complaints of left leg pain with some low back pain with the left leg pain being the chief complaint. Ultram was not helping. Nurse Practitioner McKee reviewed the MRI results as showing degenerative disc disease at L5-S1 with a mild diffuse disc bulge causing impingement on the nerve root bilaterally. On exam Petitioner had positive compression, distraction, and Patrick test bilaterally. Nurse Practitioner McKee's assessment was that of chronic low back pain, left-sided sciatica, left lumbar radiculopathy, and bilateral cellulitis with degenerative disc

disease at L5-S1 with an associated bulge. Nurse Practitioner McKee referred Petitioner to Dr. Templer for a left-sided L5-S1 epidural steroid injection and placed Petitioner under continued light-duty restrictions, including no repetitive bending, stooping, lifting, or twisting, and a 15 pound lifting restriction. (PX 5)

On June 16, 2011, Petitioner presented to Dr. James Chow for an interlinear L5-S1 epidural steroid injection. (PX 5)

Petitioner followed-up with Nurse Practitioner McKee on June 30, 2011 reporting no relief of his symptoms following the L5-S1 epidural steroid injection. (PX 5) Petitioner reported that his father had purchased an inversion table that had helped alleviate some of his left leg pain, but he continued to experience ongoing mid-line low back pain and left-sided SI joint pain. *Id.* He followed-up with Nurse Practitioner for a second lumbar epidural steroid injection, and she recommended continued work restrictions. *Id.*

On July 14, 2011, Petitioner presented to Dr. Chow for a left-sided SI joint epidural steroid injection. (PX 5)

Petitioner followed up with Nurse Practitioner McKee on July 28, 2011 reporting improvement following the left-sided SI joint epidural steroid injection. Petitioner described his pain as "waxing and waning" depending upon his activity. His primary source of pain was his left sacroiliac joint and his low back; however, he denied any radiation to either lower extremity or numbness or tingling. They discussed a medial branch block v. a repeat SI injection. Petitioner expressed the desire to have a consultation with Dr. Kovalsky. N.P. McKee also recommended continued work restrictions. (PX 5)

On September 7, 2011, Petitioner presented to Dr. Don Kovalsky for the chief complaint of low back pain with some radiation into the left buttocks and leg but no weakness. As when he initially saw the nurse practitioner, some history was obtained. On the form, it states "Not w.c." There is also a reference to the onset of leg pain on Tuesday, March 22nd. Petitioner reported that his symptoms had started about "five to six months ago" when he was working for Respondent and sustained a back injury lifting a Christmas tree box while at work for Respondent. Petitioner was unsure if "this was a contested Workmen's Comp claim from Lowe's." He was currently working at Walgreens since November of 2010 and on light duty. Petitioner reported undergoing multiple steroid injections with mild improvement of his leg pain but no significant improvement in his back pain. Dr. Kovalsky reviewed Petitioner's MRI results showing dehydration with mild narrowing at L5-S1 with no modic changes and a small central disc herniation and annular tear at L5-S1 without any significant neural compression. Dr. Kovalsky diagnosed Petitioner with degenerative disc disease, an annular tear, and a small disc herniation. Dr. Kovalsky noted a simple discectomy would not suffice in terms of treating Petitioner's condition; rather, his options would include the possibility of an interior lumbar interbody fusion, or total disc arthroplasty. According to Dr. Kovalsky's notes, Petitioner expressed a desire to avoid surgery if possible. Dr. Kovalsky, therefore, recommended physical therapy as well as a home exercise program and weight loss. Dr. Kovalsky further recommended Petitioner be fitted for a low profile lumbosacral arthrosis. Dr. Kovalsky released Petitioner to return to work full-duty without restrictions. He further suggested the use of Glucosamine as

well as Flexeril, Mobic, and Tramadol. He was to return in three months to see how he was doing. "[U]ltimately if he has surgery that will be the patient's decision, not mine since pain is his only major complaint." (PX 5)

On October 27, 2011, Petitioner presented to Bowman Chiropractic for treatment of his complaints of left-sided low back pain with radicular complaints into his left hip following an injury to his back lifting a tree while working at Respondent Lowe's in 2010. (PX 7) Following his chiropractic manipulation, it was recommended that Petitioner return for further manipulation two to three times per week for the next one to two weeks. *Id.*

Petitioner followed-up with Dr. Kovalsky on December 7, 2011. The doctor's notes state, "It's an old Work Comp injury." Petitioner was noted to be working for Walgreens without any restrictions but was using medications, including Vicodin on occasion. Therapy had reportedly helped and Petitioner had tried to go to a gym but it made his pain worse. Petitioner was noted to be working eight hours a day with heavy lifting. He reported more good days than bad days and no radicular leg pain. Dr. Kovalsky felt Petitioner was doing well, and recommended he continue his home exercise program and continue to work full-duty without restriction (PX 5)

Petitioner continued to obtain chiropractic manipulation for his complaints of low back pain at Bowman Chiropractic through the end of March, 2012. (PX 7)

On June 15, 2012, Petitioner visited Dr. Kovalsky for an updated evaluation of his continuing low back pain with radicular complaints. According to the doctor's note, "[he] had an old Work Comp injury of the lower back. He settled with Comp." Petitioner was working full-time at Walgreens as a split case picker but still having low back pain without radiation into his buttocks and legs. Petitioner admitted he had not been completing his home exercise program religiously. Petitioner further reported that he had less pain on the weekends and didn't need to take his medication but at work he was using 6 Tramadol and day and three to four regular strength Vicodin. His diagnosis was mechanical back pain. Petitioner requested Dr. Kovalsky re-fill his medication. Dr. Kovalsky re-filled Petitioner's medication and requested he follow-up in six months, noting that if Petitioner was going to continue taking narcotic pain medication, he would have to complete a urine drug screening and sign a Narcotics Agreement. (PX 5)

Petitioner visited Nurse Practitioner McKee on October 30, 2012 with complaints of chronic low back pain with "an acute flare-up since October 26th." A pain drawing reflects lower back pain and radiating left leg pain down to/through the left foot. Petitioner was at work, bent over to pick something up and felt a pop in his back and pain shooting into his left leg with numbness and tingling into his left foot. Ms. McKee noted that Petitioner had chronic low back pain on and off for the past year and a half, but the left leg pain and numbness and tingling were "acute symptoms." (PX 5) Nurse Practitioner McKee's impression was that of chronic low back pain, degenerative disc disease at L5-S1, with a new complaint of left radiculopathy with a possible herniated nucleus pulposus. *Id.* Nurse Practitioner McKee ordered an updated MRI of Petitioner's lumbar spine. Petitioner "deferred" any work restrictions but was going to try and avoid any repetitive bending, stooping, lifting, or twisting. *Id.*

An MRI of Petitioner's lumbar spine was taken on November 6, 2012. According to the

history, Petitioner had chronic low back pain with an acute flare-up since October 26, 2012 and tingling and numbness of the left foot. The MRI revealed mild disc degeneration with loss of disc height at L5-S1, and a small posterior central disc protrusion with moderate size annular disc tear, with the disc touching the surface of both the traverse and bilateral L5 nerve roots. (PX 5)

Petitioner followed up with Nurse Practitioner McKee on November 9, 2012 reporting some improvement with Prednisone. (PX 5) Nurse Practitioner McKee reviewed the results of the November 6, 2012 MRI, and recommended an evaluation with Dr. Kovalsky for possible surgical intervention. He was to continue with prednisone followed by Mobic and Neurontin. He "deferred" any injection at that time. (PX 5)

On December 13, 2012, Petitioner returned to see Dr. Kovalsky, reporting that he was working at Walgreens, doing well, and then "over the last three months" had been experiencing recurrent back and left buttock and thigh pain. Bending and lifting activities seemed to bother him and he was having some buttocks pain at night and recently changing jobs at Walgreens so he did not have to complete as much bending and lifting which has resulted in some improvement of his symptoms. Dr. Kovalsky described Petitioner's back pain as mechanical in nature and aggravated by bending and lifting. Petitioner's leg pain seemed to bother him at night. Dr. Kovalsky reviewed Petitioner's November 6, 2012 MRI noting no significant changes with a dark disc with a small tear on the left without any major disc herniation on the axial cuts. Dr. Kovalsky found, based on the MRI results, Petitioner was not a candidate for surgery or injections. Dr. Kovalsky instructed Petitioner to continue completing the home exercise program, but Petitioner admitted he had not been performing it very often. Petitioner explained that he tried to ride a bike and it bothered him as did some of the "ball" exercises he was taught in therapy. They discussed alternative exercises with Dr. Kovalsky noting his discussion with Petitioner and his mother regarding the natural history of degenerative disc disease, and how it normally does not require surgery. Dr. Kovalsky further recommended that Petitioner look into finding a different profession where he didn't have to do any bending or lifting so that he could do it for the next forty years. Petitioner was to follow up with N.P. McKee for medications. (PX 5)

On February 13, 2013, Nurse Practitioner McKee issued work restrictions including no repetitive bending, stopping, lifting or twisting, and a 15 pound lifting restriction for one month. (PX 5)

Petitioner signed his Application for Adjustment of Claim against Respondent herein on February 25, 2013, alleging an accident date of September 15, 2010 while unloading a truck. (AX 2)

Petitioner returned to see Ms. McKee at Dr. Kovalsky's office on July 30, 2013 for a "recheck of his cervical spine". Petitioner reported seeing no improvement with physical therapy. He denied any pain stating it had "totally resolved." Petitioner was taking Norco only at nighttime without any side effects. He didn't take it during the day because it made him somewhat sleepy. Petitioner was working full duty. On exam, Petitioner's cervical spine was essentially normal. Her impression was resolving neck pain that was chronic in nature, left

trapezius cervical strain. Petitioner was to continue the Norflex as needed and remain on full duty work and continue physical therapy. (PX 5)

On August 8, 2013, Petitioner, accompanied by his mother, presented to Dr. Matthew Gornet for an evaluation of his complaints, having been referred by Amanda McKee. Petitioner completed a "Medical Information" form indicating his accident occurred when he bent over and picked up a Christmas tree and felt a pop and instant pain. He began treatment on September 15, 2010. A pain drawing revealed left-sided back complaints going down his left thigh and left upper arm/shoulder complaints. Petitioner's chief complaint was low back pain to the left side of the left buttock and hip and down the left leg to his knee. Petitioner also reported intermittent neck pain into his left trapezius and left shoulder. Petitioner reported that his current problem began on September 15, 2010 while working for Respondent and lifting a Christmas tree at work. He recalled feeling a pop at that time. Petitioner had been referred to Prompt Care and further reported no significant treatment had been performed. He then went to Amanda McKee who referred him to Dr. Kovalsky who identified an annular tear at L5-S1. Injections had been done in 2011 and Petitioner had changed jobs and began working for Walgreens. Intermittently, Petitioner underwent light duty. "He had a history of a mild injury on 12/16/11 in which he was struck by a pallet, but he did not feel that this significantly altered his symptoms." He could not recall any problems of significance before September 15, 2010. According to Petitioner, Dr. Kovalsky thought a fusion procedure was an option but Petitioner wanted another opinion. Petitioner described constant pain, worse with bending, lifting, weather changes, or prolonged standing or sitting. Petitioner reported pain relief when lying down. (PX 6)

Dr. Gornet reviewed the results of Petitioner's June, 2011 and June, 2012 MRIs showing an obvious central herniation and an annular tear at L5-S1[1]. Dr. Gornet noted, "There is a medical record from March of 2011 from Amanda McKee that states that the patient states this is not a work related injury." On questioning Petitioner, "he states that he did not feel this was a work related injury related to his employment at Walgreens, as he had switched employment from Respondent to Walgreens."

According to the doctor's notes, he discussed with Petitioner that "obviously there [were] several issues involved." "First, if the patient truly has notes from Prompt Care stating that he sustained a back strain or pain as indicated on or about the date of his injury of 9/15/10, then I do believe his current symptoms are causally connected to his work related injury as described." The doctor also assumed that Petitioner has had an ongoing problem since that time. Dr. Gornet did not believe the event at Walgreens caused any significant derivation in his symptoms based upon the history he was provided. Dr. Gornet's assessment was that of an injury of the disc at L5-S1. He felt Petitioner could continue working full duty. Dr. Gornet recommended Petitioner come off Hydrocodone and attempt one additional course of physical therapy. Dr. Gornet noted that if Petitioner failed to improve, he would recommend proceeding with spinal fusion. Petitioner was to bring his records from Prompt Care with him to the next visit. Petitioner was given a note for full duty work with no restrictions. (PX 6)

Petitioner signed his Application for Adjustment of Claim against Walgreens on

[1] Noting he had 257 pages of medical records that "clearly indicate from Amanda McKee that initially Petitioner had symptoms."

September 26, 2013 and alleged an accident date of March 28, 2011 "during employment." (AX 4)

Petitioner returned to Dr. Gornet on October 3, 2013 reporting he was completely off narcotic pain medication and continuing to work at Walgreens. Petitioner advised the doctor that Prompt Care would not give him his records. Petitioner reported that he was recently hit by a pallet at work on September 16, 2013. Petitioner indicated his symptoms flared briefly before returning back to baseline. Dr. Gornet reiterated his opinion that Petitioner's symptoms were related to the September 15, 2010 work injury with Respondent. Petitioner remained on full duty. (PX 6)

On January 6, 2014, Petitioner returned to Dr. Gornet reporting continued pain affecting the quality of his life. Petitioner reported he was off narcotic pain medication and continued to work full-duty at Walgreens. An IME with Dr. Chabot was noted to be pending. His exam remained unchanged. Dr. Gornet again recommended proceeding with anterior lumbar fusion at L5-S1, however, was waiting for approval. (PX 6)

On February 26, 2014, Petitioner was evaluated by Dr. Michael Chabot at the request of Respondent. A written report followed. According to it Petitioner reported that while working for Respondent on September 15, 2010, he was unloading a truck and went to pick up a Christmas tree and his back went out. (Res. Ex. 2) Petitioner reported developing immediate low back pain with radicular complaints in his left lower extremity. Petitioner received treatment and returned to work full-duty in October, 2010 and was released from care in November, 2010. *Id.* Petitioner left his position with Respondent in November, 2010 and started working at Walgreens, first as a temp and then as a full-time employee, in March of 2011. Petitioner indicated he developed irritation and soreness in his back sometime in March, 2011 and the severity of his symptoms escalated in March, 2011 to include radicular complaints into his left leg. (RX 2, dep. ex. 2)

Dr. Chabot's assessment was that of chronic low back pain, disc degeneration, questionable history of sacroiliitis, and a history of a strain injury to the lumbar spine. *Id.* Dr. Chabot felt Petitioner reached a level of maximum medical improvement in regard to the September 15, 2010 injury on November 19, 2010, and that he developed complaints again in March of 2011 that were unrelated to the September 15, 2010 injury. *Id.* Dr. Chabot indicated that Petitioner would likely continue to experience intermittent aggravation of his symptoms involving the lower lumbosacral region associated with disc degeneration, fatigue and conditioning throughout the lumbar region and felt that it was possible even normal activities of daily living could aggravate his symptoms; however, Dr. Chabot did not find Petitioner to be a candidate for surgery. *Id.*

Petitioner followed-up with Dr. Gornet on April 7, 2014 bringing Dr. Chabot's report with him. (PX 6) Dr. Gornet reviewed the report and rejected any suggestion that Petitioner's symptoms completely resolved following the September 15, 2010 injury, noting Petitioner's symptoms had not resolved despite a progressive course of treatment over a number of years. *Id.* Dr. Gornet indicated that Petitioner had other problems with his lumbar spine and if treated surgically, he would expect him to have an excellent result and return to work without restrictions. *Id.* Dr. Gornet did note that if Petitioner could tolerate his symptoms as is, he was

currently at maximum medical improvement. Dr. Gornet noted he would continue to seek approval to perform an anterior lumbar fusion at L5-S1. The doctor wrote:

> Given the fact that [Petitioner] did not have significant symptoms prior to his work related injury at Lowe's and given the fact that he has been remarkably consistent in always reporting the same event, the fact that he had ongoing physical therapy after he was released from medical care on October 1, the fact that within a period of months he was back seeking medical attention for similar symptoms and on his return visit again reported this to be related to his work related injury Lowe's and the fact that I find [Petitioner] to be believable, I do believe his current symptoms remain causally connected to his original work related injury and annular tear. (PX 6)

On July 28, 2014, Petitioner returned to Dr. Gornet who reviewed Dr. Chabot's IME report, which found Petitioner's symptoms were related to disc degeneration. *Id.* Dr. Gornet disagreed with Dr. Chabot's contention that Petitioner's symptoms developed after starting his new job at Walgreens, noting Petitioner did not have low back symptoms prior to the September 15, 2010 injury with Respondent. *Id.* Dr. Gornet felt it was clear that Petitioner injured his back and developed an annular tear as a result of the September 15, 2010 injury.He added, "...and while his activities at Walgreen's [sic] may be a contributing factor, it is quite clear that he injured his back and in my opinion developed his annular tear as a direct result of the injury at Lowe's." (PX 6)

On December 22, 2014, Petitioner followed-up with Dr. Gornet reporting continuing complaints. Dr. Gornet reviewed MRI films revealing bilateral foraminal stenosis with a large central tear, and central herniation causing cauda compression. Dr. Gornet indicated Petitioner's best option would be an anterior decompression with anterior lumbar fusion. Dr. Gornet reiterated the Petitioner's current complaints were causally related to the September 15, 2010 work injury with Respondent. Petitioner was working full duty. (PX 6)

Dr. Gornet's deposition was taken on April 23, 2015 in regard to both cases. (PX8.) He testified that he first saw Petitioner on August 8, 2013, as a referral from Amanda McKee, at which time Petitioner complained of pain in his low back, left buttocks, left hip, and down his left leg into his knee. (PX 8, pp. 6-7) Petitioner told Dr. Gornet that he felt his problem began on September 15, 2010, when he picked up a Christmas tree and felt a pop in his back. (PX 8, p. 7) Petitioner also stated that he had not experienced low back problems of significance prior to September 15, 2010. (PX 8, p. 8) Dr. Gornet described his understanding of Petitioner's work accidents as "he has a work-related injury of 9/15/10, and I believe there is some question about whether or not his current job duties aggravate his underlying condition. (PX 8, p. 10) Dr. Gornet opined that Petitioner's symptoms were related to his work accident. He diagnosed an annular tear at L5-S1 and recommended an anterior lumbar fusion at L5-S1. (PX 8, pp. 10-12)

Dr. Gornet testified that when he met with Petitioner on October 3, 2013 Petitioner reported that his symptoms had flared and that he had most recently been hit by a pallet.

However, Petitioner felt any flare-up of symptoms due to that incident had resolved and he was back to his baseline. (PX 8, p. 12)

On cross-examination Dr. Gornet testified that the two MRIs were essentially the same and he saw no "significant changes." (PX 8, pp. 26, 32)

On cross-examination by counsel for Walgreens, Dr. Gornet was asked why he believed Petitioner's injury occurred on September 15, 2010. Dr. Gornet testified:

> Because the patient had acute pain. He reported it at or near the time of the accident. His symptoms never went away. The history he described to me is the type of history that could cause that. He has obvious pathology only at L5-S1. There really isn't any other pathology in his back that is of any significance and to me there is no other plausible explanation than to associate that structural problem with that event.
>
> (PX8, pp 30-31.)

Dr. Gornet acknowledged that some people have annular tears that can calm down and not require further treatment. However, to the doctor's knowledge, there was no indication that Petitioner's symptoms ever went away after his first incident with Respondent and, therefore, Petitioner would not be a part of that group of people. (PX 8, p. 33) When asked if Petitioner ever described a specific injury occurring at Walgreens other than the one "later in December" when he went back to baseline, Dr. Gornet replied, "My notes speak for itself. I mean that's all I can recall. Basically there was a pallet issue. I don't recall if there was any other specific event or issues, but the notes are self explanatory." (PX 8, pp. 33-34)

Dr. Gornet further testified that he agreed with Dr. Chabot that there was minimal narrowing of the spinal canal and no evidence of neural compression, however, Dr. Gornet opined that Petitioner had an annular tear at L5-S1. (PX 8, p. 15) Dr. Gornet testified that Petitioner's symptoms have never completely gone away despite conservative treatment, and also that 100% of individuals have degeneration in their spine. (PX 8, p. 16) Dr. Gornet also testified that Petitioner had some degeneration prior to his work injury at Lowe's, but that Petitioner was working full duty and Dr. Gornet would not be testifying in the case if Petitioner had not suffered a annular tear at his L5-S1 disc. (PX 8, p. 16) Dr. Gornet testified to a reasonable degree of medical certainty that Petitioner suffered an annular tear and a small disc herniation at L5-S1 while lifting a Christmas tree box at Respondent's facility on September 15, 2010, explaining earlier that the "simple fact, again, comes down to whether or not Mr. Capps' symptoms, and I underscore symptoms, began at or near the time of his accident at Respondent's facility in September of 2010; and second, whether these symptoms have ever completely gone away in spite of reasonable conservative care." As stated by Dr. Gornet, "[b]ut not for the [September 15, 2010] work-related injury and the structural injury to the disc and the annular tear at L5-S1, I do not think we would be here today." (PX 8, pp. 16-17) Dr. Gornet also testified that Petitioner's work activities at Walgreens may have aggravated Petitioner's condition, and would again in the future, but that Petitioner's structural pathology remained unchanged. (PX 8, p.19)

On cross-examination, Dr. Gornet conceded that younger people don't tend to have disc pathology that would warrant surgical treatment, because usually their pathology would resolve or be nonexistent because their spines are relatively young and healthy. (PX 8, p. 27) Dr. Gornet could not recall how often he would operate on a younger person due to an injury from a lifting incident; he testified that he once operated on a 15-year-old, but could not remember what had caused that person's spine injury. (PX 8, p. 27) Dr. Gornet could not recall any time in the last month that he had given an opinion that a person's injuries were not related to an alleged work accident. (PX 8, p. 30)

On cross-examination by counsel for Walgreens, Dr. Gornet testified that he did not see a significant change in the disc pathology between the two MRI scans that Petitioner underwent, and that Petitioner had described to him that his problems had begun with his incident at Lowe's but had experienced increasing symptoms with certain activities with Walgreens. (PX 8, p. 33) Dr. Gornet also testified that it was not unexpected that Petitioner has increased symptoms associated with his work activities at Walgreens, but that some individuals with annular tears can "calm down and not require further treatment." (PX 8, p. 33) Dr. Gornet opined that there was no indication that Petitioner's symptoms went away after the first incident with Respondent. (PX 8, p. 33)

On the same day as his deposition, Dr. Gornet met with Petitioner. According to his notes, the working diagnosis for Petitioner was "discogenic pain at L5-S1." The doctor wrote, "We believe his current symptoms are causally connected to his injury at Lowe's as well as subsequent aggravation and work activity at Walgreen's [sic]." Petitioner remained off all Hydrocodone and was working full duty. (PX 6)

Dr. Chabot was deposed on August 7, 2015. (RX 2) He testified that he had treated thousands of patients for lumbar sprains, strains, herniations, and annular tears, had performed close to 9,000 surgeries, and had practiced as a spine surgeon for 21 years. (RX 2, p. 5-6) Dr. Chabot testified that he took a history from Petitioner, in which Petitioner stated that, following his 2010 physical therapy, he had improved and was released from care without restrictions. (RX 2, pp. 8-9) Petitioner also had stated that he had stopped working for Respondent in November of 2010 and began working at Walgreens full-time in March of 2011, at which time his symptoms escalated from being a 0 or occasionally a 1. (RX 2, p. 9, p. 39)

Dr. Chabot also testified that the physical examination of Dr. Kovalsky in March of 2011 had revealed different findings than the physical examination by Dr. Gupta from September 15, 2010. (RX 2, pp. 10-11) Dr. Chabot's own physical examination was essentially normal and did not reveal and neurological deficits, difficulties with range of motion, or weakness. (RX 2, p. 13) Dr. Chabot had also reviewed MRI films from both of Petitioner's MRIs and opined that they were identical and had revealed evidence of disc desiccation at the L5-S1 level, a small central bulge, a high intensiy zone, and minimal neuroforaminal narrowing, all at the L5-S1 level. (RX 2, pp. 13-14) Both MRIs had been taken after Petitioner began working at Walgreens and after Petitioner had stopped working for Respondent. (RX 2, p. 15) Dr. Chabot testified that Petitioner had diagnoses, from any cause, of chronic back pain, disc degeneration, questionable history of sacroiliitis/SI dysfunction, and a history of a lumbar strain. (RX 2, p. 15)

Dr. Chabot also testified that he diagnosed Petitioner with a strain and inflammation to his spine as a result of his work accident at Respondent Lowe's on September 15, 2010, for which Petitioner reached maximum medical improvement on November 19, 2010. (RX 2, pp. 15-16) Dr. Chabot noted that Petitioner was 90% better by October 1, 2010, with just occasional discomfort, and that by November 19, 2010 Petitioner had no tenderness or soreness in his back or leg, nor did he have pain, even while working. (RX 2, p. 16) Dr. Chabot also testified that his opinions were supported by the fact that Petitioner himself had stated that his pain was at a "0 or occasionally a 1." (RX 2, p. 16)

Dr. Chabot testified that it was normal for people to have occasional back pain at a 1 level in their everyday life, and described level 1 pain as minimal. (RX 2, p. 17) Dr. Chabot opined that Petitioner's complaints that began after he started working at Walgreens were unrelated to his September 15, 2010 accident. (RX 2, p. 17) Dr. Chabot also agreed with Dr. Kovalsky's opinions that Petitioner is not a surgical candidate, due to the fact that Petitioner had a normal physical examination, Petitioner did not require narcotic pain medication, and Petitioner had not missed any work. (RX 2, pp. 17-18)

On cross-examination, Dr. Chabot testified that Petitioner did not appear to have any prior back pain or problems before his September 15, 2010 accident with Respondent Lowe's. (RX 2, pp. 18-21) Dr. Chabot reiterated that he found Petitioner to be at maximum medical improvement on September 15, 2010, for injuries related to his Lowe's accident, due to the fact that Petitioner had no tenderness or soreness in his back or leg on November 17 and November 19, 2010, even while working. (RX 2, p. 22) Dr. Chabot testified a high intensity zone on an MRI could be indicative of an annular tear. (RX 2, pp. 26-27) Dr. Chabot also acknowledged that it was unusual for a 20-year-old to have a degenerative disc, but that people that young or younger can have degenerated discs. (RX 2, p. 27) Dr. Chabot did not believe that Petitioner's degenerative disc at L5-S1 was caused by his September 15, 2010 accident, due to the fact that disc degeneration and desiccation is a chronic process that take years before it gets to the point that it will show up on an MRI. (RX 2, pp. 27-28)

Dr. Chabot further testified on cross-examination that disc degeneration usually occurs in the greatest weight bearing disc, and that the most commonly degenerated discs are L4-5 ad L5-S1. (RX 2, pp. 28-29) Dr. Chabot noted that Petitioner did not have degeneration at the L4-5 level, but testified that younger people commonly only have disc degeneration at one level. (RX 2, p. 29) Dr. Chabot also opined that Petitioner would have intermittent aggravations of back pain complaints and that these could be from work activities, activities of daily living, simple home maintenance, and repetitive bending, lifting, and twisting. (RX 2, pp. 31-33) Dr. Chabot further clarified that this recurring back pain is due to deconditioning and poor core strength. (RX 2, p. 33)

On cross-examination by Walgreens counsel, Dr. Chabot testified that Petitioner did not provide a history of any particular accident occurring at Walgreens. (RX 2, p. 35) Dr. Chabot also opined that Petitioner's MRI findings predated both his injury at Lowe's and his work at Walgreens. (RX 2, pp. 36-37) Petitioner's ongoing symptoms were related to the various activities in his life and due to Petitioner's deconditioning. (RX 2, p. 37)

On redirect, Dr. Chabot testified that Petitioner told him that his pain escalated once he began working at Walgreens, and he interpreted this as meaning that it escalated from being a "0 to occasionally a 1." (RX 2, p. 39) Lastly, Dr. Chabot opined that even if Petitioner did have an annular tear, it would not change or alter his opinions in any way, that he still would not recommend surgery for Petitioner. He described annular tears as "extremely common." (RX 2, pp. 38-40)

Petitioner again presented to Dr. Gornet on October 12, 2015 and they discussed his planned surgical procedure. Petitioner reported that he was working full duty but his symptoms were continuing to affect all aspects of his life. His case was noted to be going before the arbitrator. (PX 6)

Petitioner's cases proceeded to arbitration on November 4, 2015. With regard to the instant case, the disputed issues were causal connection, medical bills, and prospective care. Petitioner was the sole witness testifying at the hearing.

Petitioner testified that he had no prior treatment or injuries to his low back before September 15, 2010. He further testified (and it was stipulated to by Respondent) that Petitioner sustained an injury to his back on September 15, 2010 when he was unloading a truck and went to pick up a Christmas tree and his back went out.

Petitioner admitted that at his last visit with Care First his pain level was down to "1/10" from "8-9/10", and down from "6-7/10" when physical therapy started to "0-1/10" at the end of physical therapy.

Petitioner further testified that he started a new job with Select Remedy on November 8, 2010 under the "People with Disabilities Program." This is a job entry program for people with disabilities to be hired by Walgreens. He testified that while working for Select Remedy, Walgreens evaluates whether he can do the job with his disability. He testified his disability is severe dyslexia, and he became an employee of Walgreens on March 8, 2011.

Petitioner testified that between November 19, 2010 and March 23, 2011 he was not pain free; rather, his pain was "up and down" and would get worse with activities. Petitioner testified that the job was very physical and his back would get worse with activity and with job but he did not seek any medical treatment because he did not want to complain because he was a "temp," and he wanted the job at Walgreens. As a "temp" he could easily be replaced and he wanted to be hired full-time for Respondent. Petitioner further testified that he did not have any insurance while he was a "temp."

Petitioner testified that upon being hired by Walgreens he sought treatment at the Wellness Center, Walgreens medical facility. He could not explain why he didn't go back to the earlier therapist but recalled the facility at Walgreens was conveniently located next to the distribution center where he worked.

Petitioner testified he began treating at the Orthopaedic Center of Southern Illinois

(OCSI) on March 28, 2011.

Petitioner testified he first saw Dr. Matthew Gornet at The Orthopaedic Center of St. Louis on August 8, 2013.

Petitioner testified that Dr. Gornet is recommending a fusion at L5-S1, and Petitioner testified he wants to have the surgery because he wants to live the life of a 25-year old. He testified that for the last four years his pain goes up and down, depending on what he is doing, and his pain levels have slowly gotten worse. He testified he has never missed three consecutive days of work, but he has had intermittent periods of light duty.

Petitioner acknowledged that that the November 19, 2010 note found in RX 3 accurately reflected what was written on that date.

Petitioner testified that he could not recall what happened on March 28, 2011 other that it was maybe just a "really bad pain day" as he thought he was just gradually getting worse at that time. He could not recall why he went to the Orthopedic Center of Southern Illinois on March 28th.

Petitioner's medical bills are found in Petitioner's Exhibit 9. They total $20,225.09 (PX9).

The Arbitrator concludes:

1. **Issue F – Whether the Petitioner's current condition of ill being is causally related to the injury.**

Petitioner's current condition of ill-being in his low back is causally related to his undisputed accident on September 15, 2010. This conclusion is based upon a chain of events, Petitioner's credible testimony, and the opinion of Dr. Gornet.

In support of a chain of events analysis, the Arbitrator notes the complete absence of any evidence of injury or treatment to the Petitioner's L5-S1 disc (low back) at any time prior to the accident and the mechanism of injury (lifting a Christmas tree box) and immediate medical treatment following the accident. Petitioner credibly explained the gap in treatment between November of 2010 and March of 2011.

The Arbitrator has given careful consideration to the impact, if any, of alleged events occurring in March of 2011 and on October 26, 2012 while Petitioner was working for Walgreens. Both events were preceded by gaps in treatment. Petitioner, however, credibly explained that he was having symptoms during the 2010/2011 gap in treatment and he credibly explained the nature of those symptoms and why he didn't seek any medical treatment. Furthermore, Petitioner never testified as to any specific accident occurring on March 28, 2011 or provided any real substantive testimony as to the significance of March 28, 2011. He alluded to his back just generally worsening by that time and, overall, the Arbitrator feels his history to N.P. McKee when they

initially met thereafter generally and accurately described the situation. Respondent could have deposed N.P. McKee but didn't.

As for the events of October of 2012, again, there was a gap in treatment; however, Dr. Kovalsky had seen Petitioner in June of 2012 and indicated a six month follow up visit was in order. Thus, Petitioner's lack of treatment between June and October of 2012 is understandable. Petitioner then presented to Nurse Practitioner McKee on October 30, 2012 and provided a history of an "acute flare-up since October 26, 2012." Petitioner told Ms. McKee that he was at work for Walgreens, bent over to pick something up and felt a pop in his back and pain shooting down into his left leg with numbness and tingling into his left foot. Ms. McKee described the left leg pain, numbness, and tingling as "acute symptoms" as compared to his chronic low back pain. Her impression was of chronic low back pain, degenerative disc disease at L5-S1 and a "new complaint of left radiculopathy with a possible herniated nucleus pulposus." An MRI was ordered and work restrictions were imposed. (PX 5) While this incident might arguably undermine causation, the Arbitrator finds that, in this instance, it does not. Dr. Chabot never addressed the impact of these events. Dr. Gornet did – albeit somewhat indirectly. While not having any knowledge of the event itself, he persuasively explained that the 2011 and 2012 MRIs revealed no significant changes and that the very nature of Petitioner's injury is that he will continue to have problems with his back, including pain. While Petitioner's radicular complaints increased after the October 26, 2012 event, Petitioner had experienced radicular complaints before then and while they had quieted down prior to October 26th, Dr. Kovalsky had not released Petitioner from his care and he had already recommended a fusion procedure for Petitioner's condition; however, Petitioner wished to try and hold off. Other important considerations are the young age of Petitioner at the time of injury (20 years, 9 months) and the MRIs revealing that all other discs in Petitioner's lumbar spine are well hydrated with no abnormalities or significant findings. In addition, all of Petitioner's medical histories relate the onset of his pain to the September 15, 2010 accident with Respondent and his treatment records reflect a consistent pattern of symptoms and complaints from September 15, 2010 to the present.

Although the Arbitrator notes Petitioner has essentially missed no work and has, for the most part, been able to work full duties, Petitioner's testimony that his pain waxes and wanes depending upon activity levels, but is relatively constant and getting worse, is amply supported by the medical records and was very credible. Furthermore, he has occasionally worn a back brace. Petitioner, severely dyslexic, also came across as someone trying to hold down a full-time job regardless of how he felt. Even Dr. Chabot, Respondent's IME physician, testified Petitioner will experience intermittent aggravation of back pain due to his L5-S1 disc. Furthermore, Petitioner's testimony, as corroborated by the medical records indicates Petitioner's pain after the September 15, 2010 accident never went away completely. Even after he began working at Walgreens and sought treatment for back pain, he related the onset to the accident herein and described "increased" pain from work duties for Walgreens. In the end, the Arbitrator believes that Petitioner's back pain has never fully resolved from the September 15, 2010 accident. While some of his ongoing back pain may be due to work duties for Walgreens, the accident herein remains an ongoing cause of his ongoing complaints. In Illinois, that is sufficient to establish causal connection.

The Arbitrator has also considered the notes signed by Petitioner in 2010 regarding his therapy

and presumably great results (RX 3). While Respondent focused on the form Petitioner signed in November of 2010, he also signed one in October of 2010 and then returned for additional therapy due to ongoing complaints. The Arbitrator assigns little weight to them.

With regard to the differing opinions of Dr. Chabot and Dr. Gornet, the Arbitrator finds Dr. Chabot's opinions and testimony less persuasive. Dr. Chabot found that after sustaining a work-related injury with Respondent on September 15, 2010, Petitioner received treatment and returned to work in October of 2010 and was released from care in November, 2010. (RX 2) Dr. Chabot noted that Petitioner developed an irritation and soreness in his back increasing his symptoms sometime in March, 2011 escalating the severity of his symptoms to include radicular complaints into his left leg. *Id.* Despite, Petitioner's direct testimony explaining consistently progressively worsening symptoms following the September 15, 2010 injury with Respondent, Dr. Chabot nevertheless found Petitioner reached a level of maximum medical improvement on November 19, 2010. Dr. Chabot's medical opinion on causation directly contradicts Petitioner's own credible testimony that he remained symptomatic throughout the period from November 19, 2010 through March 28, 2011. (RX 2) Furthermore, Dr. Chabot was unaware of Petitioner's explanation as to why he failed to seek additional treatment during the period from November 19, 2010 through March 8, 2011, and that he was attempting to secure full-time employment with Respondent herein and was uninsured during this period of time. *Id.* In the end, Dr. Chabot's opinions were based upon inaccurate and incomplete information.

The Arbitrator also notes that Dr. Chabot was retained by Respondent and, given the companion claim against Walgreens, was in a unique situation to point the finger at Walgreens. Dr. Gornet, on the other hand, was retained by neither employer and, to that extent, could look at liability/causation in a more objective light.

2. Issue J – Whether all medical treatment provided was reasonable and necessary and related to the injury, and whether the Respondent is liable for payment of the medical bills associated therewith.

Consistent with her causation determination above, Petitioner is awarded the medical bills set forth in PX 9. Respondent shall make payment of the medical bills identified in Petitioner's Exhibit 9 directly to the Petitioner and his attorney, as provided in Section 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall have credit in the amount of $5,239.42, as per Respondent's Exhibit 1 for those bills it has paid.

3. Issue K – Whether the Petitioner is entitled to prospective medical care.

Petitioner is entitled to prospective medical care in the form of an L5-S1 lumbar fusion as recommended by Dr. Gornet. In support thereof the Arbitrator notes her causation determination set forth above which is adopted and incorporated herein by reference.

****

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

Jacob Capps,

Petitioner,

vs.

Walgreens Family of Companies,

Respondent,

17IWCC0066

NO: 13WC 32623

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 6, 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: FEB 6 - 2017

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

o020117
CJD/rlc
049

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

CAPPS, JACOB
Employee/Petitioner

Case# **13WC032623**

13WC007107

WALGREENS FAMILY OF COMPANIES
Employer/Respondent

17IWCC0066

On 1/6/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.50% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0246 HANAGAN & McGOVERN PC
BRIAN T McGOVERN
123 S 10TH ST SUITE 601
MOUNT VERNON, IL 62864

0180 EVANS & DIXON LLC
ROBERT HENDERSHOT
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

17IWCC0066

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)

JACOB CAPPS
Employee/Petitioner

v.

WALGREENS FAMILY OF COMPANIES
Employer/Respondent

Case # **13** WC **032623**

Consolidated cases: **13 WC 007107**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **November 4, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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, **03/28/2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$25,407.20**; the average weekly wage was **$488.60**.

On the date of accident, Petitioner was **21** 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** 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 he sustained an accident on March 28, 2011 that arose out of and in the course of his employment with Respondent, that he provided timely notice of an alleged accident on March 28, 2011, or that his current condition of ill-being is causally connected to his alleged accident of March 28, 2011. 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.

Signature of Arbitrator

January 3, 2016
Date

ICArbDec19(b)

JAN 6 - 2016

Jacob Capps v. Walgreens Family of Companies.,Case No. 13 WC 032623 (19(b))

Findings of Fact and Conclusions of Law

Petitioner has two claims pending for injuries to his low back. One case is against Lowe's Home Centers, Inc. (case number 13 WC 007107) and alleged an accident date of September 15, 2010. The instant claim is against Walgreens Family of Companies and alleges an accident date of March 28, 2011. Both cases were consolidated for purposes of the hearing; however, the parties understood that separate decisions would be issued.

The Arbitrator finds:

On September 15, 2010, Petitioner was employed with Lowe's as a receiver. Each morning, he would unload trucks, and on this day, while bending over and picking up a Christmas tree box, he suffered an injury to his low back. Lowe's stipulated to accident.

The same day, Lowe's sent Petitioner to Care First for medical treatment. (PX1, RX3.) Petitioner reported that he was picking up a Christmas tree box and felt sharp pain in his lower back that was radiating into both of his legs. Physical exam revealed bilateral tenderness with spasms in his low back at L5-S1. He was diagnosed with low back pain with an acute lumbosacral strain. He was prescribed a muscle relaxer and physical therapy. X-rays taken that day were negative for fracture, spondylolisthesis, or spondylolysis, and showed minimal degenerative change in his lower lumbar spine. (PX3.) He was released to light duty, which Lowe's accommodated.

Petitioner underwent physical therapy at Synergy Therapy three times per week from September 22, 2010 to November 19, 2010. These records indicate Petitioner's pain was waxing and waning. For example, on September 24, 2010, Petitioner notes working on September 23, 2010 and then feeling sore. On September 27, 2010, he states he was feeling better after not working over the weekend. (PX 2)

Petitioner's next visit with Care First was on October 1, 2010. He reported feeling 90 percent better with occasional discomfort and indicated physical therapy was helping. Petitioner's pain level was down to one out of ten from eight or nine out of ten, and down from six or seven out of ten when physical therapy started to zero or one out of ten at the end of physical therapy. He was released to full duty, ordered to continue physical therapy, and told to return if needed. He signed a form stating he had trouble walking and getting around now was fine. A copy of the latter was sent to Petitioner's doctor. (PX1, RX3)

Petitioner attended physical therapy at Synergy on October 4, 2010, reporting increased tightness and soreness in his lower back after having resumed full duty work. (PX 2)

On October 11, 2010, Petitioner returned to Synergy Therapeutic Group reporting increased low back symptoms over the past week. *Id.* Petitioner reported increased low back complaints when working on October 15, 2010 after unloading two trucks at work. *Id.* On

October 29, 2010, Petitioner reported increased low back soreness, as well as pain in a specific point in his back after lifting heavy grills at work. *Id.*

On November 8, 2010, Petitioner started a new position with Select Remedy in the PWD ("People With Disabilities") Program with a goal of obtaining employment with Respondent, Walgreens.

When seen at Synergy Therapy on November 10, 2010 Petitioner reported complaints of bilateral leg soreness after starting a new position. He had difficulty completing therapy exercises that day and reported continued soreness on November 12, 2010. (PX 2)

Petitioner was discharged from therapy on November 19, 2010. He signed a note stating his pain was down to a "0" or "1" and he could sit or stand as long as he wanted. A copy was sent to his doctor. (RX 3)

Petitioner was hired and officially started a new position with Respondent, Walgreens, on March 8, 2011.

On March 23, 2011, Petitioner presented to Team Works Therapy with complaints of recurrent low back pain. Due to his dyslexia Petitioner had some assistance completing a Questionnaire. According to the initial evaluation from Team Works, Petitioner reported his complaints on March 22, 2011. Petitioner reported having injured himself while working for Lowe's about five to ten months earlier and re-aggravating it with bending and twisting. Petitioner was having trouble sleeping due to pain. Petitioner was issued a back brace and advised/referred for work on strengthening and flexibility. (PX 4)

On March 28, 2011, Petitioner was evaluated by Nurse Practitioner Amanda McKee at the Orthopaedic Center of Southern Illinois. He completed a "New Complaint History Form" as part of the examination. In it, he indicated he had been referred by Dr. David DeLoso/Amorodo. His chief complaint was lower back pain extending down his left leg. As part of the history form, Petitioner reported that he is "always sore" but on the Tuesday of the previous week he started having pain radiating down his leg to right thigh. It is further noted, "while at Lowe's pick[ed] up Christmas tree box and couldn't stand up. Now at Walgreens since 11/10 and pain has been increasing. Seeing trainer at Walgreens. Trainer says left foot is turned out." (PX 5)

When examined by N.P. McKee, Petitioner related a history of an eight-month history of chronic low back pain with radicular complaints including numbness and tingling into his left lower extremity. (PX 5) Petitioner was accompanied by his mother. Petitioner reported that on September 10, 2010, while working for Lowe's, he picked up a Christmas tree weighing approximately 80 pounds and felt immediate pain in his back. According to the note, "He reports it is not a Workman's Compensation case." Petitioner further explained that he was now working for Walgreens and noticing increased back pain since doing more repetitive bending, stooping, lifting, and twisting. The note further indicates Petitioner's back pain was four out of ten and his leg pain a three out of ten. X-rays of Petitioner's lumbar spine taken during this visit failed to demonstrate any obvious fracture or dislocation. Nurse Practitioner McKee's impression was that of chronic low back pain, left-sided sciatica, lumbar radiculopathy, left sacroilitis and

bilateral pes planus. Petitioner was advised to hold off on the Doan's and Aleve and Nurse Practitioner McKee recommended a course of physical therapy for his low back, sacroiliac joint and sciatic regimens and custom orthotics for the treatment of his pes planus. She further recommended "good work shoes." He was given a prednisone taper and scripts for Relafen and Skelaxin. Petitioner declined an MRI or consultation at that time. Nurse Practitioner McKee noted that Petitioner requested no work restrictions but would continue to use a low profile back brace at work. (PX 5)

Petitioner was seen at Team Works/Mt. Vernon Wellness on April 5, 2011, at which time Petitioner reported minimal symptoms which he believed was from taking "LOW" recently. Treatment was provided. (PX 4)

Petitioner again presented to Team Works/Mt. Vernon Wellness on April 7, 2011 reporting reduced symptoms, even while working full days that week. Treatment was provided. (PX 4)

Petitioner returned to Team Works/Mt. Vernon Wellness (hereafter referred to as TM/MV) on April 12, 2011 reporting minimal symptoms. According to the note, Petitioner commented, "he feels like he did before re-injury." Treatment was provided. (PX 4)

When re-examined at TM/MV on April 14, 2011 Petitioner reported minimal symptoms in recent days. Treatment was provided. (PX 4)

As of April 21, 2011 Petitioner was advising TM/MV that his symptoms were manageable but ongoing. (PX 4)

In the TM/MV note of April 22, 2011 it was noted that physical therapy had shown consistent symptom relief throughout Petitioner's visits and as of that day Petitioner was reporting only sporadic, dull pain throughout with no radiating symptoms into his left leg. Petitioner tolerated all treatment and showed home exercise compliance; however, he "continues to have obvious postural deficits." Petitioner was to return after his nurse appointment on April 26, 2011. (PX 4)

Petitioner returned to the Orthopaedic Center of Southern Illinois and was again evaluated by Nurse Practitioner McKee on April 26, 2011. Petitioner reported minimal low back and SI joint pain and denied any left lower extremity numbness, tingling, or radicular complaints. Petitioner had finished the prednisone and was taking the Relafen and Norflex but not the Skelaxin. Physical therapy at work was reportedly helping. Nurse Practitioner McKee's assessment was that of resolving chronic low back pain, left sciatica with radiculopathy, left-sided sacroilitis, and bilateral pes planus. Nurse Practitioner McKee recommended continued physical therapy, noting Petitioner "deferred" any type of consultation, MRI, or injection at that time. (PX 5)

Petitioner returned to TM/MV on May 5, 2011 reporting that he had been referred for continued therapy exercises. It was noted that Petitioner was continuing to have a decrease in symptoms but after stopping his steroid treatment, his symptoms started increasing again. (PX 4)

As of May 10, 2011 Petitioner was reporting manageable symptoms but frustration with constant symptoms in his low back and was considering an injection. When he returned the next day, it was noted that he was in obvious pain when walking into the facility and reported having significantly increased symptoms after waking up that morning. He couldn't attribute anything to it. Petitioner's symptoms were described as "significant" when he returned on May 12, 2011 and Petitioner reported having to "take a point" the previous night because of them. Petitioner reported minimal symptom reduction and obvious difficulty walking and moving around the treatment table. (PX 4)

TM/MV therapy notes from May 17, 2011 indicate Petitioner reported no improvement. His "FM" was allowing him to clean, but Petitioner believed his symptoms eventually were just as bad due to stairs and bags of garbage. (PX 4)

On May 19, 2011, Petitioner presented to Dr. Ahmed at the Mt. Vernon Wellness Center with the chief complaint of hip and back pain, "goes to orthopedic center." Petitioner, who was noted to be 21 years old, gave a history of lumbar pain which was had begun one year earlier and was moderate in severity and radiating into his left hip. The onset of the back pain was noted to be "gradual" and precipitated by exercise. Lying down was helpful but he was having trouble sleeping. Petitioner explained that after lifting a Christmas tree at work his back "just gave out." He had undergone physical therapy for about a month and it helped for a "short time." Petitioner had been working for Respondent, Walgreens, six months "full case pick" and had undergone a "few x-rays." Petitioner explained that he did stretches in the morning; otherwise, he couldn't get out of bed. Petitioner was diagnosed with a backache and prescribed medications. He was to return in one week or call if his symptoms worsened or persisted. (PX 4)

On May 26, 2011, Petitioner followed up with Nurse Practitioner McKee complaining of significant low back and left leg pain since last being seen. He had been working "essentially full duty which is causing pain." Rather than take Relafen, Petitioner was on Mobic. The prednisone was reportedly the only thing that had really helped. He was still undergoing physical therapy at work. (PX 5) Nurse Practitioner McKee recommended Petitioner continue physical therapy, and ordered an MRI of Petitioner's lumbosacral spine to further address his complaints. *Id.* Nurse Practitioner McKee also placed Petitioner under work restrictions of no repetitive bending, stooping, lifting, twisting, or lifting more than 50 pounds. Medications were adjusted. *Id.*

An MRI of Petitioner's lumbosacral spine was taken on June 2, 2011 showing degenerative disc disease at L5-S1 with a mild diffuse disc bulge which impinged on the traversing nerve root bilaterally. *Id.*

On June 10, 2011, Petitioner followed up with Nurse Practitioner McKee with continued complaints of left leg pain with some low back pain with the left leg pain being the chief complaint. Ultram was not helping. Nurse Practitioner McKee reviewed the MRI results as showing degenerative disc disease at L5-S1 with a mild diffuse disc bulge causing impingement on the nerve root bilaterally. On exam Petitioner had positive compression, distraction, and Patrick test bilaterally. Nurse Practitioner McKee's assessment was that of chronic low back pain, left-sided sciatica, left lumbar radiculopathy, and bilateral cellulitis with degenerative disc disease at L5-S1 with an associated bulge. Nurse Practitioner McKee referred Petitioner to Dr.

Templer for a left-sided L5-S1 epidural steroid injection and placed Petitioner under continued light-duty restrictions, including no repetitive bending, stooping, lifting, or twisting, and a 15 pound lifting restriction. (PX 5)

On June 16, 2011, Petitioner presented to Dr. James Chow for an interlinear L5-S1 epidural steroid injection. (PX 5)

Petitioner followed-up with Nurse Practitioner McKee on June 30, 2011 reporting no relief of his symptoms following the L5-S1 epidural steroid injection. (PX 5) Petitioner reported that his father had purchased an inversion table that had helped alleviate some of his left leg pain, but he continued to experience ongoing mid-line low back pain and left-sided SI joint pain. *Id.* He followed-up with Nurse Practitioner for a second lumbar epidural steroid injection, and she recommended continued work restrictions. *Id.*

On July 14, 2011, Petitioner presented to Dr. Chow for a left-sided SI joint epidural steroid injection. (PX 5)

Petitioner followed up with Nurse Practitioner McKee on July 28, 2011 reporting improvement following the left-sided SI joint epidural steroid injection. Petitioner described his pain as "waxing and waning" depending upon his activity. His primary source of pain was his left sacroiliac joint and his low back; however, he denied any radiation to either lower extremity or numbness or tingling. They discussed a medial branch block v. a repeat SI injection. Petitioner expressed the desire to have a consultation with Dr. Kovalsky. N.P. McKee also recommended continued work restrictions. (PX 5)

On September 7, 2011, Petitioner presented to Dr. Don Kovalsky for the chief complaint of low back pain with some radiation into the left buttocks and leg but no weakness. As when he initially saw the nurse practitioner, some history was obtained. On the form, it states "Not w.c." There is also a reference to the onset of leg pain on Tuesday, March 22nd. Petitioner reported that his symptoms had started about "five to six months ago." He was working for Lowe's in August of 2010 and sustained a back injury lifting a Christmas tree box while at work there. Petitioner was unsure if "this was a contested Workmen's Comp claim from Lowe's." He was currently working at Respondent, Walgreens, since November of 2010 and on light duty. Petitioner reported undergoing multiple steroid injections with mild improvement of his leg pain but no significant improvement in his back pain. Dr. Kovalsky reviewed Petitioner's MRI results showing dehydration with mild narrowing at L5-S1 with no modic changes and a small central disc herniation and annular tear at L5-S1 without any significant neural compression. Dr. Kovalsky diagnosed Petitioner with degenerative disc disease, an annular tear, and a small disc herniation. Dr. Kovalsky noted a simple discectomy would not suffice in terms of treating Petitioner's condition; rather, his options would include the possibility of an interior lumbar interbody fusion, or total disc arthroplasty. According to Dr. Kovalsky's notes, Petitioner expressed a desire to avoid surgery if possible. Dr. Kovalsky, therefore, recommended physical therapy as well as a home exercise program and weight loss. Dr. Kovalsky further recommended Petitioner be fitted for a low profile lumbosacral arthrosis. Dr. Kovalsky released Petitioner to return to work full-duty without restrictions. He further suggested the use of Glucosamine as well as Flexeril, Mobic, and Tramadol. He was to return in three months to see how he was

doing. "[U]ltimately if he has surgery that will be the patient's decision, not mine since pain is his only major complaint." (PX 5)

On October 27, 2011, Petitioner presented to Bowman Chiropractic for treatment of his complaints of left-sided low back pain with radicular complaints into his left hip following an injury to his back lifting a tree while working at Lowe's in 2010. (PX 7) Following his chiropractic manipulation, it was recommended that Petitioner return for further manipulation two to three times per week for the next one to two weeks. *Id.*

Petitioner followed-up with Dr. Kovalsky on December 7, 2011. The doctor's notes state, "It's an old Work Comp injury." Petitioner was noted to be working for Respondent, Walgreens, without any restrictions but was using medications, including Vicodin on occasion. Therapy had reportedly helped and Petitioner had tried to go to a gym but it made his pain worse. Petitioner was noted to be working eight hours a day with heavy lifting. He reported more good days than bad days and no radicular leg pain. Dr. Kovalsky felt Petitioner was doing well, and recommended he continue his home exercise program and continue to work full-duty without restriction (PX 5)

Petitioner continued to obtain chiropractic manipulation for his complaints of low back pain at Bowman Chiropractic through the end of March, 2012. (PX 7)

On June 15, 2012, Petitioner visited Dr. Kovalsky for an updated evaluation of his continuing low back pain with radicular complaints. According to the doctor's note, "[he] had an old Work Comp injury of the lower back. He settled with Comp." Petitioner was working full-time at Respondent, Walgreens, as a split case picker but still having low back pain without radiation into his buttocks and legs. Petitioner admitted he had not been completing his home exercise program religiously. Petitioner further reported that he had less pain on the weekends and didn't need to take his medication but at work he was using 6 Tramadol and day and three to four regular strength Vicodin. His diagnosis was mechanical back pain. Petitioner requested Dr. Kovalsky re-fill his medication. Dr. Kovalsky re-filled Petitioner's medication and requested he follow-up in six months, noting that if Petitioner was going to continue taking narcotic pain medication, he would have to complete a urine drug screening and sign a Narcotics Agreement. (PX 5)

On October 18, 2012, Petitioner presented to Team Works Therapy, LLC, requesting athletic trainer consultation and indicated his symptoms were not work-related. (PX 4)

Petitioner visited Nurse Practitioner McKee on October 30, 2012 with complaints of chronic low back pain with "an acute flare-up since October 26th." A pain drawing reflects lower back pain and radiating left leg pain down to/through the left foot. Petitioner was at work, bent over to pick something up and felt a pop in his back and pain shooting into his left leg with numbness and tingling into his left foot. Ms. McKee noted that Petitioner had chronic low back pain on and off for the past year and a half, but the left leg pain and numbness and tingling were "acute symptoms." (PX 5) Nurse Practitioner McKee's impression was that of chronic low back pain, degenerative disc disease at L5-S1, with a new complaint of left radiculopathy with a possible herniated nucleus pulposus. *Id.* Nurse Practitioner McKee ordered an updated MRI of

Petitioner's lumbar spine. Petitioner "deferred" any work restrictions but was going to try and avoid any repetitive bending, stooping, lifting, or twisting. *Id.*

An MRI of Petitioner's lumbar spine was taken on November 6, 2012. According to the history, Petitioner had chronic low back pain with an acute flare-up since October 26, 2012 and tingling and numbness of the left foot. The MRI revealed mild disc degeneration with loss of disc height at L5-S1, and a small posterior central disc protrusion with moderate size annular disc tear, with the disc touching the surface of both the traverse and bilateral L5 nerve roots. (PX 5)

Petitioner followed up with Nurse Practitioner McKee on November 9, 2012 reporting some improvement with Prednisone. (PX 5) Nurse Practitioner McKee reviewed the results of the November 6, 2012 MRI, and recommended an evaluation with Dr. Kovalsky for possible surgical intervention. He was to continue with prednisone followed by Mobic and Neurontin. He "deferred" any injection at that time. (PX 5)

On December 13, 2012, Petitioner returned to see Dr. Kovalsky, reporting that he was working at Respondent, Walgreens, doing well, and then "over the last three months" had begun experiencing recurrent back and left buttock and thigh pain. Bending and lifting activities seemed to bother him and he was having some buttocks pain at night and recently changing jobs at Respondent, Walgreens, so he did not have to complete as much bending and lifting which has resulted in some improvement of his symptoms. Dr. Kovalsky described Petitioner's back pain as mechanical in nature and aggravated by bending and lifting. Petitioner's leg pain seemed to bother him at night. Dr. Kovalsky reviewed Petitioner's November 6, 2012 MRI noting no significant changes with a dark disc with a small tear on the left without any major disc herniation on the axial cuts. Dr. Kovalsky found, based on the MRI results, Petitioner was not a candidate for surgery or injections. Dr. Kovalsky indicated he instructed Petitioner to continue completing the home exercise program, but Petitioner admitted he had not been performing it very often. Petitioner explained that he tried to ride a bike and it bothered him as did some of the "ball" exercises he was taught in therapy. They discussed alternative exercises with Dr. Kovalsky noting his discussion with Petitioner and his mother regarding the natural history of degenerative disc disease, and how it normally does not require surgery. Dr. Kovalsky further recommended that Petitioner look into finding a different profession where he didn't have to do any bending or lifting so that he can do it for the next forty years. Petitioner was to follow up with N.P. McKee for medications. (PX 5)

On February 13, 2013, Nurse Practitioner McKee issued work restrictions including no repetitive bending, stopping, lifting or twisting, and a 15 pound lifting restriction for one month. (PX 5)

Petitioner signed his Application for Adjustment of Claim against Lowe's on February 25, 2013, alleging an accident date of September 15, 2010 while unloading a truck. (AX 2)

Petitioner returned to see Ms. McKee at Dr. Kovalsky's office on July 30, 2013 for a "recheck of his cervical spine". Petitioner reported seeing no improvement with physical therapy. He denied any pain stating it had "totally resolved." Petitioner was taking Norco only at

nighttime without any side effects. He didn't take it during the day because it made him somewhat sleepy. Petitioner was working full duty. On exam, Petitioner's cervical spine was essentially normal. Her impression was resolving neck pain that was chronic in nature, left trapezius cervical strain. Petitioner was to continue the Norflex as needed and remain on full duty work and continue physical therapy. (PX 5)

On August 8, 2013, Petitioner, accompanied by his mother, presented to Dr. Matthew Gornet for an evaluation of his complaints, having been referred by Amanda McKee. Petitioner completed a "Medical Information" form indicating his accident occurred when he bent over and picked up a Christmas tree and felt a pop and instant pain. He began treatment on September 15, 2010. A pain drawing revealed left-sided back complaints going down his left thigh and left upper arm/shoulder complaints. Petitioner's chief complaint was low back pain to the left side of the left buttock and hip and down the left leg to his knee. Petitioner also reported intermittent neck pain into his left trapezius and left shoulder. Petitioner reported that his current problem began on September 15, 2010 while working for Respondent and lifting a Christmas tree at work. He recalled feeling a pop at that time. Petitioner had been referred to Prompt Care and further reported no significant treatment had been performed. He then went to Amanda McKee who referred him to Dr. Kovalsky who identified an annular tear at L5-S1. Injections had been done in 2011 and Petitioner had changed jobs and began working for Respondent, Walgreens. Intermittently, Petitioner underwent light duty. "He had a history of a mild injury on 12/16/11 in which he was struck by a pallet, but he did not feel that this significantly altered his symptoms." He could not recall any problems of significance before September 15, 2010. According to Petitioner, Dr. Kovalsky thought a fusion procedure was an option but Petitioner wanted another opinion. Petitioner described constant pain, worse with bending, lifting, weather changes, or prolonged standing or sitting. Petitioner reported pain relief when lying down. (PX 6)

Dr. Gornet reviewed the results of Petitioner's June, 2011 and June, 2012 MRIs showing an obvious central herniation and an annular tear at L5-S1[1]. Dr. Gornet noted, "There is a medical record from March of 2011 from Amanda McKee that states that the patient states this is not a work related injury." On questioning Petitioner, "he states that he did not feel this was a work related injury related to his employment at Walgreens, as he had switched employment from Lowe's to Walgreens."

According to the doctor's notes, he discussed with Petitioner that "obviously there [were] several issues involved." "First, if the patient truly has notes from Prompt Care stating that he sustained a back strain or pain as indicated on or about the date of his injury of 9/15/10, then I do believe his current symptoms are causally connected to his work related injury as described." The doctor also assumed that Petitioner has had an ongoing problem since that time. Dr. Gornet did not believe the event at Walgreens caused any significant derivation in his symptoms based upon the history he was provided. Dr. Gornet's assessment was that of an injury of the disc at L5-S1. He felt Petitioner could continue working full duty. Dr. Gornet recommended Petitioner come off Hydrocodone and attempt one additional course of physical therapy. Dr. Gornet noted that if Petitioner failed to improve, he would recommend proceeding with spinal fusion. Petitioner was to bring his records from Prompt Care with him to the next visit. Petitioner was

[1] Noting he had 257 pages of medical records that "clearly indicate from Amanda McKee that initially Petitioner had symptoms."

given a note for full duty work with no restrictions. (PX 6)

Petitioner signed his Application for Adjustment of Claim against Walgreens on September 26, 2013 and alleged an accident date of March 28, 2011 "during employment." (AX 4)

Petitioner returned to Dr. Gornet on October 3, 2013 reporting he was completely off narcotic pain medication and continuing to work at Respondent, Walgreens. Petitioner advised the doctor that Prompt Care would not give him his records. Petitioner reported that he was recently hit by a pallet at work on September 16, 2013. Petitioner indicated his symptoms flared briefly before returning back to baseline. Dr. Gornet reiterated his opinion that Petitioner's symptoms were related to the September 15, 2010 work injury with Lowe's. Petitioner remained on full duty. (PX 6)

On January 6, 2014, Petitioner returned to Dr. Gornet reporting continued pain affecting the quality of his life. Petitioner reported he was off narcotic pain medication and continued to work full-duty at Respondent, Walgreens. An IME with Dr. Chabot was noted to be pending. His exam remained unchanged. Dr. Gornet again recommended proceeding with anterior lumbar fusion at L5-S1, however, was waiting for approval. (PX 6)

On February 26, 2014, Petitioner was evaluated by Dr. Michael Chabot at the request of Lowe's. A written report followed. According to it Petitioner reported that while working for Lowe's on September 15, 2010, he was unloading a truck and went to pick up a Christmas tree and his back went out. (RX 2) Petitioner reported developing immediate low back pain with radicular complaints in his left lower extremity. Petitioner received treatment and returned to work full-duty in October, 2010 and was released from care in November, 2010. *Id.* Petitioner left his position with Lowe's in November, 2010 and started working at Respondent, Walgreens, first as a temp and then as a full-time employee, in March of 2011. Petitioner indicated he developed irritation and soreness in his back sometime in March, 2011 and the severity of his symptoms escalated in March, 2011 to include radicular complaints into his left leg. (RX 2, dep. ex. 2)

Dr. Chabot's assessment was that of chronic low back pain, disc degeneration, questionable history of sacroiliitis, and a history of a strain injury to the lumbar spine. *Id.* Dr. Chabot felt Petitioner reached a level of maximum medical improvement in regard to the September 15, 2010 injury on November 19, 2010, and that he developed complaints again in March of 2011 that were unrelated to the September 15, 2010 injury. *Id.* Dr. Chabot indicated that Petitioner would likely continue to experience intermittent aggravation of his symptoms involving the lower lumbosacral region associated with disc degeneration, fatigue and conditioning throughout the lumbar region and felt that it was possible even normal activities of daily living could aggravate his symptoms; however, Dr. Chabot did not find Petitioner to be a candidate for surgery. *Id.*

Petitioner followed-up with Dr. Gornet on April 7, 2014 bringing Dr. Chabot's report with him. (PX 6) Dr. Gornet reviewed the report and rejected any suggestion that Petitioner's symptoms completely resolved following the September 15, 2010 injury, noting Petitioner's

symptoms had not resolved despite a progressive course of treatment over a number of years. *Id.* Dr. Gornet indicated that Petitioner had other problems with his lumbar spine and if treated surgically, he would expect him to have an excellent result and return to work without restrictions. *Id.* Dr. Gornet did note that if Petitioner could tolerate his symptoms as is, he was currently at maximum medical improvement. Dr. Gornet noted he would continue to seek approval to perform an anterior lumbar fusion at L5-S1. The doctor wrote:

> Given the fact that [Petitioner] did not have significant symptoms prior to his work related injury at Lowe's and given the fact that he has been remarkably consistent in always reporting the same event, the fact that he had ongoing physical therapy after he was released from medical care on October 1, the fact that within a period of months he was back seeking medical attention for similar symptoms and on his return visit again reported this to be related to his work related injury Lowe's and the fact that I find [Petitioner] to be believable, I do believe his current symptoms remain causally connected to his original work related injury and annular tear. (PX 6)

On July 28, 2014, Petitioner returned to Dr. Gornet who reviewed Dr. Chabot's IME report, which found Petitioner's symptoms were related to disc degeneration. *Id.* Dr. Gornet disagreed with Dr. Chabot's contention that Petitioner's symptoms developed after starting his new job at Walgreens, noting Petitioner did not have low back symptoms prior to the September 15, 2010 injury with Lowe's. *Id.* Dr. Gornet felt it was clear that Petitioner injured his back and developed an annular tear as a result of the September 15, 2010 injury. He added, "...and while his activities at Walgreen's [sic] may be a contributing factor, it is quite clear that he injured his back and in my opinion developed his annular tear as a direct result of the injury at Lowe's." (PX 6)

On December 22, 2014, Petitioner followed-up with Dr. Gornet reporting continuing complaints. Dr. Gornet reviewed MRI films revealing bilateral foraminal stenosis with a large central tear, and central herniation causing cauda compression. Dr. Gornet indicated Petitioner's best option would be an anterior decompression with anterior lumbar fusion. *d.* Dr. Gornet reiterated the Petitioner's current complaints were causally related to the September 15, 2010 work injury with Respondent. Petitioner was working full duty. (PX 6)

Dr. Gornet's deposition was taken on April 23, 2015 in regard to both cases. (PX8.) He testified that he first saw Petitioner on August 8, 2013, as a referral from Amanda McKee, at which time Petitioner complained of pain in his low back, left buttocks, left hip, and down his left leg into his knee. (PX 8, pp. 6-7) Petitioner told Dr. Gornet that he felt his problem began on September 15, 2010, when he picked up a Christmas tree and felt a pop in his back. (PX 8, p. 7) Petitioner also stated that he had not experienced low back problems of significance prior to September 15, 2010. (PX 8, p. 8) Dr. Gornet described his understanding of Petitioner's work accidents as "he has a work-related injury of 9/15/10, and I believe there is some question about whether or not his current job duties aggravate his underlying condition. (PX 8, p. 10) Dr. Gornet opined that Petitioner's symptoms were related to his work accident at Lowe's. He diagnosed an

annular tear at L5-S1 and recommended an anterior lumbar fusion at L5-S1. (PX 8, pp. 10-12)

Dr. Gornet testified that when he met with Petitioner on October 3, 2013 Petitioner reported that his symptoms had flared and that he had most recently been hit by a pallet. However, Petitioner felt any flare-up of symptoms due to that incident had resolved and he was back to his baseline. (PX 8, p. 12)

On cross-examination Dr. Gornet testified that the two MRIs (taken in 2011 and 2012) were essentially the same and he saw no "significant changes." (PX 8, pp. 26, 32)

On cross-examination by counsel for Walgreens, Dr. Gornet was asked why he believed Petitioner's injury occurred on September 15, 2010. Dr. Gornet testified:

> Because the patient had acute pain. He reported it at or near the time of the accident. His symptoms never went away. The history he described to me is the type of history that could cause that. He has obvious pathology only at L5-S1. There really isn't any other pathology in his back that is of any significance and to me there is no other plausible explanation than to associate that structural problem with that event.
>
> (PX8, pp 30-31)

Dr. Gornet acknowledged that some people have annular tears that can calm down and not require further treatment. However, to the doctor's knowledge, there was no indication that Petitioner's symptoms ever went away after his first incident with Lowe's and, therefore, Petitioner would not be a part of that group of people. (PX 8, p. 33) When asked if Petitioner ever described a specific injury occurring at Walgreens other than the one "later in December" when he went back to baseline, Dr. Gornet replied, "My notes speak for itself. I mean that's all I can recall. Basically there was a pallet issue. I don't recall if there was any other specific event or issues, but the notes are self explanatory." (PX 8, pp. 33-34)

Dr. Gornet further testified that he agreed with Dr. Chabot that there was minimal narrowing of the spinal canal and no evidence of neural compression, however, Dr. Gornet opined that Petitioner had an annular tear at L5-S1. (PX 8, p. 15) Dr. Gornet testified that Petitioner's symptoms have never completely gone away despite conservative treatment, and also that 100% of individuals have degeneration in their spine. (PX 8, p. 16) Dr. Gornet also testified that Petitioner had some degeneration prior to his work injury at Lowe's, but that Petitioner was working full duty and Dr. Gornet would not be testifying in the case if Petitioner had not suffered a annular tear at his L5-S1 disc. (PX 8, p. 16) Dr. Gornet testified to a reasonable degree of medical certainty that Petitioner suffered an annular tear and a small disc herniation at L5-S1 while lifting a Christmas tree box at Lowe's on September 15, 2010, explaining earlier that the "simple fact, again, comes down to whether or not Mr. Capps' symptoms, and I underscore symptoms, began at or near the time of his accident at Lowe's in September of 2010; and second, whether these symptoms have ever completely gone away in spite of reasonable conservative care." As stated by Dr. Gornet, "[b]ut not for the [September 15, 2010] work-related injury and the structural injury to the disc and the annular tear at L5-S1, I

do not think we would be here today." (PX 8, pp. 16-17) Dr. Gornet also testified that Petitioner's work activities at Walgreens may have aggravated Petitioner's condition, and would again in the future, but that Petitioner's structural pathology remained unchanged. (PX 8, p.19)

On cross-examination, Dr. Gornet conceded that younger people don't tend to have disc pathology that would warrant surgical treatment, because usually their pathology would resolve or be nonexistent because their spines are relatively young and healthy. (PX 8, p. 27) Dr. Gornet could not recall how often he would operate on a younger person due to an injury from a lifting incident; he testified that he once operated on a 15-year-old, but could not remember what had caused that person's spine injury. (PX 8, p. 27) Dr. Gornet could not recall any time in the last month that he had given an opinion that a person's injuries were not related to an alleged work accident. (PX 8, p. 30)

On cross-examination by counsel for Walgreens, Dr. Gornet testified that he did not see a significant change in the disc pathology between the two MRI scans that Petitioner underwent, and that Petitioner had described to him that his problems had begun with his incident at Lowe's but he had experienced increasing symptoms with certain activities with Walgreens. (PX 8, p. 33) Dr. Gornet also testified that it was not unexpected that Petitioner has increased symptoms associated with his work activities at Walgreens, but that some individuals with annular tears can "calm down and not require further treatment." (PX 8, p. 33) Dr. Gornet opined that there was no indication that Petitioner's symptoms went away after the first incident with Respondent. (PX 8, p. 33)

On the same day as his deposition, Dr. Gornet met with Petitioner. According to his notes, the working diagnosis for Petitioner was "discogenic pain at L5-S1." The doctor wrote, "We believe his current symptoms are causally connected to his injury at Lowe's as well as subsequent aggravation and work activity at Walgreen's [sic]." Petitioner remained off all Hydrocodone and was working full duty. (PX 6)

Dr. Chabot was deposed on August 7, 2015. (RX 2) He testified that he had treated thousands of patients for lumbar sprains, strains, herniations, and annular tears, had performed close to 9,000 surgeries, and had practiced as a spine surgeon for 21 years. (RX 2, p. 5-6) Dr. Chabot testified that he took a history from Petitioner, in which Petitioner stated that, following his 2010 physical therapy, he had improved and was released from care without restrictions. (RX 2, pp. 8-9) Petitioner also had stated that he had stopped working for Lowe's in November of 2010 and began working at Walgreens full-time in March of 2011, at which time his symptoms escalated from being a 0 or occasionally a 1. (RX 2, p. 9, p. 39)

Dr. Chabot also testified that the physical examination of Dr. Kovalsky in March of 2011 had revealed different findings than the physical examination by Dr. Gupta from September 15, 2010. (RX 2, pp. 10-11) Dr. Chabot's own physical examination was essentially normal and did not reveal and neurological deficits, difficulties with range of motion, or weakness. (RX 2, p. 13) Dr. Chabot had also reviewed MRI films from both of Petitioner's MRIs and opined that they were identical and had revealed evidence of disc desiccation at the L5-S1 level, a small central bulge, a high intensity zone, and minimal neuroforaminal narrowing, all at the L5-S1 level. (RX 2, pp. 13-14) Both MRIs had been taken after Petitioner began working at Walgreens and after

Petitioner had stopped working for Lowe's. (RX 2, p. 15) Dr. Chabot testified that Petitioner had diagnoses, from any cause, of chronic back pain, disc degeneration, questionable history of sacroiliitis/SI dysfunction, and a history of a lumbar strain. (RX 2, p. 15)

Dr. Chabot also testified that he diagnosed Petitioner with a strain and inflammation to his spine as a result of his work accident at Lowe's on September 15, 2010, for which Petitioner reached maximum medical improvement on November 19, 2010. (RX 2, pp. 15-16) Dr. Chabot noted that Petitioner was 90% better by October 1, 2010, with just occasional discomfort, and that by November 19, 2010 Petitioner had no tenderness or soreness in his back or leg, nor did he have pain, even while working. (RX 2, p. 16) Dr. Chabot also testified that his opinions were supported by the fact that Petitioner himself had stated that his pain was at a "0 or occasionally a 1." (RX 2, p. 16)

Dr. Chabot testified that it was normal for people to have occasional back pain at a 1 level in their everyday life, and described level 1 pain as minimal. (RX 2, p. 17) Dr. Chabot opined that Petitioner's complaints that began after he started working at Walgreens were unrelated to his September 15, 2010 accident. (RX 2, p. 17) Dr. Chabot also agreed with Dr. Kovalsky's opinions that Petitioner is not a surgical candidate, due to the fact that Petitioner had a normal physical examination, Petitioner did not require narcotic pain medication, and Petitioner had not missed any work. (RX 2, pp. 17-18)

On cross-examination, Dr. Chabot testified that Petitioner did not appear to have any prior back pain or problems before his September 15, 2010 accident with Lowe's. (RX 2, pp. 18-21) Dr. Chabot reiterated that he found Petitioner to be at maximum medical improvement on September 15, 2010, for injuries related to his Lowe's accident, due to the fact that Petitioner had no tenderness or soreness in his back or leg on November 17 and November 19, 2010, even while working. (RX 2, p. 22) Dr. Chabot testified a high intensity zone on an MRI could be indicative of an annular tear. (RX 2, pp. 26-27) Dr. Chabot also acknowledged that it was unusual for a 20-year-old to have a degenerative disc, but that people that young or younger can have degenerated discs. (RX 2, p. 27) Dr. Chabot did not believe that Petitioner's degenerative disc at L5-S1 was caused by his September 15, 2010 accident, due to the fact that disc degeneration and desiccation is a chronic process that take years before it gets to the point that it will show up on an MRI. (RX 2, pp. 27-28)

Dr. Chabot further testified on cross-examination that disc degeneration usually occurs in the greatest weight bearing disc, and that the most commonly degenerated discs are L4-5 ad L5-S1. (RX 2, pp. 28-29) Dr. Chabot noted that Petitioner did not have degeneration at the L4-5 level, but testified that younger people commonly only have disc degeneration at one level. (RX 2, p. 29) Dr. Chabot also opined that Petitioner would have intermittent aggravations of back pain complaints and that these could be from work activities, activities of daily living, simple home maintenance, and repetitive bending, lifting, and twisting. (RX 2, pp. 31-33) Dr. Chabot further clarified that this recurring back pain is due to deconditioning and poor core strength. (RX 2, p. 33)

On cross-examination by Walgreens' counsel, Dr. Chabot testified that Petitioner did not provide a history of any particular accident occurring at Walgreens. (RX 2, p. 35) Dr. Chabot

also opined that Petitioner's MRI findings predated both his injury at Lowe's and his work at Walgreens. (RX 2, pp. 36-37) Petitioner's ongoing symptoms were related to the various activities in his life and due to Petitioner's deconditioning. (RX 2, p. 37)

On redirect, Dr. Chabot testified that Petitioner told him that his pain escalated once he began working at Walgreens, and he interpreted this as meaning that it escalated from being a "0 to occasionally a 1." (RX 2, p. 39) Lastly, Dr. Chabot opined that even if Petitioner did have an annular tear, it would not change or alter his opinions in any way, that he still would not recommend surgery for Petitioner. He described annular tears as "extremely common." (RX 2, pp. 38-40)

Petitioner again presented to Dr. Gornet on October 12, 2015 and they discussed his planned surgical procedure. Petitioner reported that he was working full duty but his symptoms were continuing to affect all aspects of his life. His case was noted to be going before the arbitrator. (PX 6)

Petitioner's cases proceeded to arbitration on November 4, 2015. With regard to the instant case, the disputed issues were accident, notice, causal connection, medical bills, 8(j) credit, and prospective care. Petitioner was the sole witness testifying at the hearing.

Petitioner testified that he had no prior treatment or injuries to his low back before September 15, 2010. He further testified (and it was stipulated to by Respondent) that Petitioner sustained an injury to his back on September 15, 2010 when he was unloading a truck and went to pick up a Christmas tree and his back went out.

Petitioner admitted that at his last visit with Care First his pain level was down to "1/10" from "8-9/10", and down from "6-7/10" when physical therapy started to "0-1/10" at the end of physical therapy.

Petitioner further testified that he started a new job with Select Remedy on November 8, 2010 under the "People with Disabilities Program." This is a job entry program for people with disabilities to be hired by Walgreens. He testified that while working for Select Remedy, Walgreens evaluates whether he can do the job with his disability. He testified his disability is severe dyslexia, and he became an employee of Walgreens on March 8, 2011.

Petitioner testified that between November 19, 2010 and March 23, 2011 he was not pain free; rather, his pain was "up and down" and would get worse with activities. Petitioner testified that the job was very physical and his back would get worse with activity and with job but he did not seek any medical treatment because he did not want to complain because he was a "temp," and he wanted the job at Walgreens. As a "temp" he could easily be replaced and he wanted to be hired full-time for Respondent. Petitioner further testified that he did not have any insurance while he was a "temp."

Petitioner testified that upon being hired by Walgreens he sought treatment at the Wellness Center, Walgreens' medical facility. He could not explain why he didn't go back to the earlier therapist but recalled the facility at Walgreens was conveniently located next to the

distribution center where he worked.

Petitioner testified he began treating at the Orthopaedic Center of Southern Illinois (OCSI) on March 28, 2011.

Petitioner testified he first saw Dr. Matthew Gornet at The Orthopaedic Center of St. Louis on August 8, 2013.

Petitioner testified that Dr. Gornet is recommending a fusion at L5-S1, and Petitioner testified he wants to have the surgery because he wants to live the life of a 25-year old. He testified that for the last four years his pain goes up and down, depending on what he is doing, and his pain levels have slowly gotten worse. He testified he has never missed three consecutive days of work, but he has had intermittent periods of light duty.

Petitioner acknowledged that that the November 19, 2010 note found in RX 3 accurately reflected what was written on that date.

Petitioner testified that he could not recall what happened on March 28, 2011 other that it was maybe just a "really bad pain day" as he thought he was just gradually getting worse at that time. He could not recall why he went to the Orthopedic Center of Southern Illinois on March 28th.

Petitioner's medical bills are found in Petitioner's Exhibit 9. They total $20,225.09 (PX9).

The Arbitrator concludes:

Issue C – Whether Petitioner sustained an accident on March 28, 2011 that arose out of and in the course of his employment with the Respondent.

Petitioner failed to prove he sustained an accident arising out of and in the course of his employment with Respondent on March 28, 2011. All of Petitioner's medical histories relate the onset of Petitioner's pain to the September 15, 2010 accident at Lowe's (the companion claim) and Petitioner's treatment records reflect a consistent pattern of symptoms and complaints from September 15, 2010 to the present.

Petitioner credibly testified that he first injured his back at Lowe's on September 15, 2010, and he has continued, since that time, to have problems with his back. By his own admission and his medical records, he has never been completely pain free. To the extent he has been pain free, it has been temporary and short lived. Petitioner's medical records support his testimony that his pain has waxed and waned, gone up and down, and varied with activity; however, it all began with the accident on September 15, 2010.

Petitioner credibly testified he really has never been pain free since the accident at Lowe's on September 15, 2010 and that his pain is sometimes better, sometimes worse, depending on his activities or lack thereof, but the pain is not so severe to keep him from working. Petitioner has consistently reported that his symptoms were the result of a work-related injury on September 15, 2010 while an employee of Lowe's. Despite the appearance of a gap in treatment from November 19, 2010 through November 23, 2011 Petitioner credibly testified that he did not express any complaints at that time in the hope of securing full-time employment with Respondent herein and also because he was uninsured during this time period. Furthermore, Petitioner could not recall whether he sustained an accident on March 28, 2011 as he could not recall what happened that day. This further appears consistent with the applications for adjustment of claim filed in both cases – ie.,. the one against Lowe's is very specific in its description of the accident ("unloading truck") and the one against Respondent herein is very vague ("during employment").

The Arbitrator is fully aware that Petitioner reported complaints on March 22, 2011 (see PX 4) and presented to Team Works Therapy the next day. It is fairly reasonable to conclude from the March 23, 2011 records at Team Works that Petitioner felt repetitive bending and twisting from work duties was bothering his back. However, contemporaneously with that history (and subsequent ones to other providers) Petitioner always alluded to the September 15, 2010 accident and his pain since then has been described as "chronic." Dr. Gornet testified that Petitioner's work activities of bending and lifting while at Walgreens may be aggravating Petitioner's back but such activities have not changed Petitioner's underlying mechanical back issues. In the end, Petitioner's inability to testify with specificity to an accident (whether specific or repetitive) on/about March 28, 2011 defeats his claim.

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

Even if Petitioner sustained an accident on March 28, 2011 Petitioner produced no evidence to establish that he notified Respondent herein of the alleged accident within forty five days of March 28, 2011 as required by Section 6(c) of the Act.

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

Even if Petitioner sustained an accident on March 28, 2011 that arose out of and in the course of his employment with Respondent, Petitioner failed to prove his current condition of ill-being in his back is causally related to the alleged March 28, 2011 injury. This conclusion is based upon Petitioner's testimony and the medical opinions and testimony of Dr. Gornet.

Petitioner testified credibly and consistently as to progressively worsening low back pain with radicular complaints following a work-related injury with Lowe's on September 15, 2010. Petitioner testified he had not experienced any low back complaints prior to September 15, 2010. Further, Petitioner credibly and consistently reported a history of developing low back pain with radicular complaints as a result of a work place injury working for Lowe's on September 15, 2010, as evidenced throughout the medical records. When asked by Nurse

Practitioner McKee on March 28, 2011, Petitioner indicated his condition was not work-related as he was no longer employed by Lowe's. (PX 5) Petitioner testified that he injured his back on September 15, 2010 in a work-related incident while working for Lowe's and has had continuing problems since that time.

The Arbitrator relies on the opinions of Dr. Matthew Gornet and finds his medical opinions more persuasive than those of Dr. Michael Chabot. Dr. Gornet found that Petitioner's current symptoms related to the September 15, 2010 work injury with Lowe's and did not believe any event occurred while working for Respondent Walgreen's could have been responsible for his symptoms. (PX 6) Dr. Gornet rejected any suggestion that Petitioner's symptoms completely resolved following the September 15, 2010 injury, noting his symptoms had not resolved despite a progressive course of treatment over a number of years. *Id.* Dr. Gornet testified in regards to his opinion that the September 15, 2010 injury was responsible for Petitioner's complaints, stating "because the patient had acute pain, he reported it at or near the time of the accident. His symptoms never went away. The history that he described to me is the type of history that could cause that. He has obvious pathology only at L5-S1. There isn't any other pathology in his back that is of any significance. And to me, there is no other plausible explanation than to associate that structural problem with that event." (PX 8, p. 31) Dr. Gornet further testified that he was unable to identify any change in the underlying condition of the annular tear and small disc herniation as identified in the MRI prior to working at Respondent herein and after working for Respondent herein. (*Id.* at 32) While Dr. Gornet testified that Petitioner's work activities for Respondent "might" be a contributing factor he repeatedly went back to the specific incident in 2010 as the cause of Petitioner's back problem. As such, it appears that Dr. Gornet was suggesting that Petitioner's symptoms from certain work activities for Respondent were, at most, a manifestation of symptoms of the underlying condition caused by the September 15, 2010 accident with Lowe's.

Dr. Chabot's opinion on medical causation lacks persuasiveness and must be considered in light of the fact Dr. Chabot was retained by Lowe's. Dr. Chabot found that after sustaining a work-related injury with Lowe's on September 15, 2010, Petitioner received treatment and returned to work in October of 2010 and was released from care in November, 2010. (RX 2) Dr. Chabot noted that Petitioner developed an irritation and soreness in his back increasing his symptoms sometime in March, 2011 escalating the severity of his symptoms to include radicular complaints into his left leg. *Id.* Despite Petitioner's direct testimony explaining consistently progressively worsening symptoms following the September 15, 2010 injury with Lowe's. *Id.* Dr. Chabot somehow found Petitioner reached a level of maximum medical improvement on November 19, 2010. Dr. Chabot's opinion is also in contradiction to the reports of Petitioner himself, who associated his complaints before his evaluation with a September 15, 2010 injury with Lowe's. Dr. Chabot reviewed the results of Petitioner's MRI findings noting long-standing degenerative changes and admitted that these pre-dated his employment with Respondent herein. (RX 2) Dr. Chabot's medical opinion on causation directly contradicts Petitioner's own testimony that he remained symptomatic throughout the period from November 19, 2010 through March 28, 2011. (RX 2) Furthermore, Dr. Chabot was unaware of Petitioner's explanation as to why he failed to seek additional treatment during the period from November 19, 2011 through March 8, 2010, and that he was attempting to secure full-time employment with Respondent herein and was uninsured during this period of time. *Id.* Dr. Chabot was provided inaccurate and

incomplete information.

All remaining issues are rendered moot.

Petitioner's claim for compensation is denied and no benefits are awarded.

****

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

Rhonda Riley,
Petitioner,

17IWCC0067

vs.

NO: 12WC 27868

Massac Memorial Hospital,
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, occupational disease, 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, 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: FEB 6 - 2017

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

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CJD/rlc
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RILEY, RHONDA
Employee/Petitioner

Case# **12WC027868**

MASSAC MEMORIAL HOSPITAL
Employer/Respondent

17IWCC0067

On 2/2/2016, 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 0.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0355 WINTERS BREWSTER CROSBY ET AL
LINDA J CANTRELL
111 W MAIN ST PO BOX 700
MARION, IL 62959

1109 GAROFALO SCHREIBER HART ETAL
JAMES R CLUNE
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

17IWCC0067

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

Rhonda Riley
Employee/Petitioner

v.

Massac Memorial Hospital
Employer/Respondent

Case # 12 WC 27868

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **11/10/2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On 2/22/2012, 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 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 $71,591.00; the average weekly wage was $1,376.75.

On the date of accident, Petitioner was 47 years of age, *single* with 0 dependent children.

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

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

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

Respondent is entitled to a credit of $0 under Section 8 of the Act for payment of medical services.

ORDER

The petitioner has failed to prove by a preponderance of credible evidence that she sustained an accident or was exposed to an occupational disease arising out of and in the course of her employment. The petitioner has further failed to proved by a preponderance of credible evidence that her condition of ill-being, if any, is related to any accident or exposure arising out of and in the course of her employment on or about February 22, 2012. Compensation is denied. See the attached findings of fact and law for an explanation of this 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.

Signature of Arbitrator

1/18/16
Date

FEB 2 - 2016

17IWCC0067

Rhonda Riley v Massac Memorial Hospital
12WC27868

Findings of Fact and Conclusions of Law

Findings of Fact:

The petitioner, Rhonda Riley, was a paramedic for the respondent, Massac Memorial Hospital, since October 1994. In May 2006 the paramedics moved into quarters located on North Avenue in Metropolis. The petitioner described the building as being in generally poor shape. This included poor repair and the presence of "some mold on the walls."

In April 2011 there was a flood in the area and the paramedic quarters was affected. The petitioner testified that frequently after that time they had to use Shop-Vacs to "suck up water" from the floors and carpeting. This would happen, too, every time it rained per the petitioner.

The petitioner described her job as involving two 24-hour shifts per week. She would work from Sunday night starting at 11:00 PM until Monday night at 11:00 PM, and then again from Wednesday morning from 7:00 AM until Thursday morning at 7:00 AM. When she worked these shifts she would sleep at the paramedic quarters.

There were two bedrooms in the quarters. The petitioner was assigned to the smaller of the two rooms; actually an attachment that had been built onto the original structure. She testified that her routine was to arrive at her assigned time and spend her free time cleaning the quarters. She testified that she would assist in cleaning the quarters and that "we" would vacuum, dust, clean the toilets, clean the sinks, clean the refrigerator, and try and clean the mold off the walls "to keep it down." She described this as "everyday household cleaning duties" as "part of our job there."

On what appears to be Sunday through Monday February 19 - 20, 2012 the petitioner stated that she did her usual cleaning and later started having shortness of breath, coughing, a hoarse voice, and a rash on her face and "matting" around her eyes. Her eyes were watering and where itchy. When she reported to work on Wednesday February 22, and was in the process of bringing a patient into the ER she noticed again that she was having difficulty breathing. Her supervisor told her to see her personal physician. (PX 4) After an evaluation with the physician's assistant the petitioner was told to go to the ER because the assistant was concerned the petitioner might have a pulmonary embolism. Finally the ER concluded that the petitioner had "asthmatic bronchitis" and "acute laryngitis" per the petitioner's testimony. She was prescribed antibiotics, a nebulizer, and to undergo a pulmonary function test. She was also placed on 12-hour shifts rather than 24-hour shifts.

The petitioner's primary care doctor (Dr. Patel) is not a pulmonologist so he referred the petitioner to Dr. Keith Kelly (PX 7 & 14). Dr. Kelly concluded that the petitioner had a "history and clinical findings" consistent with asthma. (PX 14 at p. 5) Dr. Kelly conducted what he described as a spirometry on October 11, 2012. The result of that exam was normal. (PX 14, p. 8) The petitioner returned to Dr. Kelly on April 8, 2013 and on September 24, 2013 with complaints of asthmatic symptoms after being exposed to pollen in April and after cleaning the paramedic quarters in September. Dr. Kelly ordered a pulmonary function test in September and that allegedly showed a decrease in airflow.

In July 2013 the petitioner described an incident with her eyes, which she described as swollen shut and matted. This prompted her to go to the ER and she eventually sought the services of Dr. Ahmad (PX 15), an opthalmologist at the Marion Eye Center (PX 9). He diagnosed keratitis and conjunctivitis. He prescribed antibiotics and steroids for her eyes.

In August 2013 the petitioner was referred to Dr. Eisenbeis at SLU Care (PX 12). Her understanding was that she was referred to Eisenbeis for vocal strengthening. Eisenbeis concluded the petitioner had VCD: vocal chord dysphagia. (PX 12, pp. 9 - 10, 17; Bates stamp pp. 369 – 370, 377; RX 1, pp. 12, 24-25)

The petitioner followed up with Dr. Ahmad for cataract treatment. Dr. Ahmad concluded that the steroid treatment associated with her perceived asthma condition contributed to her development of cataracts at her age. A posterior subscapular type of cataract, which the petitioner had, is consistent with steroid use. (PX 15, p. 15 – 17, 20; RX1 p. 17)

The petitioner confirmed on cross-examination that while she engaged in cleaning the quarters during her shifts, she acknowledged that others did in her absence, so she could not conclude that the condition of the quarters on February 22, 2012 was the same as when the mold samples were taken in 2013 and 2014 to establish mold presence. (See PX 17)

Dr. Glennon Paul examined the petitioner on August 6, 2015. (RX 1, deposition exhibit 2). Dr. Paul is board certified in Asthma, Allergy, and Immunology, board certified in Internal Medicine, and is fellowship trained in Pulmonology. Dr. Paul conducted an examination of the petitioner over five hours, which examination included a methocholine challenge test, pulmonary function testing, and allergy tests involving 78 scratch tests and 25 intradermal tests. Dr. Paul also reviewed the records of Dr. Kelly, the records of Dr. Eisenbeis, the records of Massac Memorial Hospital, the records of Dr. Patel, and petitioner's exhibit 17 consisting of two mold tests conducted on the quarters in 2013 and 2014.

No other doctor in this case conduction a methacholine challenge test. No other doctor conducted allergy tests, including mold allergy tests.

As a result of the examination conducted by Dr. Paul, he concluded that the petitioner did not suffer from asthma. This is because no asthmatic can take and have a negative result from a methacholine challenge test as the petitioner did. Dr. Paul further concluded that if the petitioner was exposed to mold as a result of her work duties, the exposure contributed nothing to her condition. The petitioner was not and is not allergic to mold. (RX 1, p. 23) Her exposure to mold, if it occurred on February 22, 2012, did not cause asthma because the petitioner does not suffer from asthma. (RX 1, p. 23)

The petitioner suffered from and suffers from vocal chord dysphasia or vocal chord dysfunction. It is very common to confuse this condition with asthma and it is frequently mistreated accordingly. (RX 1, pp. 23 – 26) The condition is actually treated with diaphragmatic breathing exercises. It is caused by anxiety and the associated symptoms of breathing difficulties, tingling, hyperventilation, reduced ability to speak mimic some of the symptoms of asthma, but are not caused by or related to asthma.

Legal Standard:

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 casual connection between work and the alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. Three "D" Discount Store v Industrial Commission, 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 vs. 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). "[A]lthough medical testimony as to causation is not necessarily required, where the question is one within the knowledge of experts only, and not within the common knowledge or comprehension of laymen, expert testimony is necessary to show that a claimant's work activities caused the condition complained of." Interlake Steel v. Industrial Commission, 136 Ill. App. 3d 740 (1985). See also Ledbetter v State of Illinois, 13 IWCC 0131, regarding the relative knowledge of testifying experts.

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 vs. 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), and 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).

Conclusions of Law:

C & F.

Did an accident occur that arose out of and in the course of Petitioner's employment with Respondent?
Is Petitioner's current condition of ill-being causally related a work injury or illness on or about February 22, 2012?

The petitioner has failed to prove by a preponderance of the evidence that she inhaled mold on or about February 22, 2012. Although she described her work quarters as having mold present on the walls, there is no evidence that this was

tested to determine if it was mold, the nature of the mold if it was mold, nor any evidence that if mold was present on the walls, it was also present in the air, any more than mold is present in the environment generally. (As to the presence of mold in the environment generally see RX 1, pp. 31- 33; PX 14, p. 20)

It is not sufficient to merely establish the presence of mold, just as in the supreme court case of Sperling v Industrial Commission, 129 Ill.2d 416, 544 N.E.2d 290 (1989) where the petitioner alleged that because hepatitis was present in the hospital her condition of hepatitis B must have been caused by her employment conditions. "Indirect proof of a causal connection between work conditions and an occupational disease [is] an improper standard." Sperling, *supra*. Neither is direct proof required, but proof of exposure is necessary and it was lacking in Sperling as it is lacking in this case. While Sperling had expert testimony establishing that hepatitis was present in the hospital, no testimony established that she was exposed to a patient with hepatitis; a disease that is prevalent in the world at large outside of the hospital setting. The court noted that Sperling could not provide a description of even one incident where she had been exposed to a patient's blood or exposed to a patient that had hepatitis.

In the instant case, while the petitioner claims she was exposed on February 22, 2012, there is no evidence that she inhaled mold or was exposed in any other fashion. In fact, for almost a year, twice per week, the petitioner had been performing her housekeeping and cleaning duties in the quarters after the flood of April 2011. She had also noted mold presence in the quarters before April 2011, dating back to May 2006. Since no evidence was presented, we cannot speculate that there was some type of qualitative difference between the presence of the mold on February 22, 2012 and at any other time prior to that date when the mold was present. In other words, there is no evidence that the petitioner sustained some type of exposure on February 22. The only evidence we have is that mold was present in the quarters, not that she inhaled it, ingested it, or came into dermal contact with it. The exhibits showing collection and testing in 2013 and 2014 (PX 17) are not probative to the environment in 2012, particularly noting that the petitioner and her coworkers changed the condition of the quarters daily when performing their housekeeping duties. Even the petitioner's expert, Dr. Kelly, could not describe the nature of the petitioner's alleged exposure to mold, other than her anecdotal history that mold was present in her quarters. (PX 14, p. 22)

Even if the petitioner could prove an actual exposure to the mold that was present, medical testing proves that she is not allergic to mold. The petitioner's expert, Dr. Kelly, testified that mold is not a cause of asthma, but is a trigger "for people sensitive to molds." (PX 14, p. 27) Testing confirmed the petitioner is not sensitive to molds. (RX 1, deposition exhibit 2)

Medical testing further confirms that the petitioner does not suffer from asthma. Medical records and expert testimony confirms that the petitioner suffered from a

vocal chord dysfunction which is caused by anxiety, but which mimics asthma symptoms. Unfortunately, the petitioner was treated with steroids in an effort to address what was presumed to be asthma and this treatment, unrelated to anything associated with her work, resulted in her development of and treatment for cataracts.

Compensation is denied. The petitioner did not prove an exposure to an occupational disease and did not sustain an accident arising out of and in the course of her employment with respondent on February 22, 2012. Further, while the petitioner claims to suffer from asthma associated with a mold allergy, she neither has asthma nor an allergy to any mold. The petitioner suffers from a personal condition unrelated to work and not aggravated or accelerated by work.

17IWCC0068

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BENJAMIN B. ADEBAYO,

Petitioner,

vs. NO: 12 WC 40275

CITY OF CHICAGO, BUILDING DEPT.,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, medical expenses, nature and extent, and penalties, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below, but attaches the Decision for the purpose of the statement of facts, which is attached hereto and made a part hereof, with the modifications noted below.

The Commission finds that Petitioner's current state of ill-being is causally connected to the automobile accident of October 11, 2012. Petitioner testified he never had any problems with his back, neck, shoulders or leg prior to the October 11, 2012 auto accident. (T. p. 21-22) Petitioner's complaints to MercyWorks and to Dr. Foreman gave consistent accounts of the accident as well as the injuries sustained. (Px2 and Px3). Conservative treatment of physical therapy and pain medication did not appear effective, so Dr. Foreman referred Petitioner to a pain specialist, Dr. Jain, for epidural injections which seemed to bring Petitioner some relief. (Px3 and Px5) Further, Petitioner's complaints were consistent to all of the medical providers from whom he sought treatment, and the medical records of Dr. Jain reflect the treatment was reasonable and related to Petitioner's accident of October 11, 2012. (Px5) Respondent did not present any witnesses or introduce any medical records to refute Petitioner's history of accident or medical complaints.

Based on the above finding of causal connection, we hereby award Petitioner medical

expenses of $14,227.30 under §8(a) of the Act, subject to the fee schedule in §8.2 of the Act. This includes those expenses incurred after October 11, 2012, which were denied by the Arbitrator. Respondent shall be entitled to §8(j) credit for payments made by its group insurance carrier; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit.

We find that Petitioner sustained injuries to his back, neck, shoulders and leg as a result of the October 11, 2012 accident and that his condition remains causally related to that accident. The parties stipulated that Petitioner's average weekly wage was $1,837.76 at the time of that accident and that is the wage on which we are awarding permanency benefits. Based on the five factors in §8.1b(b), we find that no impairment rating was introduced by either party so that is given no weight. Regarding his occupation as a building inspector, Petitioner testified that he needs to take frequent breaks and elevate his leg. We give this factor some weight. We find that at 56 years of age at the time of injury, Petitioner has less anticipated work years ahead of him than a younger worker and give this less weight. There is no evidence of future earning capacity and Petitioner continues to work for Respondent. This factor is given some weight. Regarding evidence of disability corroborate by the treating medical records, we find that Petitioner sustained injuries to his back, neck, shoulders and leg. He reports needing to take frequent breaks. The Commission places great weight on this factor. Based on the above, we find that Petitioner has sustained the loss of use of 2% of the person as a whole under §8(d)2.

We affirm the Arbitrator's award regarding the denial of penalties and fees.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.55 per week for a period of 10 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of use of 2% of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $14,227.30 for medical expenses under §8(a) of the Act, subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit under §8(j) of the Act for payments made by its group insurance carrier; 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 Petitioner's Petition for Penalties pursuant to §§16, 19(k), and 19(l) of the Act, is hereby denied.

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

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

17IWCC0068

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: FEB 6 - 2017

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

CJD/dmm
O:1/18/17
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ADEBAYO, BENJAMIN
Employee/Petitioner

Case# **12WC040275**

CITY OF CHICAGO
Employer/Respondent

17IWCC0068

On 10/6/2015, 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 0.06% 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:

0307 ELFENBAUM EVERS & AMARILIO
KAROLINA M ZIELINSKA
940 W ADAMS ST SUITE 300
CHICAGO, IL 60607

0010 CITY OF CHICAGO-LAW DEPT
ELIZABETH MANNION
30 N LASALLE ST 8TH FL
CHICAGO, IL 60602

17IWCC0068

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

Benjamin Adebayo
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **12** WC **40275**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **3/26/15** and **5/20/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of 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. [ ] Is Petitioner entitled to any prospective medical care?
L. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other

17IWCC0068

FINDINGS

On the date of accident, **10/11/2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$95,563.54**; the average weekly wage was **$1,837.76**.

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

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

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

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

ORDER

The Respondent shall pay the bill for St. Bernard Hospital, date of services 10/11/12, in the amount of $173.00, in accord with the fee schedule, directly to the provider, with a credit for any payment made by the Respondent.

The Petitioner's further claim for benefits and permanent partial disability 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

August 6, 2015
Date

ICArbDec19(b)

OCT - 6 2015

17IWCC0068

INTRODUCTION

This matter proceeded to hearing on March 26, 2015 before Arbitrator Steven Fruth. Hearing was continued for close of proofs on May 20, 2015. The disputed issues were: ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***E:*** Was timely notice of the accident given to Respondent?; ***F:*** Is Petitioner's condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***L:*** What is the nature and extent of the injury?; ***M:*** Should penalties or fees be imposed on Respondent?

FINDINGS OF FACT

Petitioner testified that on October 11, 2012 he was working as a building inspector. As an inspector he responds to 311 calls of complaint. He was headed to his next inspection stop when the accident happened. He was driving his personal vehicle which he used for his employment by Respondent. Respondent reimbursed Petitioner for expenses in operating his personal vehicle for his employment. He was involved in a motor vehicle accident as he was making a left turn across the path of an approaching police vehicle. Petitioner testified when his vehicle was struck his body jerked back and forth. Petitioner testified he was wearing his seatbelt at the time.

Petitioner was transported by ambulance to St. Bernard Hospital following the accident. (PX #1) Petitioner reported "(m) y breast, ribs hurt. I was in a car accident. The car hit me at the back." He testified that he also complained of back pain. No abnormalities were found on examination. No x-rays were taken. Petitioner was diagnosed with chest wall contusion and discharged that same day. No medication was administered or prescribed.

Petitioner testified he contacted his supervisor, Don Mitchell, from the hospital and reported that he was injured in a motor vehicle accident while driving to inspect a building. Petitioner reported to work the next day. He continued to work up to the day of the hearing.

Petitioner followed up care with MercyWorks (PX #2) on October 22, 2012 where he was seen by Homer Diadula, M.D. He complained of neck, right shoulder, and right chest pain. He also complained of 7/10 low back pain which radiated into his left leg numbness and tingling. His neck pain radiated into upper right arm but without numbness or tingling. Petitioner reported that he had physical therapy twice already. He denied that he had had any similar condition in the past.

On exam Dr. Diadula noted slightly limited cervical range of motion. The shoulder was not swollen and had full range of motion with pain. The chest wall was tender. Lumbar flexion was restricted but other motion of the spine was normal.

Petitioner had difficulty with heel-toe walking. He had a positive straight leg on the left at 45°. X-rays were negative for fracture or dislocation. Dr. Diadula diagnosed neck, right shoulder, and lower back strain, along with right chest wall contusion. He prescribed 600 mg ibuprofen and 10mg cyclobenzaprine (muscle relaxant).

Petitioner was placed at full duty capacity and advised to continue physical therapy. Dr. Diadula estimated the duration of the condition to be 2-3 weeks.

Petitioner returned to Dr. Diadula at MercyWorks on November 9, 2012. He had missed an appointment on November 6. He reported his right-sided neck pain at 5/10, on and off, but without radiation into the arm. Back pain was reported at 7/10 and radiating into the left leg. On exam shoulder range of motion was full. The chest was still tender. The low back exam results were the same as on October 22. Dr. Diadula now added left sciatica to the prior diagnoses. He recommended a lumbar MRI and wanted to see Petitioner after the MRI or on November 27. He continued Petitioner at full duty work.

Petitioner did not keep the November 27 appointment.

Petitioner followed up for further medical treatment with Dr. Michael Foreman of Hyde Park Medical. (PX #3) On October 22, 2012, Dr. Foreman noted Petitioner's complaints of neck, mid back, low back, and chest injuries. There were no complaints regarding either shoulder. Petitioner reported that he was driving a vehicle that was stationary when it was struck in rear by another vehicle. In history Petitioner complained of 6/10 pain in his neck and mid-back. Pain radiated into the right arm. He also complained of 7/10 low back pain with pain and numbness into his left leg.

On examination Dr. Foreman found tenderness and hypertonicity in Petitioner's cervical, thoracic, and lumbar spines. Reduced sensation in the left leg was also noted. Straight leg raise reproduced radicular pain in the left leg. Dr. Foreman diagnosed Petitioner with cervical, thoracic, and lumbar strains along with cervical and lumbar radiculopathy. Dr. Foreman considered physical therapy and allowed Petitioner to work "as tolerated".

Dr. Foreman signed a patient current condition form on October 21, 2012, stating Petitioner's "cervical/thoracic/lumbar strain" were work related. Clinical and billing records (PX #3) show Petitioner began physical therapy on October 29. Dr. Foreman's clinical notes for follow-up visits were hand-written and unreadable. Another caregiver, whose signature is unreadable, charted clinical assessments on October 29 and 31; November 4, 8, 9, 13, 14, 16, 20, 27, 29 and 30; December 3, 4, 14, 17, and 18, 2012. Petitioner's therapy continued through February 5, 2013.

On February 6, 2013 Petitioner's feet were casted for orthotics. There is not documentation whether the orthotics were necessary to treat Petitioner's back complaints.

Petitioner had MRIs ordered by Dr. Foreman of the cervical and lumbar spines on November 19, 2012. Minimal diffuse disc bulges were noted at C3-4, C4-5, C5-6, and C6-7. The bulge at C4-5 extended to the left with no central canal stenosis or foraminal narrowing. Minor diffuse disc bulges were noted from L3 to S1. There was also mild loss of hydration at L3-4 and L4-5. There was no finding of nerve root impingement. There were no disc herniations.

Petitioner continued to work full duty while under Dr. Foreman's care and during the physical therapy.

Dr. Foreman wrote a note on November 20, 2012. There was no documentation of a clinical visit on November 20. The report is the format of a report written for the purposes of litigation. Dr. Foreman copied Petitioner's history verbatim his note from October 22, 2012. Petitioner's complaints of persistent neck pain with radicular symptoms in the right arm and persistent low back pain with weakness and radicular symptoms in the left leg were documented. On November 20 Dr. Foreman listed his diagnoses: **1.** Acute cervical strain, **2.** Acute thoracic strain, **3.** Acute lumbar strain, **4.** Chest contusion, **5.** Upper extremity radiculopathy, **6.** Lower extremity radiculopathy, **7.** Cervical spondylosis, **8.** Thoracic spondylosis, **9.** Lumbar spondylosis, **10.** Right shoulder derangement. Dr. Foreman noted that he last saw Petitioner clinically on November 15. There are no clinical notes for November 15. Clinical notes dated November 14, 2012 are illegible due to poor handwriting. On November 20 Dr. Foreman noted that Petitioner was taking pain medication without stating what the medication was. Dr. Foreman repeated his opinion that Petitioner's condition was related to a work accident.

There are no readable clinical notes by Dr. Foreman documenting a clinical exam or assessment of the right shoulder. There are no radiology studies noting spondylosis anywhere in Petitioner's spine.

Dr. Foreman did not document any order for prescriptive pain relief medication. Dr. Foreman billed $120.00 for an "intermediate followup" on October 26, but there are no clinical notes of such an assessment.

Dr. Foreman referred Petitioner to Dr. Neeraj Jain at Chicago Pain and Orthopedic Institute (Chicago Pain). (PX #5) Dr. Foreman did not document the clinical indications for referral to Dr. Jain.

Petitioner first saw Dr. Jain on November 8, 2012. Petitioner gave a history of injury from a motor vehicle accident when he was struck by a high speed vehicle as he was turning left. Petitioner reported that he had immediate neck, mid-back, and lower back pain. He also complained that pain radiated into his left arm and into his left leg. Petitioner also reported that he was working full time.

On exam Dr. Jain found normal curvature of the lumbar spine. Petitioner limped, favoring his right side. There were no gross motor or sensory deficits. Dr. Jain noted a positive left straight leg raise without specifying whether it was positive for back pain or leg pain. Dr. Jain also noted that patellar reflexes were asymmetric without specifying which side was faster or slower. Dr. Jain noted that there were no Waddell signs. His impressions were the radiologist's findings on the MRIs.

Dr. Jain's plan was to give "left-sided transforaminal" at L3-4, L4-5, and L5-S1. He also planned a cervical epidural steroid injection. Dr. Jain did not document the clinical indication for either treatment plans. Dr. Jain opined that Petitioner should continue physical therapy and medication without noting what medication Petitioner was taking. He added his opinion that Petitioner's condition was related to his work accident.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner was injured in an accident that arose out of and in the course of his employment by Respondent.

Petitioner was a building inspector for Respondent. His unrebutted testimony established that he drove his personal automobile to travel from one location to another in the City of Chicago in response to 311 reports. Petitioner testified that at the time of his automobile accident he was travelling from one assignment to another. The accident occurred during his period of employment in the City in fulfillment of his job duties as a building inspector. Travelling between inspection sites is incidental to Petitioner's employment by Respondent and is the expected means for Petitioner to perform his work duties.

The facts are not dissimilar to those in *Kertis v. IWCC,* 2013 IL App (2d) 120252 WC. In *Kertis* the petitioner, a bank manager, was injured when travelling from one branch bank to another. The Appellate Court held that the petitioner was injured from an accident that arose out of and in the course of his employment. The Court found that the petitioner was engaged in reasonable conduct that "might normally be anticipated or foreseen" by his employer, just as Petitioner was doing as a building inspector for Respondent.

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

The Arbitrator finds that Petitioner proved that timely notice of his work-related injury was given to Respondent in compliance with the Act.

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

The Arbitrator finds that Petitioner failed to meet his burden of proof that his current condition of ill-being was causally related to the injury. The evidence showed that Petitioner did sustain soft tissue strains to his cervical and lumbar spines as a result of the accident. There was no evidence that he sustained any underlying spinal pathology, such as a fracture or vertebral disc injury, as a result of the accident.

Also, based on Petitioner's confused and contradictory testimony, he did not prove that he sustained an injury to either shoulder as a result of the accident. In fact, at one point Petitioner testified that his shoulder complaints were pre-existing, a fact not shared with his treating physicians. There was no evidence that the accident aggravated his pre-existing shoulder conditions.

Petitioner exaggerated his complaints and current condition on the date of hearing. Petitioner exhibited no outward evidence of pain or discomfort as he sat through the hearing. Petitioner has worked full duty since the date of accident up to and including the date of hearing. Yet, Petitioner testified that the auto accident of October 11, 2012, has had a "great effect" on his ability to do his job.

Chicago Pain billing records in PX #5 document the administration of transforaminal injections on February 2, 2013. There are no clinical notes of those procedures in PX #5. Billing records contain charges for clinical visits on February 22, March 21, and May 18, 2013. There were no clinical notes for February 22. Dr. Jain noted on March 21 that Petitioner had continuing complaints but had 80% relief from the epidural injection. The exam was the same as before: positive straight leg sign on the left and no gross motor or sensory deficits. He recommended another epidural injection and continuation of ibuprofen.

Petitioner's Exhibit # 4 included the procedure note of Dr. Jain's epidural transforaminal injections at L3-4, L4-5, and L5-S1 on February 2. Dr. Jain noted "The physical examination revealed no contraindication to this procedure." There were no clinical notes for the physical examination. The anesthesia record is blank but for the start and stop times. The Anesthesia Associates Charge Sheet is difficult to read due to poor quality copying.

On May 18, 2013 Petitioner saw Dr. Heather Nath at Chicago Pain. Petitioner presented with complaints of bilateral shoulder pain and low back pain. No complaints of cervical pain or radicular symptoms were documented. On exam Dr. Nath found full strength in the upper and lower extremities and good range of motion. There were no notes of any findings on a neurologic exam. Based on this exam and review of Petitioner's "available" records Dr. Nath recommended an EMG. She did not document what records she reviewed or the clinical indication for an EMG.

Petitioner testified to ongoing chiropractic treatment currently. He testified that he is in pain every day with pain in both shoulders and in his low back into his left leg. He also receives acupuncture for his continuing pain. Petitioner did not offer any documentary evidence of medical care to support his testimony of medical care since May 18, 2013. He acknowledged that he has not returned to the physicians who initially treated his injuries for his continuing complaints.

Petitioner testified that he underwent an EMG but the medical records admitted in evidence did not document that that procedure was ever done. In later testimony Petitioner retracted his statement that he had an EMG. Petitioner also testified in a confused manner that he had bilateral shoulder pain since 2010 or 2011.

The Arbitrator notes that Petitioner sat throughout his testimony at the hearing without any apparent signs of discomfort.

Petitioner testified he has been working for the City of Chicago for the past 22 years as a building inspector. Medical records entered into evidence from Kaliana Medical Services (RX #4) contain notes from Petitioner's consultations on November 13, 2012 and May 3, 2013. There are no notes on either of those days of Petitioner reported an injury on October 11, 2012 or complaints of neck or shoulder or back pain.

Petitioner testified there is nothing strenuous in his job as a building inspector. Petitioner has continued to work full duty since the date of accident. Petitioner confirmed no doctor ever placed him off work for the incident.

Petitioner testified he often needs to keep his leg elevated when sitting for a while or often will stop driving to "stretch" his muscles, but the Arbitrator notes that Petitioner sat through the entire arbitration hearing without adjusting his seated position or leg for relief of apparent discomfort. He testified he chose to keep working due to "financial reasons" but admitted on cross-examination that no doctor had ever placed him off of work for his condition. The Arbitrator takes note that a building inspector is required to walk about sites of inspection and must frequently climb and descend stairs. Also, The Arbitrator takes note that building inspectors must often bend, stoop, and kneel. Petitioner did not testify that his claimed injuries impaired any of his work duties. Petitioner's complaints of 7/10 pain are clearly inconsistent with the full time work duties he engaged in over the period of his treatment and that he was only prescribed 600 mg of ibuprofen for pain.

Pettioner's credibility was further undermined by the records from Kaliana Medical Services which were silent about the work-related accident or any injuries sustained in that accident.

On the date of hearing Petitioner testified to constant pain in both shoulders which he believed to be due to the accident. The medical records do not support this claim, and no injury to either shoulder was noted in the initial emergency room visit. Subsequent medical records show only right shoulder complaints. Bilateral shoulder complaints first appeared in May 2013 medical treatment records, 6 months after the accident. Petitioner even testified that he had shoulder complaints as early as 2010.

Additionally, Petitioner did not produce any medical records after May 2013 to support his claim for constant ongoing medical treatment for other complaints, including his low back. The Arbitrator also notes that on his clinical visit at MercyWorks on October 22, 2012 he reported that he had already had 2 sessions of physical therapy. The only records documenting physical therapy in that time frame were from Hyde Park. Clinical and billing records show that physical therapy began on October 29, 2012. In addition, the credibility of Petitioner's claim is further undermined by the curious note by Dr. Forman dated October 21, 2012, the day before the first clinical and billing entries.

In coming to the above conclusions the Arbitrator disregarded Dr. Foreman's note date November 20, 2012. It did not comport to any clinical exam and was clearly created for the purpose of this litigation.

The injuries sustained by Petitioner in the work incident of October 11, 2012 appear to have fully resolved. The Arbitrator finds that Petitioner's testimony regarding his alleged current complaints was not credible. Petitioner failed to meet his burden that his physical condition and complaints as of the date of hearing were causally related to the work incident.

J: Were 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 care provided to Petitioner was largely based on his subjective complaints rather than objective clinical findings. The Arbitrator did not find Petitioner to be credible when he testified regarding his subjective complaints, past and present.

Dr. Diadula at MercyWorks initially diagnosed spinal strains. Nonspecific sciatica was added later. Dr. Foreman diagnosed cervical, thoracic, and lumbar spondylosis (arthritic degeneration) and strains. Dr. Diadula opined that Petitioner's condition should resolve with physical therapy. Dr. Foreman provided physical therapy at Hyde Park Medical Center through February 2013. The Arbitrator finds that the emergency care provided at St. Bernard Hospital on the day of the accident was reasonable and necessary. The Arbitrator also finds that the medical provided at MercyWorks was reasonable and necessary. The physical therapy provided to Petitioner at Hyde Park is poorly documented. However, the Arbitrator, in light of Dr. Diadula' s opinions and Petitioner's testimony, finds that the physical therapy provided at Hyde Park Medical was reasonable and necessary.

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that the medical care he received at Chicago Pain and Orthopedic Institute by Drs. Jain and Nath was reasonable or necessary. Dr. Foreman referred Petitioner to Chicago Pain for assessment by Dr. Jain, a specialist in pain management. The referral was made without Dr. Foreman documenting the clinical necessity for the referral. The referral was made before Petitioner completed a round of physical therapy, before physical therapy was given a chance to resolve Petitioner's complaints.

The Arbitrator notes that the only documented pain medication which was prescribed for Petitioner was ibuprofen. He was advised to take 600 mg, a dose one may take with 3 tabs of over-the-counter versions of ibuprofen. This is not the type of analgesic that suggests pain severe enough to warrant a referral for pain management. The Arbitrator also takes note that neither Dr. Jain nor Dr. Nath fully documented their clinical findings or assessments or the clinical indications for the transforaminal injections and attendant services.

Petitioner was unable to sustain his burden of proving the reasonableness and necessity of medical care and professional charges for Chicago Pain and Orthopedic, Metro Milwaukee Anesthesia, and Accredited Ambulatory Care for the paucity of evidence submitted by Petitioner.

Respondent presented evidence, Exhibits #1 and #2, that it paid charges for reasonable and necessary medical care and services provided to Petitioner by in accord with The Act and the fee schedule. The Arbitrator finds this evidence of payment to be credible.

Petitioner submitted Petitioner's Exhibit #7 into evidence, claiming unpaid related bills totaling $14,227.30. The only bill which appears to remain outstanding on the date of hearing is the St. Bernard Hospital emergency care bill for $173.00. The Arbitrator finds that Respondent shall pay $173.00 to St. Bernard Hospital in accord with the fee schedule, directly to the provider, with a credit for any payment made.

L: <u>What is the nature and extent of the injury?</u>

The Arbitrator evaluated the nature and extent of Petitioner's claim for permanent partial disability in accord with § 8.1b(b) of the Act:

Steven J. Fruth, Arbitrator

October 6, 2015

17IWCC0068

(i) The Arbitrator notes that an AMA impairment rating was offered in evidence. As such, the Arbitrator places no weight on this factor.

(ii) Petitioner worked as a building inspector for Respondent. Petitioner continued to work full time without restriction after that accident. There was no evidence that Petitioner's claimed injuries adversely affected to performed his assigned work duties. The Arbitrator places no weight on this factor.

(iii) Petitioner was 56 years old at the time of the incident. He had a statistical life expectancy of 24 years. He had a work-life expectancy of 8 years. In light of Petitioner's compromised credibility the Arbitrator places little weight on this factor.

(iv) Petitioner presented no evidence that his future earning capacity was affected by his work-related injury. The Arbitrator places no weight on this factor.

(v) The medical records submitted in evidence show that Petitioner sustained cervical and lumbar strains which resolved. The medical evidence did not show objective evidence of the medical necessity for pain management referral or for the transforaminal injections performed by Dr. Jain. The questionable credibility of Petitioner along with the inconsistencies and contradictions within the medical evidence do not support a finding of permanent partial disability.

Based on the above, the Arbitrator finds that Petitioner failed to prove that he is entitled to an award for permanent partial disability.

M: Should penalties or fees be imposed upon Respondent?

Petitioner has requested penalties and attorney's fees under § 19(k), § 19(1), and § 16 of the Act. Petitioner filed a Petition for Penalties on August 19, 2014, with noted status date of September 9, 2014. This status date for this Petition passed without the motion being presented. On the date of trial, Petitioner filed a new Petition for Penalties, identical to the August 19, 2014 filing, without prior notice to Respondent. Respondent objected to the new Petition and its entry as an exhibit.

The Arbitrator finds the Petitioner's Petition for Penalties was not untimely. The Petition is flawed on its face in that it does not set forth any facts, but rather, pleads conclusions. Further, Petitioner presented no evidence at the hearing to support the allegations set forth in the Petition for Penalties. The record is clear that Respondent did not pay the St. Bernard emergency care bill in accord with § 8(a) of the Act. However, Petitioner put forth no evidence that Respondent failed to comply with the notice of delay or denial requirement of § 19(l).

For these stated reasons, Petitioner's Petition for Penalties is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

☐ 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

TARA GARRISON,

Petitioner,

17IWCC0069

vs. NO: 14 WC 12824

ILLINOIS DEPARTMENT OF HUMAN SERVICES/
WARREN G. MURRAY DEVELOPMENTAL CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue(s) of causal connection, medical expenses, wage calculation, and TTD benefits and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 labor agreement governing Petitioner's employment with Respondent provides that full wages are to be paid to an employee who sustains an injury at work that is the result of a physical act of violence and is subsequently removed from working pursuant to a physician's order because of that injury. Pursuant to this agreement, Respondent paid Petitioner her regular wages in the amount of $756.97 for the days she was temporarily totally disabled, March 2, 2014, through March 9, 2014. The Decision of the Arbitrator did not credit Respondent for this. The Commission, therefore, modifies the Decision of the Arbitrator only to the extent that it awards Respondent a credit in the amount of $504.65 towards amount due Petitioner under §8(b) of the Act.

17IWCC0069

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $504.65 per week for a period of 57-4/7 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 or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit applied to temporary total disability benefits under §8(b) in the amount of $504.65 due to Respondent paying to Petitioner her regular wages from March 2, 2014, through March 9, 2013, per the applicable provision of the labor agreement between Petitioner's union and Respondent.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $27,136.13 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the prospective medical treatment as prescribed by Dr. Kovalsky, including but not limited to, sacroiliac joint fusion(s) 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.

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; 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.

FEB 7 - 2017

DATED:
KWL/mav
O: 12/19/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

17IWCC0069

GARRISON, TARA
Employee/Petitioner

Case# 14WC012824

SOI/MURRAY DEVELOPMENTAL CENTER
Employer/Respondent

On 6/1/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.47% 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:

0246 HANAGAN & McGOVERN PC
BRIAN T McGOVERN
123 S 10TH ST SUITE 601
MT VERNON, IL 62864

0558 ASSISTANT ATTORNEY GENERAL
KENTON OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

JUN 1 - 2016

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

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

17IWCC0069

TARA GARRISON
Employee/Petitioner

v.

SOI/ MURRAY DEVELOPMENTAL CENTER
Employer/Respondent

Case # 14 WC 012824

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 **12/03/2015**. 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. ☒ 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, **03/01/2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$18,707.80 over 24 5/7 weeks**; the average weekly wage was **$756.97**.

On the date of accident, Petitioner was **39** years of age, ***single*** 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 **$22,603.86** 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 **$to be determined** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $27,136.13, 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 treatment as recommended by Dr. Kovalsky, including but not limited to, SI joint fusion(s), as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $504.65/week for 57 4/7 weeks, commencing 3/2/14 through 3/9/14 (1 1/7 weeks) and 3/25/14 through 4/23/15 (56 3/7 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

5/25/16
Date

ICArbDec19(b)

FINDINGS OF FACT

The parties stipulated that Petitioner was injured on March 1, 2014 while employed with the Respondent. She was hurt when an agitated resident of the Respondent attempted to attack another resident. Petitioner intervened and was knocked into a shower door and fell onto a concrete floor. She promptly reported the accident and went to the emergency room. She complained of pain in her right hip, right hand and bottom of her neck. She had bilateral shoulder pain and back pain. She also reported a burning pain going into both ankles. (PX 1.)

She followed up with her primary care physician, Karen Hummel, P.A., on March 3, 2014. She again complained of pain to her right hip, bilateral upper neck, shoulder area, and mid-to-low back. She kept Petitioner off work. Her follow up appointment on March 10, 2014 reported no change in her condition. Her medications were refilled, she was referred to physical therapy, and she was released to light duty which the Respondent accommodated. Under the "objective" section of the physical therapy evaluation of March 17, 2014, it shows "numbness/tingling: LE and buttocks into legs." She had tenderness at all levels of her back, as well as her bilateral "gluts."

At her March 24, 2014 follow up, it was noted she had severe pain after the one physical therapy session and had not returned, although she continued to work light duty. An MRI was scheduled. She did have another physical therapy session on March 27, 2014. The MRI was done on April 1, 2014, which was read as "near normal," except for a minimal disc bulge at L4-5.

Upon her return to Karen Hummel on April 2, 2014, she reported that Respondent had terminated her for unexcused absences. Her neck pain was significantly improved. The therapist had cancelled physical therapy, but Karen Hummel re-ordered it.

On April 16, 2014, the Petitioner continued to complain of low back pain with a 6 out of 10 rating. It is again noted she had no prior history of back problems. She was referred to Dr. Kovalsky and ordered to continue physical therapy. (PX 1).

Dr. David Robson examined the Petitioner at the Respondent's request on May 14, 2014. She reported that her predominant symptom was her low back that radiates into the posterior aspect of both her legs.

His cervical spine exam revealed reduced range of motion and positive Hoffman's sign in her right hand but no muscle spasm. His lumbar spine exam was negative. There was no specific indication of sacroiliac joint testing. He diagnosed disc bulging at L4-5, L5-S1, and neck pain. He felt the March 14, 2014 injury was the aggravating factor for both diagnoses. The Petitioner was not at MMI, and he recommended a cervical spine MRI and L5-S1 epidural steroid injection. (RX 2.)

Petitioner saw Dr. Kovalsky on June 18, 2014. Dr. Kovalsky's physical exam revealed low back pain at the lumbosacral junction, as well as the bilateral sacroiliac joints. Fortin's finger test, thigh thrust, and Patrick's/Faber's tests were positive bilaterally. Gaenslen's and pelvic distraction and compression tests were mildly positive. She had equivocal straight leg testing bilaterally at 90 degrees. Her strength and sensation were normal from L3 to S1, as was her neurological exam. She had mild decreased motion in the lumbar spine, reaching 4-5 inches off the floor before having pain at the lumbosacral junction with some radiation into the SI

joints. She had mild lumbar muscle spasm. She had no Waddell's signs or evidence of symptom magnification. She had a positive Spurlings test on her c-spine with no neurological deficits. She had moderate cervical muscle spasms. X-rays of her lumbar spine were negative. He diagnosed the Petitioner with acute lumbosacral contusion, bilateral SI joint dysfunction, and left cervical radiculopathy with cephalgia. He recommended a cervical spine MRI. He recommended physical therapy for her low back and SI joints. He prescribed Prednisone, Mobic, Tramadol, and Zanaflex. (PX 3.)

Petitioner has seen Dr. Kovalsky regularly until November 6, 2015. (PX 3A.) Dr. Kovalsky performed physical exams throughout the Petitioner's treatment, and she continually had positive tests for SI joint dysfunction. Other pertinent treatment has been epidural steroid injections at L4-5 and two at C5-6. Petitioner testified these shots improved her pain. In fact, her neck pain was completely resolved. (T. 17-18.) She also had a left SI joint injection and two right-sided SI joint injections. Petitioner testified the left-sided injection improved her pain by 75 percent for a few weeks. (T. 16-17.) She testified the first right-sided injection improved her pain by 80 percent for a few weeks. (T. 18.) Dr. Kovalsky has been recommending an SI joint fusion since February 19, 2015.

Respondent had Dr. Robson do a records review only on April 7, 2015. He felt the SI joint fusion surgeries being recommended were unwarranted and not related to the March 1, 2014 accident. He felt the Petitioner was at MMI. (RX 3.)

Petitioner testified PX 6 was accurate in that she was hired by the Respondent on September 9, 2013 and the gross and overtime wages appeared to accurately represent her earnings while employed with the Respondent. She testified overtime was mandatory.

The Petitioner testified that her first employment following her termination was with Vintage Support Group (VSG) on April 24, 2015.

CONCLUSIONS OF LAW

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

Dr. Kovalsky testified that statistically more people will have lumbar radiculopathy with buttocks and leg pain than those with sacroiliac joint pain. Therefore, he wants to make sure there is no significant evidence of lumbar radiculopathy. (PX 4, p. 11.) He repeatedly testified SI joint dysfunction is a diagnosis of exclusion. He testified that absent high speed trauma with SI joint disruption, anatomical studies, such as x-rays, MRIs, CT scans, etc., do not reveal SI joint dysfunction. (PX 4, p.13.) He testified he agreed with the radiologist's reading of the Petitioner's lumbar spine MRI; that it was near normal in that it showed only some minor degenerative changes. (PX 4, p. 19.) He testified he wants to see at least 3 out of 5 positive, provocative SI joint tests following his physical exam. (PX 4, p. 11.) He testified that following his first visit of June 18, 2014, clinically, she had bilateral SI joint dysfunction based upon his physical exam findings, no real clinical evidence of radiculopathy, and negative films. (PX 4, p. 11.) Therefore, he needed diagnostic injections of the low back and SI joints to confirm his clinical diagnosis. (PX 4, p. 21.)

He testified the epidural steroid injection at L4-5 done in October of 2014 gave only short-term relief of pain but did not help the Petitioner's buttock or leg pain on either side (PX 4, p. 20), which gave credence to the

SI joint dysfunction diagnosis. He testified the left SI joint injection provided 50 percent relief, which was consistent with the SI joint being the pain generator. (PX 4, p. 25.) The Petitioner testified she got 75 percent relief. (T. 17.)

He testified the right SI joint injection gave her 100 percent relief, again making SI joint dysfunction the most likely diagnosis. (PX 4, p. 27.) The Petitioner testified she got 80 percent relief.

He testified that based on no history of SI joint symptoms prior to March 1, 2014, negative imagining studies, repeated positive physical exam findings, and one confirmatory injection on the left and two on the right, the Petitioner's bilateral SI joint pain is a direct result of the March 1, 2014 accident. (PX 4, pp 34-36.)

He further testified the Petitioner meets all the criteria to have SI joint fusion surgery. That is, symptoms greater than 6 months, pain greater than 5 (out of 10), pain improved over 50 percent with injections, and failed conservative treatment. (PX 4, p. 38.)

Dr. Robson testified the March 1, 2014 accident caused disc bulging at L4-5 and L5-S1 and her neck pain. (RX 4, p. 9.) He testified that at the time of his May 14, 2014 IME he had recommended further evaluation of her neck, including an MRI, and an epidural steroid injection at L5-S1, because he felt that most related to her buttock and posterior leg pain. (RX 4, p. 10.)

He testified following his April 7, 2015 records review he felt she had a small amount of foraminal encroachment at C5-6, which would account for her neck, shoulder, and arm symptoms. (RX 4, pp 12-13.)

He testified, as did Dr. Kovalsky, that the minimal improvement following the L4-5 injection performed by Dr. Kovalsky shows that L4-5 was not generating her symptoms. (RX 4, p. 14.) He did not feel injections or surgery to the SI joints was necessary because he had no basis to diagnose SI joint dysfunction. (RX 4, p. 17.) He testified he did do Patrick's/Faber testing but did not list it in his report. (RX 4, p. 23.) He testified he did palpate her SI joints. (RX 4, pp 22-23.) He testified where his report said he palpated the lumbosacral spine, that included the SI joints. (RX 4, pp 23-24.) He admitted SI joint dysfunction is a clinical and injection-based diagnosis. (RX 4, p. 32.) He admits absent severe trauma or psoriatic arthritis imaging studies are useless. (RX 4, p. 33.)

Regarding the SI joint, both Dr. Kovalsky and Dr. Robson agreed the diagnosis of SI joint dysfunction is primarily a clinical diagnosis. Dr. Kovalsky's physical examinations were very thorough and done repeatedly during the Petitioner's treatment with him. Both doctors further agreed that imaging studies are not helpful in diagnosing SI joint dysfunction absent significant trauma or significant and unusual arthritis. Both doctors further agreed that injections are also necessary to the diagnostic process of SI joint dysfunction.

The Arbitrator finds the opinions and testimony of Dr. Kovalsky more persuasive than those of Dr. Robson. Based on the foregoing, and the record as a whole, the Arbitrator finds the Petitioner's current condition in her bilateral SI joints, neck, and low back is causally related to her accident of March 1, 2014.

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

The Arbitrator further finds the treatment provided to date has been reasonable and necessary. The Arbitrator further finds the Petitioner is entitled to prospective medical treatment including, but not limited to, SI joint fusion(s), as recommended by Dr. Kovalsky.

Respondent shall pay reasonable and necessary medical services of $27,136.13, 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 treatment as recommended by Dr. Kovalsky, as provided in Sections 8(a) and 8.2 of the Act.

Issue (G): **What were Petitioner's earnings? Average weekly wage**
Issue (L): **What temporary benefits in dispute? Temporary total disability**

On the Request for Hearing, the Petitioner alleged her average weekly wage is $758.21. The Respondent disputes claiming the Petitioner's average weekly wage is $616.45.

Both parties submitted Petitioner's wage statement into evidence. (PX 6, RX 1, p. 2.) Petitioner began her employment on September 9, 2013, and her first pay period ended on September 15, 2013. The Arbitrator notes that the small amount of earnings, $291.21, coincides with a start date of September 9, 2013. The Arbitrator further notes the last pay period is February 28, 2014. The day before Petitioner's date of injury of March 1, 2014. Petitioner's gross straight time earnings were $15,234.93. The Petitioner's gross overtime earnings were $5,209.30, not $15,234.93, as shown on Petitioner's Exhibit 6. Petitioner's un-rebutted testimony indicates that overtime was mandatory and paid at ($23.22), one and one half times her normal hourly earnings rate of $15.48. The Arbitrator notes that Petitioner worked overtime in all but two of the pay periods during her employment with Respondent. Therefore, the Arbitrator finds the Petitioner's overtime was both mandatory and regular and therefore her overtime earnings should be included, at the straight time rate, in the Petitioner's gross earnings when calculating her average weekly wage. The Arbitrator finds $5,209.30 at straight time is $3,472.87 ($5,209.30 ÷ $23.22/hour = 224.345 hours x $15.48/hour = $3,472.87). Thus, the Petitioner's gross earnings in the year preceding the injury were $18,707.80 ($15,234.93+$3,472.87).

Section 10 of the Act provides four possible methods to calculate average weekly wage. The first two require the Petitioner to have worked for 52 weeks prior to the injury. The Arbitrator finds the third method contained in Section 10 is the appropriate method to utilize in this case. The third method of Section 10 provides:

> When 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.

Here, the Arbitrator finds the Petitioner worked 24 5/7 weeks of the 52 weeks preceding the accident,

September 9, 2013 through February 28, 2014, the day prior to the accident. The Arbitrator find the Petitioner's average weekly wage is $756.97 ($18,707.80 ÷ 24 5/7 (24.714) = $756.97)).

The parties agree that Petitioner's period of incapacity was March 2, 2014 through March 9, 2014 and from March 25, 2014 through April 23, 2015. Respondent disputed only its liability for benefits based upon causal connection. Based upon the foregoing, including the Arbitrator's findings with regard to issue F, and the record taken as a whole, the Arbitrator finds Petitioner is entitled to temporary total disability benefits for 57 4/7 weeks from March 2, 2014 through March 9, 2014 (1 1/7 weeks) and from March 25, 2014 through April 23, 2015 (56 3/7 weeks).

Respondent shall pay Petitioner temporary total disability benefits of $504.65/week for 57 4/7 weeks, commencing March 2, 2014 through March 9, 2014 (1 1/7 weeks) and March 25, 2014 through April 23, 2015 (56 3/7 weeks), as provided in Section 8(b) of the Act. Respondent shall be given a credit of $22,603.86 for temporary total disability benefits that have been paid.

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

MAUREEN LYNCH,

Petitioner,

17IWCC0070

vs.

NO: 10 WC 37691

LOYOLA UNIVERSITY MEDICAL CENTER,

Respondent.

DECISION AND OPINION ON REVIEW PURSUANT TO SECTION 19(h) and SECTION 8(a) PETITION

On February 19, 2014, an arbitration decision was filed with the Commission in which it was found Petitioner's lumbar complaints and chronic depression to be causally related to her compensable August 10, 2009, workplace accident. The same arbitration decision found Petitioner had failed to prove that her neurogenic bladder was causally related to the same August 10, 2009, workplace accident. Petitioner timely filed a Petition for Review of Arbitration Decision with the Commission on September 5, 2014. Concurrent with her filing of her Petition for Review of Arbitration Decision, she also filed a Petition for Review under Section 19(h) and Section 8(a) of the Act. During the pendency of her Petition for Review of Arbitration Decision, her Petition for Review under Section 19(h) and Section 8(a) of the Act was stayed.

The Commission, on August 18, 2016, unanimously affirmed and adopted the February 19, 2014, arbitration decision. In so doing, the Commission concluded Petitioner's lumbar complaints and chronic depression were causally related to her August 10, 2009, workplace accident but her neurogenic bladder condition was not. No appeal was taken of the Commission's August 18, 2016, Decision and Opinion on Review. As a matter of law, therefore, Petitioner's neurogenic bladder condition is unrelated to her August 10, 2009, workplace accident.

The Petition for Review under Section 19(h) and Section 8(a) was heard by the

17IWCC0070

Commission on December 13, 2016. At that time, it was argued that Petitioner's neurogenic bladder condition had worsened since February 19, 2014. This condition was the only one that was addressed on December 13, 2016. The Commission, again, notes Petitioner did not appeal the February 19, 2014, arbitration decision that found Petitioner's neurogenic bladder condition to be unrelated to her August 10, 2009, workplace accident. The Commission is precluded from entertaining Petitioner's claim to the contrary.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition for additional benefits for an alleged worsening of her condition and additional medical care under Section 19(h) and 8(a) is denied.

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: FEB 7 - 2017
KWL/mav
O: 12/13/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

☐ 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

CHRIS RICHARDS,

Petitioner,

vs.

17IWCC0071

NO: 09 WC 32064

MARK LEMP HOME IMPROVEMENT &
STATE TREASUER EX OFFICIO CUSTODIAN
OF THE IWBF,

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

The Commission modifies the Decision of the Arbitrator only to the extent that the benefit awarded Petitioner under Section 8(e) of the Act is increased to 25% loss of use of the left hand.

The Decision of the Arbitrator correctly recounted the medical treatment Petitioner received as a result of his accident as well as many of Petitioner's residual complaints, but it failed to address the residual complaints that continue to negatively impact Petitioner's left hand. As a result of his compensable accident, Petitioner has diminished grip strength, decreased tactile accuracy and cannot fully close his left hand. Petitioner, a carpenter at the time of accident and now an automobile mechanic, now uses his right hand more often to perform tasks he would otherwise perform with his left hand but for the residual effects from his work accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to

17IWCC0071

Petitioner the sum of $433.33 per week for a period of 3-5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $390.00 per week for a period of 51.25 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 25% loss of use of the left hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay for medical services as contained in Petitioner's Exhibits 1 through 4 as provided in Sections 8(a) and 8.2 of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider – including the Illinois Department of Health and Family Services – and shall provide payment information to Petitioner relative to any credit due.

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 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 Section4(d) of the Act. In the event Respondent fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefit paid due and owing Petitioner pursuant to Section 5(b) and 4(d) of the Act. Respondent shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent that are paid to Petitioner from the Illinois Workers' Compensation Fund.

DATED: FEB 7 - 2017
KWL/mav
O: 01/10/17

Thomas J. Tyrrell

Michael J. Brennan

DISSENT

I respectfully dissent from the decision of the majority. I would affirm Arbitrator Rowe-Sullivan's thorough and well-reasoned decision in its entirety and without modification.

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0071

RICHARDS, CHRIS
Employee/Petitioner

Case# **09WC032064**

MARK LEMP HOME IMPROVEMENT & STATE TREASURER EX OFFICIO CUSTODIAN OF THE IWBF
Employer/Respondent

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

If the Commission reviews this award, interest of 0.39% 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:

2333 WOODRUFF JOHNSON & PALERMO
LEANDRO ALHAMBRA
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

0000 MARK LEMP HOME IMPROVEMENTS
8705 PARKDALE
CASEYVILLE, IL 62231

4948 ASSISTANT ATTORNEY GENERAL
WILLIAM H PHILLIPS
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

17IWCC0071

Chris Richards
Employee/Petitioner

v.

Mark Lemp Home Improvement & State Treasurer *Ex Officio* Custodian of the IWBF
Employer/Respondent

Case # **09** WC **32064**

Consolidated cases: **n/a**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **June 22, 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 **IWBF Liability**

FINDINGS

On **February 19, 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 **$33,800.00**; the average weekly wage was **$650.00**.

On the date of accident, Petitioner was **29** years of age, ***single*** with **3** dependent children.

The parties stipulated at the time of hearing that Respondent paid **$0** in TTD, **$0** in TPD, **$0** in maintenance, **$0** in non-occupational indemnity disability benefits, and **$0** in other benefits, for which credit may be allowed under Section 8(j) of the Act.

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$433.33**/week for **3 5/7 weeks** for the timeframe of February 19, 2009 through March 16, 2009, as provided in Section 8(b) of the Act.

Respondent shall pay for medical services as contained in Petitioner's Exhibits 1 through 4 as provided in Sections 8(a) and 8.2 of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider – including the Illinois Department of Healthcare and Family Services -- and shall provide payment information to Petitioner relative to any credit due.

Respondent shall pay Petitioner the sum of **$390.00/week** for a further period of **41 weeks**, as provided in Section 8(e) of the Act, because the injuries caused **20% loss of use of the left hand.**

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

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

17IWCC0071

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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

8/5/16
Date

ICArbDec p. 2

AUG 8 - 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

17IWCC0071

Chris Richards
Employee/Petitioner

Case # **09** WC **32064**

v.

Consolidated cases: **N/A**

Mark Lemp Home Improvement & State Treasurer
***Ex Officio* Custodian of the IWBF**
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he lives in Caseyville and was employed by Mark Lemp Home Improvement on February 19, 2009. He testified that Mark Lemp Home Improvement did remodeling, roofing and siding, and that they were located on Parkdale Drive in Caseyville, Illinois. He testified that he worked full-time as an installer/laborer, and did roofing, siding, basic home remodeling and exterior work.

Petitioner testified that he began working for Mark Lemp Home Improvement in April of 2007, and that he had a brief interview with Mark Lemp, the owner. He testified that his supervisor was Mr. Lemp, who was also the owner. He testified that he typically started work at 7:00 a.m. Monday through Friday and worked Saturdays as needed, and that Mr. Lemp set the hours. He testified that they did not clock in and out, but that Mr. Lemp would monitor their hours and that Petitioner would keep his own personal time sheet.

Petitioner testified that projects were assigned through Mr. Lemp, and that they would know which project they were working on when they met in the morning to start a new job. He testified that they would be assigned to an address and given work orders, and that Mr. Lemp would start the job and monitor. He testified that they would meet Mr. Lemp at his residence on Parkdale. He testified that Mr. Lemp would accompany them to the jobs and would be there every day in the morning, would be in and out and then would return in the evening to wrap up. He testified that Ricky Rider was more like a foreman and that Mr. Lemp would do the main supervising, and that any questions about the job went through Mr. Lemp.

Petitioner testified that the equipment they typically used included ladders, saws and drills, which Mr. Lemp provided. He testified that the materials provided for the job were provided by Mr. Lemp, and that he owned the work trucks that were provided. He testified that the work trucks were parked at Mr. Lemp's residence, and that they would pick up the work trucks in the morning and targeted getting to the job at 7:00 am. He testified that when they were done for the evening, the trucks would go back to Mr. Lemp's residence.

Petitioner testified that if he needed to take a day off, he had to get approval from Mr. Lemp. He testified that he and the others met with Mr. Lemp at his residence, that they typically worked Monday through Friday, and that if the end of the week came and they were in the middle of a job, they would work the weekend. He testified that once a project was done they typically knew which project to do next

based on the work orders, and that bidding on projects was done by Mr. Lemp. He testified that he worked on average a minimum of 40 hours per week and that he was paid in cash weekly every Friday. He testified that his hourly rate of pay was $16.25, and that he earned the same hourly rate for the 52 weeks prior to the accident.

Petitioner testified that on February 19, 2009, he was working for Mark Lemp Home Improvement and it was the first day on that particular job. He testified that they got there around 7:00 a.m., and that it was a roofing job on a residential home in Granite City. He testified that he and 5 others set up ladders and tore the roof off, and that there was a piece of wood that needed to be replaced. He testified that he and Terry Jones, a co-worker, were replacing the bad wood in order to get the new shingles started, and that Mr. Jones was cutting a piece of wood and asked him to hold it. He testified that he was cutting away from him, and that the saw "kicked back" and cut the top of his left hand. He testified that it was an electric circular saw.

Petitioner testified that he immediately noticed that he had a very bad cut on his left hand. He testified that a co-worker, Ricky Ryder, told him to get into the truck and took him to the closest hospital in Granite City. He testified that Ricky Ryder was like a supervisor and had more seniority. He testified that he did not personally notify Mr. Lemp about the accident, but he must have been notified by someone because he showed up at the hospital that day to see him before he had surgery.

Petitioner testified that he was seen at Gateway Medical Center on February 19, 2009, and that Dr. McKee performed surgery. He testified that he stayed overnight at the hospital but was discharged the next day. He testified that Dr. McKee took him off work at that time and that he followed up on February 24th, at which time he was placed in a splint. He testified that Dr. McKee indicated that he could do light duty, one-handed work at that time and that he notified Mr. Lemp about the restrictions, but he was not able to provide work.

Petitioner testified that he next saw Dr. McKee on March 2nd, at which time the sutures were removed and he was referred to physical therapy for his hand. He testified that that he had therapy at Memorial Hand Therapy Center and had five sessions from March 6th through March 19th. He testified that he last saw Dr. McKee for his left hand on March 16, 2009, at which time the pins were removed and x-rays were taken. He testified that he was also given a full duty release, but denied returning to work for Mr. Lemp.

Petitioner testified that his medical bills were paid through Public Aid and that he was not getting any bills. He denied having any problems prior to February 19, 2009 with his left hand and testified that he is right-handed. He testified that since the accident, he has lost grip strength and cannot close his hand all the way. He testified that his index finger sticks up if he makes a fist. He testified that the knuckle on the left index finger sits back further and that he has numbness across the scar. He testified that he has tenderness and that he also has numbness across the scarring on the knuckle.

Petitioner testified that he is currently working as a mechanic at Thorpe's Corvette Shop in O'Fallon. He testified that he does not have as much grip strength with his left hand, so he is more likely to use his right hand to grip tools.

On cross examination, Petitioner testified that he uses pneumatic tools and turns wrenches. He testified that he does some heavy lifting. He testified that he was not able to perform the duties to his full capabilities due to the loss of grip strength. He testified that he is right-handed.

On cross examination, Petitioner agreed that he testified that he was paid in cash and further testified that there were no taxes withheld from his checks. He denied having a uniform. He testified that

there was always work but it was seasonal, and that they would not work if it was raining or snowing badly. He testified that that he did not recall any periods where there were not any jobs.

On cross examination, Petitioner agreed that he received treatment for his injuries from February 19th through March 16th of 2009. He denied having any treatment after 2009. He denied taking any medications or wearing any kind of brace for his hand.

The Medical Bills Exhibit for Dr. McKee was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The Medical Bills Exhibit for Gateway Medical Center was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The Medical Bills Exhibit for Anderson Hospital was entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The Medical Bills Exhibit for Memorial Hand Therapy was entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The IHFS/Public Aid Lien Documentation was entered into evidence at the time of arbitration as Petitioner's Exhibit 6.

The medical records for Memorial Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. Petitioner was seen on March 6, 2009 for an initial evaluation for hand therapy. It was noted that the onset date/injury date was that of February 19, 2009, at which time Petitioner was injured when a circular saw cut through his hand. It was noted that Petitioner reported that he hit his hand on a fan the night prior. The Outpatient Discharge Summary dated August 10, 2009 noted that Petitioner failed to return for treatment and was seen for the dates of service of March 3, 2009 to March 26, 2009. It was noted that Petitioner was a no call/no show on March 3rd, 23rd and 26th. (PX7).

The medical records for Gateway Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The Discharge Summary noted that Petitioner was admitted on February 19, 2009 with an admitting diagnosis of saw injury to the left dorsal hand. It was noted that the surgical procedure performed was that of open reduction/internal fixation of the second metacarpal, bone grafting to the third metacarpal, repair of the extensor tendon to the second and third digits and repair of the radial collateral ligament to the second. The interpretive report for x-rays of the left hand revealed fractures of the second and third metacarpal bones. The Initial Assessment Form noted that while at work a power saw slipped and cut Petitioner across the volar surface of the left hand, and that the left hand had a large laceration and was bleeding. It was noted that Petitioner complained of numbness and a decreased ability to use his left index finger. (PX8).

The medical records for Dr. Craig McKee were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. Petitioner was seen on February 24, 2009, at which time it was noted that he had repair of extensors two and three over the metacarpals and pinning and bone graft to the 2nd and some bone graft to the 3rd on the left hand, and that there were no signs of infection. Petitioner stated that the pain was subsiding and he was placed in a two finger extension splint. At the time of the March 2, 2009 visit, sutures were removed. At the time of the March 16, 2009 visit, it was noted that the pins had remained stable, that Petitioner was working with therapy at Memorial and that they were making some progress with limbering the fingers. It was noted that Petitioner had bumped his hand and went to the ER in Sparta and was given a prescription for Keflex, but he did not fill it. The records reflect that two pins were removed on that date without difficulty. The records reflect that Petitioner was a no call/no show for the March 30th and April 3rd visits. (PX9).

The Certificate of Non-Compliance was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The Notice of Hearing sent to Respondent on June 16, 2016 was entered into evidence at the time of arbitration as Petitioner's Exhibit 11. The Notice of Motion & Order sent to Respondent on April 25, 2016 was entered into evidence at the time of arbitration as Petitioner's Exhibit 12.

CONCLUSIONS OF LAW

With respect to disputed issues (A) through (E), given the commonality of facts and evidence relative to those issues, the Arbitrator addresses those concurrently.

The Arbitrator finds that Respondent was operating under and subject to the Illinois Workers' Compensation Act, that there was an employee-employer relationship, that an accident occurred that arose out of and in the course of Petitioner's employment by Respondent Mark Lemp Home Improvement on February 19, 2009, that timely notice of the accident was given to Respondent Mark Lemp Home Improvement and that Petitioner's condition of ill-being is causally related to the accident in light of the unrebutted testimony of Petitioner and the medical records in Petitioner's Exhibits 7-9 as entered into evidence at the time of arbitration.

With respect to disputed issue (F), the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the injury in light of the medical records entered into evidence at the time of arbitration. (PX7; PX8; PX9). The Arbitrator notes that the medical records recorded a similar history as testified to by Petitioner at the time of arbitration, and that Petitioner ultimately underwent surgery for the injuries sustained to the left hand on February 19, 2009. As a result thereof, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the accident of February 19, 2009.

With respect to disputed issue (G) pertaining to average weekly wage, the Arbitrator finds that Petitioner's earnings during the year preceding the injury were $33,800.00 and that the average weekly wage, calculated pursuant to Section 10 of the act, was $650.00 based upon the unrebutted testimony of Petitioner at the time of arbitration.

With respect to disputed issue (J) pertaining to medical services, the Arbitrator finds that the medical services that were provided to Petitioner were reasonable and necessary in light of the injuries sustained. The Arbitrator further finds that Respondent has not paid all appropriate charges for all reasonable and necessary medical services, but rather that the Illinois Department of Healthcare and Family Services ("IHFS") paid for the treatment rendered to Petitioner in this case. That said, Respondent shall hold Petitioner harmless for all amounts paid by IHFS as reflected in Petitioner's Exhibit 6 for the reasonable, necessary and causally related medical bills as reflected in Petitioner's Exhibits 1-4.

With respect to disputed issue (K) pertaining to temporary total disability benefits, the Arbitrator notes that Petitioner seeks temporary total disability benefits from February 19, 2009 through March 16, 2009. (AX1). Petitioner testified at the time of arbitration that he underwent surgery on February 19, 2009 at which time Dr. McKee took him off work, that he followed up with Dr. McKee on February 24th at which time he was placed in a splint and was placed on light duty restrictions related to which he notified Mr. Lemp but further testified that his restrictions were not accommodated, and that Petitioner failed to return to Dr. McKee after the visit of March 16, 2009. (PX9). As such, the Arbitrator finds that Petitioner attained maximum medical improvement for the injuries sustained as of March 16, 2009. Therefore, the Arbitrator finds that Respondent shall pay temporary total disability benefits for a period of 3 5/7 weeks for the timeframe of February 19, 2009 through March 16, 2009, given the Arbitrator's findings with respect to disputed issues (C) and (F).

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, the Arbitrator notes that the injuries occurred before September 1, 2011 as it pertains to Section 8.1b of the Act. The Arbitrator notes that Petitioner testified at the time of arbitration testified that he does not have as much grip strength with his left hand, that he cannot close his hand all the way and that his index finger sticks up if he makes a fist, that the knuckle on the left index finger sits back further, that he has numbness across the scar and that he has tenderness. The records reflect that Petitioner underwent open

reduction/internal fixation of the second metacarpal, bone grafting to the third metacarpal, repair of the extensor tendon to the second and third digits and repair of the radial collateral ligament to the second. (PX8). Based on the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of 20% loss of use of the left hand under Section 8(e) of the Act.

With respect to disputed issue (O) pertaining to IWBF liability, the Arbitrator notes that the Illinois State Treasurer, *ex-officio* custodian of the Injured Workers' Benefit Fund, was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. The Certificate of Non-Compliance was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. (PX10). In light of the foregoing, the award is hereby entered against the IWBF to the extent permitted and allowed under Section 4(d) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF ROCK ISLAND)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Doris Mathis,

Petitioner,

vs.

NO: 14WC 21191

17IWCC0072

Vaughan & Bushnell,

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, notice, 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 October 20, 2015, 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.

17IWCC0072

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,000.00. 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: FEB 8 - 2017

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

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CJD/rlc
049

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

MATHIS, DORIS
Employee/Petitioner

Case# **14WC021191**

17IWCC0072

VAUGHAN & BUSHNELL
Employer/Respondent

On 10/20/2015, 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 0.11% 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:

4707 LAW OFFICE OF CHRIS DOSCOTCH
DAMON YOUNG
2708 N KNOXVILLE AVE
PEORIA, IL 61694

0264 HEYL ROYSTER VOELKER & ALLEN
DANA J HUGHES
PO BOX 6199
PEORIA, IL 61601-6199

STATE OF ILLINOIS)
)SS.
COUNTY OF Rock Island)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

17IWCC0072

DORIS MATHIS
Employee/Petitioner

v.

VAUGHAN & BUSHNELL
Employer/Respondent

Case # 14 WC 21191

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 **GREGORY DOLLISON**, Arbitrator of the Commission, in the city of **Rock Island, Illinois**, on **July 8, 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. ☒ 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 _____

17IWCC0072

FINDINGS

On the date of accident, **November 1, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$29,408.60**; the average weekly wage was **$565.55**.

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $2,795.00, as provided in Section 8(a) and 8.2 of the Act. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and provide documentation with regard to said fee schedule payment calculation to Petitioner.

Respondent shall authorize the medical treatment as prescribed by Dr. Barnhart which includes bilateral carpal tunnel surgery and bilateral thumb injections.

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

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

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

Signature of Arbitrator

10/13/15
Date

ICArbDec19(b)

OCT 20 2015

Attachment to Arbitrator Decision
(14 WC 21191)

STATEMENT OF FACTS:

17IWCC0072

Petitioner testified she was an employee of Respondent for 21 years. Petitioner stated she worked on the pack line, commonly called the "box girl". Petitioner stated Respondent produces hammers and it was her job to box them and get them ready for shipping.

Petitioner testified she did multiple job duties. Petitioner stated she had to stamp boxes, label boxes, place hammers in boxes, build boxes, and place them in tape machines. Petitioner had to move racks and place labels on hammers, move racks and lacquer hammers, put sleeves on hammers, put them in a shrink wrap machine, and load boxes which were anywhere from 2 to 30 lbs. on pallets. Petitioner also had to get boxes off shelves and organize and count them. Petitioner had to trim grips on hammers. Petitioner also stated the boxes she had were connected and she had to pull them apart which took a lot of effort. She did approximately 1 to 300 boxes per day. Petitioner stated she had to place rubber guards on hatchets, which was very difficult, and she had to do this around 300 times per day. Petitioner testified her job tasks took about 15 to 30 seconds to complete. The number of boxes and hammers she handled varied per day based on the type and numbers ordered by customers.

Respondent placed into evidence a job duties DVD as Respondent's Exhibit #1. Petitioner testified at trial the video was accurate in what it depicted, but it was a very short snippet, about 11 minutes, out of an 8 hour work day. Petitioner also testified the video did not show certain job duties she had to perform such as putting sleeves on hammers, pulling apart connected boxes, and placing rubber guards on hatchets.

Petitioner testified her hand numbness started in the spring of 2011. Petitioner stated this progressively got worse until November 1, 2013 when she notified her employer. A Form 45 was completed (PX 9) whereby Petitioner correlated her hand and thumb complaints to her work duties at this time. She states she notified Elmer Heikes.

Petitioner first sought medical treatment on November 22, 2013 when she saw Dr. Benjamin W. Phillips at Graham Medical Group. The doctor recorded that she was complaining of bilateral hand pain and numbness. Petitioner was suffering from numbness and tingling for the last three years in duration. Petitioner had been using carpal tunnel braces for the last year and waking up at night with pain. She was having a decrease in grip strength. (PX 2) The assessment was carpal tunnel syndrome and an EMG was recommended. (PX 2) The Arbitrator notes that Elmer Heikes from Vaughan & Bushnell Manufacturing Company sent a letter to Graham Medical Group on November 15, 2013 verifying the appointment. (PX 2)

An EMG was performed at IPMR on January 17, 2014. (PX 3) The findings were compatible with moderate bilateral medial nerve compression neuropathy at the wrist on the right and borderline slowing of the left ulnar motor nerve across the elbow. (PX 3)

Petitioner next followed up with Dr. Phillips on January 28, 2014. Dr. Phillips noted Petitioner failed wearing braces and referred Petitioner to Dr. Barnhart for further management. He recommended wearing wrist splints nightly. (PX 2)

On February 7, 2014, Petitioner followed up with Dr. Barnhart. Dr. Barnhart took a history of Petitioner working at Vaughan & Bushnell Manufacturing in Bushnell, Illinois. She worked there for 20 years in the same position on the pack line. Dr. Barnhart noted she worked 40 hours per week and she tore apart boxes by hand,

unroll and labels boxes and folded them over and flipped them around and tapes them. Dr. Barnhart also noted Petitioner processed about 800-1200 boxes per 8 hour shift. (PX 2) After an exam, the assessment was bilateral media nerve entrapment and bilateral osteoarthritis generalized to the hand and bilateral thumb arthritis. Dr. Barnhart recommended right carpal tunnel release and left carpal tunnel release four weeks later. Dr. Barnhart also performed bilateral CMC joint injections in the thumbs. (PX 2)

Petitioner next followed up with Dr. Barnhart on July 11, 2014. Dr. Barnhart noted he had recommended carpal tunnel release, but it was denied by workers' compensation. Dr. Barnhart noted Petitioner brought in a box and demonstrated how she folded boxes at work. Dr. Barnhart noted Petitioner held her wrist in a mostly flexed position and was gripping and twisting in a flexed position in the process. She informed Dr. Barnhart she folds over 200-300 of the boxes in a shift and also labels and packed items. The doctor noted, "She certainly does have activities at her job which seem that they would contribute to her CTS…"(PX 2)

Dr. Barnhart's evidence deposition was taken on June 15, 2015. (PX 7) Dr. Barnhart testified he was a Board Certified Orthopaedic Surgeon. As part of his practice, he performs carpal tunnel surgeries and this is probably one of the three most common surgeries he performed. (PX 7, pg 5) Dr. Barnhart stated he took a history of Petitioner working for Respondent for over 20 years and had been working mainly the same position over that time period. It was his understanding she worked on the pack line and worked about 40 hours per week. (PX 7, pg 8) He stated he understood Petitioner tore apart and assembled boxes by hand. She unrolled labels, folded them over and flipped them around taped boxes. Dr. Barnhart stated it is his understanding she did this from 800-1200 times per 8 hour shift. (PX 7, pg. 8) Dr. Barnhart also testified Petitioner brought in a box and demonstrated in the office how she folded and shaped the box in his office. (PX 7, pg. 11)

Dr. Barnhart testified after doing a physical examination and reviewing the EMG findings, it was his opinion Petitioner had bilateral carpal tunnel syndrome and recommended a bilateral carpal tunnel release. (PX 7, pg. 11) Dr. Barnhart also diagnosed Petitioner with degenerative joint disease in the thumb, carpal/metacarpal joints bilaterally in which he performed injections. (PX 7, pg. 9) Dr. Barnhart stated he would recommend a repeat of the injections in the bilateral thumbs. (PX 7, pg. 12) Dr. Barnhart also viewed Respondent's Exhibit #1, the job duties DVD. (PX 7, pg. 14)

Dr. Barnhart testified that based on taking a history from Petitioner, having Petitioner demonstrate how she folded boxes in his office, and reviewing the video of her job duties he testified to a reasonable degree of medical certainty Petitioner's bilateral carpal tunnel and bilateral thumb condition was related to her work duties. (PX 7, pg. 15) Dr. Barnhart noted from what he had seen in the job duties DVD, a good portion of the activities involved wrist flexion, pronation, opposition of the fingers in association with the wrist and pronation. He stated according to the DVD, very little of Petitioner's work duties are spent in the neutral position. (PX 7, pg. 15) Dr. Barnhart stated even though the job duties changed during the work shift, each job duty on its own was very hand intensive. (PX 7, pg. 17)

Respondent had Petitioner seen by Dr. Williams for a Section 12 examination. Dr. Williams' evidence deposition was completed on June 17, 2015. Dr. Williams testified he was a Board Certified Orthopaedic Surgeon. (RX 2, pg. 6) Dr. Williams testified he saw Petitioner for an Independent Medical Examination in March 2014. Dr. Williams took a history from Petitioner of her working at Vaughan & Bushnell Manufacturing since May, 1994 and did the same job since she was hired working the pack line. (RX 2, pg. 10) He stated Petitioner told him her job involved doing 2000-4000 hammers per day. Dr. Williams took a very specific work history from Petitioner which entailed pulling boxes apart, labeling, placing hammers in boxes, and folding boxes. (RX 2, pgs. 11-12) Dr. Williams also stated he reviewed a job duties DVD. This DVD depicted Petitioner performing her job duties for the Respondent. (RX 2, pg. 13) Dr. Williams stated the DVD did demonstrate the job duties she did at work, but the video wasn't long enough in comparison to her work shift. (RX 2, pg. 13) Dr. Williams testified he reviewed the medical records from Dr. Phillips and Dr. Barnhart. He

also reviewed the EMG/NCV from IPMR. (RX 2, pgs 14-21) After taking a history from Petitioner, reviewing medical treatment and job duties DVD, Dr. Williams testified, to a reasonable degree of medical certainty, that he did not feel there was a causal relationship between the job duties and Petitioner's bilateral carpal tunnel syndrome or bilateral thumb CMC joint arthritis. (RX 2, pg. 21)

Dr. Williams testified he did not feel the activities demonstrated any sustained forceful gripping, or pinching, vibration, and/or impact to the hands which was neither sustained nor repetitive in accordance with NIOSH. (RX 2 pgs. 21-22) Dr. Williams stated NIOSH is the National Institute of Occupational Safety and Health and it was a dictum which was written in regard to repetitive disorders of the upper extremity which defines different activities that would give different kinds of problems to the upper extremities and in regard to carpal tunnel syndrome and in regard to what would be considered repetitive and what would not. (RX 2, pg. 22) Dr. Williams testified the NIOSH standards for repetitive activity requires a cycle time of one single activity every 30 seconds for greater than 50% of the shift. (RX 2, pg. 22) Dr. Williams testified with respect to the bilateral thumb issues, he felt the activities did not involve any sustained forceful pinching or griping. Thus, he did not believe the arthritis in Petitioner's thumbs was related or worsened by Petitioner's work duties. (RX 2, pg. 23)

On cross examination, Dr. Williams admitted Petitioner was honest and did not exhibit symptom magnification. (RX 2, pg. 29) Dr. Williams admitted he did not know how many hours in a day she folded boxes, was unsure of how many hammers she boxed in a day, and did not know how much time she spent boxing hammers. (RX 2, pgs. 33-34) Dr. Williams stated he used the NIOSH standards in regard to his causation opinion. Dr. Williams admitted he misquoted the NIOSH standards in regard to the definition of repetitiveness. (RX 2, pg. 37) Dr. Williams admitted the exact definition for any activity to be repetitive in accordance with NIOSH is it has to be a duty you do for less than 30 seconds a cycle time or something done for at least 50% of the work shift. (RX 2, pg. 37) Dr. Williams stated he felt each job Petitioner performed took greater than 30 seconds to complete. (RX 2, pg. 39) Dr. Williams testified there were no activities which required high force. Dr. Williams admitted according to the NIOSH definition, high force was defined as any use of force greater than 6 kilograms or 13.2 pounds. Dr. Williams admitted Petitioner had to move boxes which were greater than 13.2 pounds. (RX 2, pgs. 41-44) Dr. Williams admitted NIOSH stated there is a positive association between highly repetitive work and carpal tunnel, but disagreed that Petitioner's duties were highly repetitive work (RX 2, pg. 44) Dr. Williams then seemed to discredited the NIOSH report because of the year the studies were completed indicating, "I believe much more scientific evidence has been found since NIOSH was written…" (RX 2, pg. 45)

CONCLUSIONS:

In support of the Arbitrator's decision relating to (E), Was timely notice of the accident given to Respondent? The Arbitrator finds and concludes as follows:

Petitioner testified she notified Respondent of her work accident on November 1, 2013. Also, Petitioner placed into evidence the Form 45 as Petitioner's Exhibit #9. The Form 45 demonstrates Respondent was notified within 45 days.

Contained in Petitioner's Exhibit #2 is a letter from the director of human resources for Respondent, Elmer Heikes, to Graham Medical Group scheduling the appointment for Petitioner's first medical visit for November 22, 2013. This letter was written on November 15, 2013.

Based upon Petitioner's testimony, the Form 45 and Respondent scheduling Petitioner's first medical appointment, Arbitrator finds Petitioner proved she notified Respondent within 45 days.

In support of the Arbitrator's decision relating to (C), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent? And (F), Is Petitioner's current condition of ill-being causally related to the injury? The Arbitrator finds and concludes as follows:

Petitioner testified she worked for Respondent for over 20 years performing the same job duties. Petitioner described in detail her job duties which included folding boxes, placing hammers in boxes, moving racks, placing labels on handles, placing sleeves on hammers, and loading boxes. Petitioner stated each job duty she performed took about 15 – 30 seconds to complete. Respondent placed into evidence a job duties DVD which was reviewed. Petitioner's treating physician, Dr. Barnhart, was able to review the job duty DVD. Petitioner demonstrated how she folded the boxes in Dr. Barnhart's office and he took an extensive history of Petitioner's job duties. Based upon this information, Dr. Barnhart causally connected Petitioner's bilateral carpal tunnel syndrome and her bilateral thumb arthritis to her job duties.

(The Arbitrator notes Respondent lodged a *Ghere* objection seeking to bar Dr. Barnhart's testimony regarding his causal connection opinion.

It is well established that the purpose of having the claimant's physician send a copy of his or her records to the employer no later than 48 hours prior to the arbitration hearing is to prevent the claimant from springing surprise medical testimony on the employer. *Ghere*, 278 Ill. App. 3d at 845.

As noted in *Ghere*, the employee died of a heart attack while working as a flagman for employer. The employee's doctor testified that he treated the employee on several occasions, but never treated him for heart problems. The arbitrator sustained the employer's objection to the physician's testimony concerning whether the employee's work activities or environment could or might have precipitated his heart attack because the opinions were not furnished to the employer 48 hours before the hearing. On appeal, the court found that the physician's causation opinion would have gone beyond the contents of his medical records because there was no mention of causation in the records or that the physician ever treated the employee for a heart condition. Accordingly, the court held that there was nothing in the records to put the employer on notice that the physician had an opinion regarding causation that the employer could have requested, and upheld the arbitrator's exclusion.

In *Homebrite Ace Hardware*, 351 Ill. App. 3d at 339, 814 N.E.2d at 126, the Court noted that there was no indication in *Ghere* that its holding must be so strictly interpreted. The *Ghere* court examined the physician's records and treatment history to determine whether the employer was put on notice regarding the possibility that the physician might provide causation testimony. The court did not set forth a bright-line rule or presumption that undisclosed opinion testimony constitutes surprise. The *Homebrite* court noted that in *Ghere* the physician had never treated the employee's heart condition, whereas in *Homebrite* the treating physician did treat claimant for his neck problems and his records contain details about his treatment of claimant's neck complaints and therefore the records put employer on notice that the treating physician might testify as to a causal relationship between the neck condition and claimant's work accident. The only contested issue at arbitration was claimant's cervical injury.

In the present case, Respondent in the deposition acknowledged receipt of Dr. Barnhart's records. It's clear in the doctor's records that Petitioner was being treated for her bilateral carpal tunnel and thumb conditions of ill-being. Dr. Barnhart's recorded entry of February 7, 2014 show the doctor recommended right and left carpal tunnel releases. The entry also indicates Dr. Barnhart performed bilateral CMC joint injections in the thumbs that day. As such Dr. Barnhart's records contain details about his treatment of claimant's bilateral carpal tunnel and thumb complaints and therefore the records put employer on notice that the treating physician might testify as to a causal relationship between the conditions. Furthermore, there is direct evidence of the doctor's causal connection opinion in the records when on July 11, 2014 when Dr. Barnhart wrote, "She

certainly does have activities at her job which seem that they would contribute to her CTS..." Respondent's *Ghere* objection is overruled.)

Respondent had Petitioner seen by Dr. Williams for an Independent Medical Examination. Dr. Williams took an extensive history and also viewed the work duties DVD. Dr. Williams did not causally connect Petitioner's bilateral carpal tunnel syndrome and bilateral thumb arthritis to her job duties. For the basis of his opinion, Dr. Williams relied on NIOSH standards. On cross-examination, Dr. Williams admitted the NIOSH standards exact a definition that any activity has to be a duty you do for less than 30 seconds a cycle time or something done for at least 50% of the work shift as opposed to an activity has to be a duty you do for less than 30 seconds a cycle time and something done for at least 50% of the work shift. The Arbitrator notes after viewing the job duties DVD and Petitioner's unrebutted testimony stating it takes about 15 – 30 seconds to complete each task, Arbitrator finds her job duties are repetitive. Also, the Arbitrator notes while Petitioner did not perform the same task throughout her day, she does multiple tasks which require repetitive work with extensive use of the hands and wrist extension and flexion.

Based upon this information, the Arbitrator finds Dr. Barnhart's opinion more persuasive and finds Petitioner's bilateral carpal tunnel syndrome and bilateral thumb arthritis are related to Petitioner's November 1, 2013 work accident.

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:

The findings and conclusions of Arbitrator relating to accident and causation are adopted and incorporated herein.

Petitioner introduced into evidence the following medical expenses incurred as a result of the Petitioner's November 1, 2013 work accident:

Graham Medical Group 11/22/13-7/11/14	$1,086.00
Graham Medical Group 8/29/14	$ 485.00
IPMR – EMG 1/17/14	$1,224.00
TOTALS	**$2,795.00**

Based on Arbitrator's finding relating to accident and causation, Arbitrator finds the medical treatment rendered to Petitioner in regards to bilateral carpal tunnel syndrome and bilateral thumb arthritis was reasonable and necessary and causally related to the work accident of November 1, 2013.

The Arbitrator also finds the prescribed treatment by Dr. Barnhart is reasonable and necessary and causally related medical treatment which Respondent shall authorize pursuant to Section 8(a) of the Act.

17IWCC0073

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

DAVID EAGAN,

Petitioner,

vs.

NO: 15 WC 12683

MIDWEST DRILLED FOUNDATIONS & ENGINEERING,

Respondent,

DECISION AND OPINION ON REVIEW

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

The Commission finds that the opinion of Respondent's Section 12 examiner, Dr. Cole, is most persuasive on not only Petitioner's ability to return to work full duty but also that he is not at maximum medical improvement (MMI).

Petitioner's physician, Dr. Garapati, opined on May 16, 2014, that Petitioner was at MMI but needed a functional capacity evaluation (FCE) to determine his work status. Respondent's first examiner, Dr. Tu, concurred with this opinion in his letter dated July 15, 2014. However, on September 22, 2014, Dr. Garapati noted that Petitioner was still having pain and he performed another injection in the knee. On February 27, 2015, Dr. Garapati prescribed anti-inflammatories, ice, and a counterforce strap for patellar tendinitis.

On April 29, 2015, the FCE was performed and the evaluator found that Petitioner was capable of performing at the "limited heavy" demand level, but that this did not meet the requirements of his pre-injury profession.

17IWCC0073

On May 14, 2015, Petitioner was examined by Dr. Cole who opined that Petitioner had chronic patellar tendinitis that still warranted management. He recommended a counterforce strap, Voltaren topical gel, and consideration of a platelet-rich plasma injection along with physical therapy for 4-6 weeks. Dr. Cole felt that Petitioner was not at MMI due to his continually symptomatic right knee. Despite the need for additional treatment, Dr. Cole noted that he had reviewed the FCE and, based on his examination, stated that Petitioner could work full duty without restrictions and that he had a good prognosis over the next 6-12 weeks.

On May 18, 2015, Dr. Garapati opined that, based on the FCE results, Petitioner was not able to return to his pre-injury job but could perform minimal low level work without significant heavy lifting on a chronic basis.

Although the evidence is conflicting, we find that the opinion of Dr. Cole is most persuasive in light of all of the evidence. We find that Petitioner is entitled to further medical treatment, if he so chooses, as recommended by Dr. Cole. However, based on our finding that Petitioner is capable of returning to his pre-injury job, his request for maintenance and vocational rehabilitation is denied. Therefore, we reverse the Arbitrator's award of $874.00 in vocational rehabilitation costs, prospective vocational rehabilitation, and ongoing maintenance benefits. We find that Petitioner is entitled to 78-2/7 weeks of temporary total disability benefits from November 13, 2013, through the date of Dr. Cole's examination on May 14, 2015.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,004.00 per week for a period of 78-2/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that, pursuant to the parties' stipulation, "Respondent has paid or will pay, and agrees to indemnify and hold Petitioner harmless for, all bills relating to right knee treatment for dates of service from November 11, 2013 through the August 17, 2015 date of Hearing for all medical providers (including their referrals) that were disclosed to the Respondent prior to August 17, 2015. All bills are subject to the parties respective rights under Section 8(a) and the fee schedule."

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall provide, if Petitioner so chooses, prospective medical treatment as recommended by Dr. Cole under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

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

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

17IWCC0073

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1,000.00. 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: FEB 8 - 2017

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

SE/
O: 12/14/16
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

EAGAN, DAVID
Employee/Petitioner

Case# **15WC012683**

MIDWEST DRILLED FOUNDATIONS & ENGINEERING
Employer/Respondent

17IWCC0073

On 10/16/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1505 SLAVIN & SLAVIN LLC
DAVID VANOVERLOOP
20 S CLARK ST SUITE 510
CHICAGO, IL 60603

0445 RODDY LAW LTD
PAUL KRAUTER
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

17IWCC0073

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

David Eagan
Employee/Petitioner

v.

Case # **15** WC **12683**

Consolidated cases: **N/A**

Midwest Drilled Foundations & Engineering
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Ketki Steffen**, Arbitrator of the Commission, in the city of **Chicago**, on **8/17/15**. 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 **Vocational Rehabilitation and Maintenance under Section 8(a)**

FINDINGS

On **11/11/13**, 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 **$78,312.00**; the average weekly wage was **$1,506.00**.

On the date of accident, Petitioner was **35** years of age, ***single*** with **1** dependent children.

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

Respondent has paid or will pay, and agrees to indemnify and hold Petitioner harmless for, all bills relating to right knee treatment for dates of service from November 11, 2013 through the August 17, 2015 date of Hearing for all medical providers (including their referrals) that were disclosed to the Respondent prior to August 17, 2015. All bills are subject to the parties' respective rights under Section 8(a) and the fee schedule.

Respondent shall be given a credit of **$84,686.58** for TTD and/or maintenance benefits, **$603.98** for TPD, and **$0.00** for other benefits, for a total credit of **$85,290.56**.

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 $1,004.00/week for 26-3/7 weeks, commencing 11/13/13 through 5/16/14, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of $1,004.00/week for 62-5/7 weeks, commencing 5/17/14 through 2/8/15 and 2/28/15 through 8/17/15 as provided in Section 8(a) of the Act.

Respondent shall be given a credit of $84,686.58 for temporary total disability and maintenance benefits that have been paid.

Respondent shall pay to Petitioner incurred vocational rehabilitation costs of $874.00, as provided in Section 8(a) of the Act. Request for future tuition payment is declined.

Respondent shall pay for vocational rehabilitation, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner ongoing maintenance benefits of $1,004.00/week throughout the duration of Petitioner's vocational rehabilitation, commencing 8/18/15, as provided in Section 8(a) of the Act.

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

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

Ketki S. Steffen 10/15/15

Signature of Arbitrator Ketki Shroff Steffen — Date

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OCT 16 2015

FACTUAL HISTORY

Petitioner, David Eagan, was involved in an undisputed work accident on November 11, 2013, while working for Respondent, Midwest Drilled Foundations & Engineering. Petitioner found his employment with Midwest Drilled Foundations & Engineering through his union, Local 150 Operating Engineers. On the date of the accident, Petitioner had not yet reached journeyman status with the Union, however he had completed 4-1/2 years of apprenticeship work. Petitioner testified that the job duties of an apprentice Operating Engineer vary, but include working in deep tunnel situations where there is a lot of squatting and physical demand, as well as working on an elevator or a tower crane. (Testimony of Petitioner, "TX")

On November 11, 2013, Petitioner was working in the job position of an oiler, and his specific job duties at that time were comprised of servicing machines such as cranes and drill rigs, as well as assisting operators. While in the process of servicing a drill rig on November 11, 2013, Petitioner was trying to avoid a pipe being hoisted and jumped down a 5-6 foot grade, landing on his right leg. Petitioner testified he tumbled after landing, and thereafter had difficulty standing due to pain in his right knee. Petitioner testified he had never experienced pain like that in his right knee before. (TX)

Petitioner notified his supervisor, and went to Advocate Medical Group. Petitioner was given restrictions and began a course of conservative treatment including physical therapy at Athletico. On December 23, 2013, Petitioner was referred to an orthopedic specialist due to ongoing symptoms in his right leg and was recommended to remain off work until cleared by the orthopedic specialist. (TX, Pet. Ex. 1, Pet. Ex. 2)

On the referral from Advocate Medical Group, Petitioner then began his treatment with Dr. Garapati at Illinois Bone and Joint Institute. Dr. Garapati continued the course of conservative treatment with more therapy, as well as administering injections in Petitioner's right knee on January 17, 2014 and March 7, 2014. Petitioner testified that the injections did not provide any lasting relief. Throughout his treatment of Petitioner, Dr. Garapati kept Petitioner on light duty. (Pet. Ex. 3)

On January 27, 2014, Petitioner presented to Dr. Kevin Tu for a Section 12 Examination at the Respondent's request. In his February 12, 2014 report authored following the examination, Dr. Tu opined that Petitioner suffered from a right knee MCL sprain and patellar tendonitis, related to the work injury. Dr. Tu recommended a work conditioning program as well as continued restrictions of no lifting, pushing or pulling greater than 15 pounds, and to avoid any kneeling or squatting activities. (Pet. Ex. 5)

On March 17, 2014 Petitioner underwent an ultrasound of his right knee at Dr. Garapati's request. Following the ultrasound, Dr. Garapati recommended work conditioning. Petitioner underwent the work conditioning at Athletico. On May 16, 2014, Petitioner returned to Dr. Garapati, who then opined Petitioner to be at maximum medical improvement. Dr. Garapati recommended Petitioner undergo a functional capacity evaluation ("FCE") for determination of restrictions. (Pet. Ex. 3)

On June 30, 2014, Petitioner returned to Dr. Kevin Tu at Respondent's request for a second Section 12 Examination. In his July 15, 2014 report authored following the second examination, Dr. Tu confirmed his initial diagnosis and related continued quadriceps atrophy and weakness in Petitioner's lower extremity accompanied by medial joint line tenderness. Dr. Tu noted that Petitioner had completed work conditioning, and opined that Petitioner had reached maximum medical improvement.

Dr. Tu likewise recommended an FCE to determine the extent of permanent work restrictions required. (Pet. Ex. 6)

Petitioner testified that once Dr. Garapati advised him that he would have permanent restrictions he realized he would not be able to face the physical demands of an Operating Engineer and began to seek alternative employment. Through his own research he identified computer-aided drawing ("CAD") as a career path that would not present the same physical demands and stresses, and would be a fit with his past education and talent for drawing, as well as providing a suitable income that would allow him to continue to support his three and a half year old son. (TX)

Petitioner testified that his research revealed CAD certification classes available at Harper College as an opportunity to pursue this field, and enrolled in such classes. After withdrawing once due to difficulty assimilating back into the classroom setting, Petitioner completed the first of four semesters required for the certification in September of 2014. As of the date of hearing, Petitioner was enrolled in the second semester of classes which had not yet begun, and had paid $874.00 in tuition and related expenses for the first two semesters. (TX, Pet. Ex. 8, 9)

After Petitioner began taking the CAD classes, Respondent offered Petitioner an accommodated position that consisted of office work and a little bit of errand running. The position was described to Petitioner as a permanent position; however, the position only lasted 3 weeks in February of 2015. While Petitioner performed the accommodated work, Petitioner received TPD benefits for any difference between his average weekly wage at the time of the undisputed work accident and his weekly earnings in the accommodated position. After the position ended, Respondent resumed off-work benefits in their entirety. (TX, Arb. Ex. 1)

Petitioner also attempted to generate income by starting a dog walking service named "Woofie Pals." Despite creating a dedicated website as well as a Facebook page with reviews and even running special offers for discounted services, Petitioner testified that in the entire year of existence of "Woofie Pals" he had had only two customers, one of whom was his next door neighbor who wrote the sole review on his Facebook website. Throughout that year Petitioner generated an estimated total earning of $75.00. (TX, Res. Ex. 5-7)

Petitioner ultimately did undergo an FCE on April 29, 2015 at Athletico. The examination identified Petitioner as demonstrating maximum voluntary effort during testing, as well as objective findings of limitations in pushing, pulling and lifting evaluations. Further, the examination documented observable edema surrounding Petitioner's right patella following musculoskeletal evaluation and testing. (Pet. Ex. 2)

On May 14, 2015, Petitioner presented for a third Section 12 Examination at Respondent's request. However, instead of returning to Dr. Tu, Respondent requested Petitioner be seen by Dr. Brian Cole. Dr. Cole performed a physical examination and noted tenderness to palpation in the right knee at the patellar tendon origin. Dr. Cole diagnosed Petitioner with recalcitrant chronic right knee patellar tendinitis, and recommended use of a counterforce strap as well as Voltaren topical gel and consideration for a platelet-rich plasma injection. Dr. Cole also recommended additional physical therapy, as well as manipulation in the tendon and eccentric strengthening of the quads. (Res. Ex. 1)

Petitioner testified that he did not wish to proceed with the treatment plan recommended by Dr. Cole as he "had been poked and prodded over the past year and a half" and did not believe further measures would help his knee. (TX)

Petitioner returned to Dr. Garapati on May 18, 2015. Dr. Garapati reviewed the FCE results from Athletico, and opined that the test appeared valid, as Petitioner gave full physical effort, and showed Petitioner capable of performing at the limited heavy physical demand level. Dr. Garapti also noted the presence of swelling and ecchymosis in Petitioner's right knee following the examination. Dr. Garapati released Petitioner with permanent restrictions consistent with the FCE, noting Petitioner was unable to return to his preinjury job, but was able to perform work at a limited heavy demand level without significant heavy lifting on a chronic basis. (Pet. Ex. 4)

Petitioner testified that prior to November 11, 2013, he had suffered injuries before in his line of work as an Apprentice Operations Engineer. On October 23, 2010 he injured his back and proceeded with a Workers' Compensation claim for that injury. Petitioner underwent surgery for his back and ultimately had an FCE relative to that injury. His treating surgeon for that injury, Dr. Phillips, reviewed the FCE and released Petitioner to full duty work without restrictions. Petitioner acknowledged receiving a settlement in resolution of that Workers' Compensation case. (TX, Pet. Ex. 7, Res. Ex. 2)

Petitioner further testified that in 2006 he was involved in a motor vehicle accident that resulted in a fractured right femur requiring surgical repair. Petitioner testified that in the years since treatment ended for that injury he has not had any problems with his right knee until the undisputed work accident of November 11, 2013. (TX)

Petitioner testified that he continues to have a throbbing, sharp pain in the right front of his kneecap with occasional swelling. He is unable to participate in athletics, fishing, hockey or golf, as he could prior to the injury. (TX, Pet. Ex. 9)

FINDINGS/ANALYSIS

(K) In support of the Arbitrator's decision regarding whether Petitioner is entitled to TTD, maintenance or both, the Arbitrator concludes the following:

There is no issue as to accident or causation and the parties have further stipulated to TPD, and Petitioner testified that he was appropriately paid TPD during his short period of accommodated work with Respondent. There is also no dispute that Petitioner is entitled to benefits for his time off work for the periods of November 13, 2013 through February 8, 2015 and February 28, 2015 through May 22, 2015. The issue in dispute is Petitioner's entitlement to maintenance benefits from May 23, 2015 through the August 17, 2015 (hearing date).

"Maintenance is awarded incidental to vocational rehabilitation." *Interstate Scaffolding v. Ill. Workers' Comp. Comm'n*, 385 Ill.App.3d 1040, 1049 (3rd Dist. 2008). Section 8(a) of the Act provides for an award of maintenance benefits while an employee is engaged in a prescribed rehabilitation program. *Nascote Indus. v. Indus. Comm'n (Berry)*, 353 Ill. App. 3d 1067, 1075 (5th Dist. 2004); *Connell v. Industrial Comm'n*, 170 Ill. App. 3d 49, 55 (1988)). There is also no prohibition against claimant-created and directed vocational rehabilitation programs, although they are disfavored. *Roper Contracting v. Industrial Comm'n*, 349 Ill. App. 3d 500, 505-506 (5th Dist. 2004).

The Arbitrator finds Petitioner is entitled to maintenance benefits for May 17, 2014 through February 8, 2015 and February 28, 2015 through August 17, 2015. The Arbitrator finds the opinion of Dr. Garapati and Dr. Tu to be more credible than the opinion of Dr. Cole. Dr. Garapati maintained Petitioner on light duty restrictions throughout the course of conservative treatment rendered, ultimately releasing the Petitioner with permanent restrictions determined by a valid FCE. Dr. Garapati's opinions are mirrored by Respondent's Section 12 Examiner Dr. Tu, who confirmed Dr.

Garapati's diagnosis and recommended treatment plan following his first examination of Petitioner, and likewise confirmed Petitioner's ongoing symptoms and the necessity of an FCE to determine the extent of the permanent restrictions warranted by Petitioner's right knee condition following his second examination. Furthermore, the valid FCE identified specific objective findings resulting in recommended restrictions in line with both Dr. Garapati's and Dr. Tu's opinions; Dr. Garapati memorialized these findings as permanent restrictions following his May 18, 2015 final visit with Petitioner.

In contract, Respondent's second Section 12 examiner, Dr. Cole opines that Petitioner was capable of work without restrictions. However, the Arbitrator finds Dr. Cole's opinion regarding Petitioner's ability to work to be unpersuasive. First, Dr. Cole examined Petitioner at Respondent's request only after Respondent's primary Section 12 examiner, Dr. Tu, had twice agreed with Petitioner's treating physician, Dr. Garapati, regarding Petitioner's need for ongoing restrictions. Second, Dr. Cole identified specific ongoing symptomatology in Petitioner's right knee that he related to the undisputed work accident. As a result, Dr. Cole prescribed a detailed, comprehensive treatment plan to address Petitioner's ongoing symptoms, including the apparent ongoing weakness in Petitioner's quadriceps. The Arbitrator finds Dr. Cole's opinion that the Petitioner is capable of work without any restrictions to be contrary to the remainder of his report, particularly wherein he identified ongoing difficulties to the extent that further treatment was warranted. As such, Dr. Cole's opinion that Petitioner is capable of working without restrictions is not credible.

Accordingly, the Arbitrator gives more weight to the opinions of Drs. Garapati and Tu. In doing so, the Arbitrator finds Petitioner unable to work without restrictions, and

that Petitioner has permanent restrictions as outlined in the valid FCE recommended by both Drs. Garapati and Tu, and specifically adopted by Dr. Garapati.

Regarding TTD benefits, the Arbitrator notes Petitioner was entitled to TTD compensation from the time an injury incapacitates him for work until such time as he is as far recovered or restored as the permanent character of his injury will permit. Interstate Scaffolding, Inc. v. Com'n, 923 N.E.2d 266 (Ill. 2010 In this case, the Arbitrator finds Petitioner to have reached MMI on May 16, 2014 when Dr. Garapati opined Petitioner was at MMI and recommended an FCE to determine permanent restrictions. The Arbitrator notes Respondent stipulated to owing TTD during this period, and Respondent will receive a credit for all benefits paid.

Further, by case law a claimant is entitled to maintenance after he reaches MMI until either Petitioner finds work within his restrictions or the Respondent can show that there are jobs reasonably available within Petitioner's restrictions. Illinois Workers' Compensation Comm'n v. Intermet Decatur Foundry Wagners Castings, 01 IL. W.C.41704, 2009 WL 3269722. Moreover, pursuant to Rule 7110.10 of the Rules Governing Practice Before the Illinois Workers' Compensation Commission, when it can be reasonably determined that the injured worker will, as a result of the injury, be unable to resume the regular duties in which engaged at the time of injury, or when the period of total incapacity for work exceeds 120 continuous days, whichever first occurs... [t]he employer or his representative, in consultation with the injured employee... shall prepare a written assessment of the course of medical care, and, if appropriate, rehabilitation required to return the injured worker to employment. 50 Ill.Adm.Code 7110.10(a) (2009). However, there is no rule prohibiting claimant-created and directed vocational rehabilitation programs. Greaney v. Industrial Com'n, 832

N.E.2d 331 (Ill.App. 1 Dist. 2005), citing Roper Contracting, 812 N.E.2d 65 (Ill.App. 5 Dist. 2004). Moreover, a Petitioner can be entitled to maintenance while undergoing a diligent self-directed vocational rehabilitation plan, and taking the appropriate steps to obtain a certification required in a specified career field can be evidence of such diligent vocational rehabilitation efforts. (See W.B. Olson, Inc., v. Workers' Compensation, 981 N.E.2d 25 (Ill.App. 1 Dist. 2012) where the Commission's award of maintenance for a period during which the claimant was preparing to obtain a CDL pursuant to his self-directed plan to seek a truck-driving position was not against the manifest weight of the evidence).

As discussed above, the Arbitrator finds that from May 17, 2014 and continuing through the August 17, 2015 date of hearing, Petitioner had ongoing restrictions relative to his right knee as a result of the undisputed work accident.

Respondent presented no evidence that there are jobs reasonably available within Petitioner's restrictions. Furthermore, Petitioner has not found suitable employment within his restrictions. The only period of time during which Respondent was able to accommodate Petitioner's restrictions was from February 9, 2015 through February 27, 2015 when Petitioner was performing the office work and errands. Thereafter, Respondent resumed paying benefits to Petitioner.

There is nothing in the record to indicate Respondent complied with Rule 7110.10. After Respondent's own Section 12 Examiner, Dr. Tu, opined that Petitioner had reached MMI and would likely have permanent restrictions following his July 30, 2014 examination of Petitioner, it could be reasonably determined that Petitioner would be unable to resume the regular duties in which he was engaged at the time of the injury. However, instead of coordinating a rehabilitation plan, Respondent first

developed an accommodated position for Petitioner that, although advertised as being permanent, only lasted three weeks. Thereafter, Respondent made no further efforts to return Petitioner to employment and instead sought the opinion of a different Section 12 Examiner to obtain a full duty release to work.

Rule 7110.10 clearly dictates that it is Respondent's obligation to institute a plan to return Petitioner to work, Petitioner testified that he decided to obtain a CAD (Computer Assisted Drawing) certification, His efforts to complete the course are lacking and there is little or no evidence to show that this certification will result in gainful employment. It is noted that as of the date of hearing, Petitioner had completed only one of four semesters towards the CAD certification and is enrolled to take the second semester in the upcoming fall.

The Petitioner has also started an online dog walking service. The success of this endeavor is abysmal with "Woofie Pals" having earned the Petitioner approximately $75.00 in a year's time. Although "Woofie Pals" or CAD certification may provide stable employment to some, in Petitioner's case both are close to utter failures. In the Arbitrator's estimation neither side has presented proof that Petitioner is or can be employed in a stable, competitive labor market under his current efforts and without Vocational Assessment and or guidance.

For the foregoing reasons, the Arbitrator finds Petitioner is entitled to TTD for November 13, 2013 through May 16, 2014, and maintenance benefits for the periods of May 17, 2014 through February 8, 2015 and February 28, 2015 through August 17, 2015. The Arbitrator notes all TPD alleged has been stipulated and paid. Respondent is given a credit for all other benefits paid.

(O) In support of the Arbitrator's decision regarding whether the Petitioner is entitled to vocational rehabilitation and ongoing maintenance under Section 8(a) of the Act, the Arbitrator concludes the following:

The Arbitrator finds that the Petitioner is entitled to Vocational Rehabilitation under Section 8(a) of the Act, and all maintenance costs and expenses incidental thereto.

Section 8(a) of the Illinois Workers' Compensation Act ("Act") plainly states certain obligations imposed upon employers with regard to vocational rehabilitation and states, in pertinent part: "The employer shall also pay for treatment, instruction and training necessary for the physical, mental and vocational rehabilitation of the employee, including *maintenance* costs and expenses incidental thereto." 820 ILCS 305/8(a) (*emphasis added*).

As discussed above, Petitioner has permanent restrictions relative to his right knee resulting from the undisputed work accident of November 11, 2013. As further discussed above, Respondent has shown that it has no permanent position to accommodate Petitioner's restrictions, and has made no good faith effort to assist Petitioner in returning to gainful employment as is required by Rule 7110.10. The Arbitrator finds Petitioner's self-directed job search with CAD classes or "Wolfie Pals" to be a very poor substitute for a proper, vocational rehabilitation plan. Although, there is no rule prohibiting claimant-created and self-directed vocational rehabilitation program; in this case the Arbitrator declines to award the same. Greaney, 832 N.E.2d at 347 Petitioner's inadequate progress and inability to generate even a minimum wage employment for himself has convinced the Arbitrator to decline his request for a self-directed plan. To do so will force the Respondent to pay long term maintenance benefits while the Petitioner travels towards assured failure.)). This reasoning is

echoed in *Roper Contracting v. Industrial Comm'n*, 349 Ill. App. 3d 500, 505-506 (5th Dist. 2004) which reasoned that although there is also no prohibition against claimant-created and directed vocational rehabilitation programs, although they are disfavored.

In spite of her ruling denying a self-directed job search or training the Arbitrator awards Petitioner incurred vocational rehabilitation costs of $874.00, as provided in Section 8(a) of the Act. Although the Arbitrator found the Petitioner's program lacking, the Petitioner undertook the same in good faith. Based of Respondent's failure to provide any program or guidance in job search, the Arbitrator awards this sum. Petitioner's request for future tuition is declined.

Instead, the Arbitrator hereby awards Petitioner Vocational Rehabilitation and orders the Respondent to provide a well-regarded, certified or otherwise appropriate and qualified vocational program for the Petitioner. Additionally, Respondent shall pay maintenance benefits during this period.

It should be noted that "Maintenance is awarded incidental to vocational rehabilitation." *Interstate Scaffolding v. Ill. Workers' Comp. Comm'n*, 385 Ill.App.3d 1040, 1049 (3rd Dist. 2008). Section 8(a) of the Act provides for an award of maintenance benefits while an employee is engaged in a prescribed rehabilitation program. *Nascote Indus. v. Indus. Comm'n (Berry)*, 353 Ill. App. 3d 1067, 1075 (5th Dist. 2004); *Connell v. Industrial Comm'n*, 170 Ill. App. 3d 49, 55 (1988

Respondent shall pay Petitioner ongoing maintenance benefits of $1,004.00/week throughout the duration of Petitioner's vocational rehabilitation, commencing 8/18/15, as provided in Section 8(a) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TRACY VINSEL,

Petitioner,

vs. NO: 05 WC 18804

CONTEEN CORPORATION,

17IWCC0074

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue(s) of medical treatment, temporary total disability, prospective medical treatment, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 the decision of the Commission that even had Arbitrator Dollison not determined that Petitioner was barred by *res judicata*, that Petitioner's medical condition had not changed from the time a decision issued from Arbitrator Mathis on April 23, 2012, until the time of hearing by Arbitrator Dollison, and therefore, benefits were appropriately denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 2, 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

17IWCC0074

expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

FEB 9 - 2017

DATED:
CJD/dmm
O: 2/1/17
49

Joshua D. Luskin

Ruth W. White

DISSENT

I must respectfully dissent from the majority's decision that the Petitioner failed to prove that his current condition of ill-being was not causally connected or caused by the accident on April 9, 2005. I would instead find that Petitioner's need for a fusion at L4-L5 is a new medical condition, brought about by an insufficient fusion at L5-S1, and that the law of the case does not apply to a new medical condition.

The law of the case doctrine requires that where an issue has been litigated and decided, a court's unreversed decision on that question of law or fact settles that question "for all subsequent stages of the suit". Norton v. City of Chicago, 293 Ill.App.3d 620, 624 (1997); Penn v. Gerig, 334 Ill.App.3d 345, 352 (2002). Exceptions exist, thus "invoking the law of the case might still not preclude reconsideration of an earlier judge's order if the facts before the court changed or error or injustice were manifest. People v. Williams, 138 Ill.2d 377, 392-393 (1990). The law of the case doctrine is no bar where "the facts before the court changed." Id.

Petitioner's condition worsened between the time of the 2011 hearing and the hearing in 2015. Petitioner's current condition in respect to L4-L5 is an aggravation of a pre-existing condition due to the L5-S1 fusion. Petitioner's L5-S1 fusion was previously determined to be causally related to the April 9, 2005 accident. Both Respondent's

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expert, as well as Petitioner's treating physician, agreed that adjacent failure next to the spinal fusion, is a predictable, common consequence. Respondent's own expert opined that the level above a fused spinal vertebra is prone to injury, and recommended fusion of L4-L5. In fact, in his supplemental IME report dated April, 16, 2015, Respondent's expert opined that Petitioner should have an add-on posterior spinal fusion. (Rx6)

In the instant case, the Commission expressly stated in its previous order that Petitioner could seek additional TTD in the future, remanding the matter "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). Moreover, the Commission also stated "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." (Emphasis added.)

Based on the above, I would award Petitioner TTD from the date of the last hearing through present, unpaid medical, and the prospective medical for the fusion at L4-L5.

Charles J. DeVriendt

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

VINSEL, TRACY
Employee/Petitioner

Case# **05WC018804**

CANTEEN CORPORATION
Employer/Respondent

17IWCC0074

On 2/2/2016, 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 0.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2028 RIDGE & DOWNES LLC
JOHN E MITCHELL
415 N E JEFFERSON AVE
PEORIA, IL 61603

2593 GANAN & SHAPIRO PC
BRET E TAYLOR
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

STATE OF ILLINOIS)
)SS.
COUNTY OF Peoria)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

17IWCC0074

Case # 05WC 018804

Consolidated cases: _____

Tracy Vinsel
Employee/Petitioner

v.

Canteen Corporation
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 **Gregory Dollison**, Arbitrator of the Commission, in the city of **Peoria, Illinois**, on **December 11, 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. ☒ 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

17IWCC0074

On the date of accident, **4/9/2005**, 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 not* causally related to the accident.

In the year preceding the injury, Petitioner earned $**45,796.40**; the average weekly wage was $**880.70**.

On the date of accident, Petitioner was **39** 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 $**14,510.50** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**6,044.33** for medical benefits, for a total credit of $**20,554.83**.

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

ORDER

Having found that the Commission's Decision is the law of the case, and therefor *res judicata,* Petitioner's request for TTD subsequent to November 1, 2010, and for the proposed surgery at L4-L5 is hereby 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

1/29/16
Date

ICArbDec19(b)

FEB 2 - 2016

17IWCC0074

This claim involves injury to Petitioner's low back when lifting a case of soda while in the employ of Respondent on April 9, 2005. The claim was initially arbitrated pursuant to Section 19(b) of the Act on September 28, 2011. (PX-1) On April 23, 2012, the Arbitrator rendered his decision on the issue of causal relationship for medical treatment and temporary total disability benefits subsequent to November 1, 2010. (PX-2)

The original 19(b) decision of April 23, 2012, extensively outlines Petitioner's complaints, diagnostic findings, medical treatment and the medical suggestions of numerous treating orthopedic surgeons and neurosurgeons for Petitioner's conditions of ill-being at L4-L5 and L5-S1. (PX-2) The record reflects Petitioner sought treatment with three different neurosurgeons before Dr. Dzung Dinh performed a left L5-S1 hemilaminotomy, foraminotomy and discectomy on May 3, 2007. (PX-1; PX-2) Petitioner continued to have post-operative complaints, and underwent three additional years of treatment at L4-L5 and L5-S1. (PX-1; PX-2) On January 26, 2010, Dr. Dinh performed an anterior lumbar interbody fusion at L5-S1. (PX-1; PX-2) Following the fusion surgery, Petitioner underwent post-operative physical therapy and work conditioning and ultimately an FCE on September 16, 2010. (PX-1; PX-2) The FCE evaluator felt Petitioner could return to his former employment for Respondent without restrictions. (PX-1; PX-2)

Following the FCE, Petitioner began treating with Dr. Matthew Gornet, an orthopedic surgeon, on September 27, 2010. (PX-1; PX-2) Dr. Gornet ordered a CT scan which he believed showed a failed fusion at L5-S1. (PX-1; PX-2) At that time, Dr. Gornet suggested a fusion versus disc replacement at L4-L5 and a revision posterior fusion at L5-S1. (PX-1; PX-2; PX-6) Thereafter, Dr. Dinh reviewed Dr. Gornet's opinions regarding additional surgery and the CT scan of September 27, 2010. (PX-1; PX-2) Dr. Dinh disagreed with Dr. Gornet, noting the CT scan showed a proper fusion at L5-S1 and no surgery at L4-L5 was necessary. (PX-1; PX-2) Dr. Dinh did not recommend any additional treatment and released Petitioner to return to his former employment without restriction as of November 1, 2010. (PX-1; PX-2)

After the initial hearing and before a decision was rendered, the Arbitrator requested a follow up Section 12 examination with Dr. Avi Bernstein who had previously performed multiple Section 12 examinations in this case. On January 24, 2012, Dr. Bernstein issued an addendum report noting no obvious evidence of a failed fusion at L5-S1, noting the instrumentation was in stable condition with no evidence of hardware loosening. (PX-2; PX-14) Dr. Bernstein indicated if Petitioner were to pursue a revision fusion at L5-S1, an add-on fusion should also be performed at L4-L5. (PX-14)

On April 23, 2012, the Arbitrator rendered his decision finding Petitioner had reached maximum medical improvement as of November 1, 2010. (PX-2) The Arbitrator specifically found that any medical treatment beyond November 1, 2010, including Dr. Gornet's suggestion of a fusion surgery at L4-L5 and a posterior revision fusion at L5-S1, was not reasonable, necessary or causally related to the accident of April 9, 2005. He further found no period of temporary total disability was owed by Respondent subsequent to November 1, 2010. (PX-2)

Petitioner appealed the Arbitrator's decision to the Commission. On March 25, 2013, the Commission ordered a new MRI to determine whether the L5-S1 fusion had failed and whether Petitioner was in need of a revision surgery. (PX-3) The Arbitrator's decision as to all other issues, and in all other respects, including causal relationship for medical treatment or temporary total disability benefits subsequent to November 1, 2010, was affirmed. (PX-3)

Petitioner appealed the decision of the Commission to the Circuit Court of Tazewell County. On March 14, 2014, Judge Paul Gilfillan found "It cannot be said that the Arbitrator's/Commission's finding that medical treatment beyond November 1, 2010 is not reasonable, necessary, or causally related to the accident of April 9, 2005, is against the manifest weight of the evidence." (PX-5) Petitioner filed no further appeals.

During the pendency of Petitioner's appeal process, he continued to treat with Dr. Gornet. (PX-6) Throughout this time, Dr. Gornet continued to suggest either a fusion or disc replacement at L4-L5 and a revision fusion at L5-S1. On August 12, 2013, Dr. Gornet ordered a follow up CT scan of the lumbar spine. (PX-6; PX-8) At that time, Dr. Gornet noted L5-S1 was solidly fused as previously indicated by both Dr. Dinh and Dr. Bernstein. (PX-6) However, Dr. Gornet continued in his opinion that L4-L5 should also be fused. (PX-6) Following the CT scan of August 12, 2013, Dr. Gornet still believed Petitioner's treatment options at L4-L5 were fusion versus disc replacement. (PX-6) Petitioner has continued to seek follow up visits with Dr. Gornet pending the surgery Dr. Gornet is suggesting at L4-L5. (PX-6; PX-8) At arbitration, Petitioner testified Dr. Gornet continues to suggest a fusion versus disc replacement surgery at L4-L5.

On July 14, 2015, Dr. Bernstein authored an addendum report following review of additional medical records, diagnostic studies, and Dr. Gornet's deposition testimony since his previous report of January 24, 2012. (RX-5) Dr. Bernstein noted the CT scan of August 12, 2013, and the MRI of March 2, 2015, confirmed a successful fusion at L5-S1 as he had previously opined in January 2012. Dr. Bernstein felt Petitioner would be a candidate for a posterior spinal fusion at L4-L5. (RX-5) Dr. Bernstein also provided his deposition testimony in the present matter. As to the surgical suggestion at L4-L5, Dr. Bernstein testified:

Q. In reviewing Dr. Gornet's deposition testimony he was suggesting surgery at L4-L5 as well; correct?

A. Yes.

Q. And at this point he was suggesting either a fusion or a disc replacement at that level; yes?

A. Yes.

Q. Doctor, to a reasonable degree of medical and surgical certainty, you have been reviewing medical records and diagnostic studies, conducting clinical exams going back to 2007 on Mr. Vinsel's case?

A. Yes.

Q. Is the surgical procedure that you have suggested, if necessary, the fusion surgery at L4-L5, is that the same procedure that you were suggesting as far back as 2012?

A. As far as 2008.

Q. As far as 2008?

A. Yes.

Q. Okay. And, Doctor, this fusion at L4-L5 that you were discussing, is it to treat the same condition that was in existence as far back as 2008?

A. Yes.

Q. The same complaints?

A. Yes.

Q. Same diagnostic findings?

A. Yes.

Q. And is that to a reasonable degree of medical and surgical certainty?

A. Yes.

Q. You have reviewed Dr. Gornet's records throughout?

A. Yes.

Q. And now you've reviewed his deposition testimony as well?

A. Yes.

Q. Is the surgery that he is suggesting, is that the same surgery that he was suggesting as far back as September of 2010?

A. Yes.

Q. And the surgery that he is suggesting, is it to treat the same condition that was in existence at least back to 2010?

A. Yes.

Q. The same diagnostic findings?

A. Yes.

(RX-7, pp. 11-13)

Dr. Gornet also testified as to the surgery he is recommending at L4-L5. (PX-8) Dr. Gornet affirmed the surgery he is currently recommending at L4-L5 is the same surgery he has always recommended at this level since his initial visit with Petitioner on September 27, 2010. (PX-8, pp. 14-17)

Petitioner testified he has made no attempts to return to work for Respondent, nor made any attempts to find employment elsewhere, since the initial arbitration hearing on September 28, 2011. He testified he continues to rely on the opinion of Dr. Gornet that he should be off work.

With respect to issues (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; (K.) Is Petitioner entitled to any prospective medical care; (L.) What temporary benefits (TTD) are in dispute; the Arbitrator finds as follows:

Dr. Gornet has suggested either a fusion surgery or a disc replacement surgery at L4-L5 since September 27, 2010, over one year prior to Petitioner's original 19(b) hearing on September 28, 2011. This surgical recommendation at L4-L5, as well as a revision fusion surgery at L5-S1 was at issue in the original Section 19(b) hearing. In its decision, on March 25, 2013, the Commission ordered a new MRI to determine whether the L5-S1 fusion had failed and whether Petitioner was in need of a revision surgery. The Arbitrator's decision as to all other issues, and in all other respects, including causal relationship for medical treatment or temporary total disability benefits subsequent to November 1, 2010, was affirmed. (PX-3)The surgery Petitioner is requesting in the current 19(b) proceeding is Dr. Gornet's continued recommendation of a fusion surgery versus a disc replacement surgery at L4-L5. Based upon the record, there does not appear to have been any change in Dr. Gornet's opinion as to the treatment options at L4-L5. On September 27, 2010, and again on June 16, 2011, prior to the initial 19(b) hearing, Dr. Gornet suggested fusion via an oblique bone dowel versus a disc replacement at L4-L5. (PX-6)) Both Dr. Gornet and Dr. Bernstein agree this is the same surgery to treat the same condition at L4-L5 which was in existence prior to the initial 19(b) hearing in this matter. As noted above, Petitioner was found to have reached maximum medical improvement and was able to return to his regular employment activities without restriction as of November 1, 2010. Compensability for this surgical procedure was previously adjudicated and found not causally related. This finding was appealed to the Commission and to the Circuit Court, and affirmed in both instances. The Commission's decision regarding causal relationship is the law of the case and, thus, *res judicata*. Petitioner's claim for additional medical treatment, specifically a fusion versus disc replacement procedure at L4-L5, is denied.

The Arbitrator further finds Petitioner has made no attempt to return to his employment with Respondent or to find employment elsewhere despite the previous decision finding Petitioner could return to his previous employment activities without restriction as of November 1, 2010. Petitioner is not entitled to any period of additional TTD benefits subsequent to November 1, 2010. Petitioner's claim for additional TTD subsequent to November 1, 2010 is denied.

The Arbitrator notes that the parties stipulated at arbitration Respondent would be entitled to a credit for any medical bills paid for treatment rendered subsequent to November 1, 2010, as well as any temporary total disability benefits paid subsequent to November 1, 2010. Respondent's Exhibit 8 reflects Respondent paid medical bills for treatment rendered subsequent to November 1, 2010 in the amount of $6,044.33. Respondent shall receive a credit for these medical benefits paid.

Further, at the time of the initial 19(b) decision of April 23, 2012, the Arbitrator found Respondent was entitled to a credit for "any additional TTD benefits paid subsequent to the initial hearing on this matter on September 28, 2011." (PX-2) At the time the prior decision was issued, TTD benefits paid between the date of hearing and the date of the arbitration decision could not be quantified. Respondent's Exhibit 9 reflects TTD was paid from January 5, 2012 through March 18, 2012, in the amount of $6,877.81. These TTD benefits were previously awarded and can now be quantified. In addition, Respondent has paid $7,632.69 in TTD from September 9, 2015 through December 1, 2015. Respondent is entitled to a credit for TTD paid during this time period as well. The total TTD credit equates to $14,510.50.

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

BENJAMIN LEANDRO SEGURA,

Petitioner,

17IWCC0075

vs.

NO: 12 WC 21378

SUPERIOR STAFFING, INC., loaning employer &
JUNO LIGHTING, INC., borrowing employer

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 issue(s) of temporary total disability, permanent partial disability, causal connection and reasonableness and necessity of medical expenses, penalties and fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission modifies the Decision of the Arbitrator regarding payment of the reasonable and necessary medical expenses. Respondent shall pay to the Petitioner the following reasonable and necessary medical expenses pursuant to Sections 8(a) and 8.2: 1) Marque Medicos bills itemized in Petitioner's Exhibit 6; 2) Medicos Pain & Surgical Specialists, SC itemized medical bills in Petitioner's Exhibit 7 for those charges related solely to Dr. Engel's September 5, 2012 surgical clearance examination and specifically excluding any and all transportation and other remaining outstanding charges; 3) Industrial Pharmacy Management bills itemized in Petitioner's Exhibit 8; 4) Ambulatory Surgical Care Facility, LLC bills, itemized in Petitioner's Exhibit 9 for those charges relating solely to the surgery performed by Dr. Erickson on September 7, 2012, excluding any and all transportation expenses and excluding the injections performed in February and August 2013; 5) American Center for Spine & Neuro, Dr. Robert Erickson's bills, itemized in Petitioner's Exhibit 10, for the treatment rendered between August 3, 2012 and September 17, 2014; 6) Lake County Neuromonitoring bills

17IWCC0075

itemized in Petitioner's Exhibit 11; 7) IMS Experts, LLS, for medical bills itemized in Petitioner's Exhibit 12; 8) Metro Anesthesia, solely for medical bills itemized in Petitioner's Exhibit 13 for the services relating to anesthesia administered on September 7, 2012 and excluding charges relating to the injection of February 14, 2013; 9) Hawthorne Works Medical Imaging bills itemized in Petitioner's Exhibit 14; and 10) Elite Physical Therapy bills itemized in Petitioner's Exhibit 15.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on February 3, 2016, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $319.00 per week for a period of 67-2/7 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 $319.00 per week for a period of 62.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused permanent partial disability to the extent of 12.5% body as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the following reasonable and necessary medical expenses pursuant to Sections 8(a) and 8.2 of the Act: 1) Marque Medicos bills itemized in Petitioner's Exhibit 6; 2) Medicos Pain & Surgical Specialists, SC itemized medical bills in Petitioner's Exhibit 7 for those charges related solely to Dr. Engel's September 5, 2012 surgical clearance examination and specifically excluding any and all transportation and other remaining outstanding charges; 3) Industrial Pharmacy Management bills itemized in Petitioner's Exhibit 8; 4) Ambulatory Surgical Care Facility, LLC bills, itemized in Petitioner's Exhibit 9 for those charges relating solely to the surgery performed by Dr. Erickson on September 7, 2012, excluding any and all transportation expenses and excluding the injections performed in February and August 2013; 5) American Center for Spine & Neuro, Dr. Robert Erickson's bills, itemized in Petitioner's Exhibit 10, for the treatment rendered between August 3, 2012 and September 17, 2014; 6) Lake County Neuromonitoring bills itemized in Petitioner's Exhibit 11; 7) IMS Experts, LLS, for medical bills itemized in Petitioner's Exhibit 12; 8) Metro Anesthesia, solely for medical bills itemized in Petitioner's Exhibit 13 for the services relating to anesthesia administered on September 7, 2012 and excluding charges relating to the injection of February 14, 2013; 9) Hawthorne Works Medical Imaging bills itemized in Petitioner's Exhibit 14; and 10) Elite Physical Therapy bills itemized in Petitioner's Exhibit 15.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for an award of penalties and fees under Sections 19(k), 19(l) and 16 is denied.

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

17IWCC0075

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: FEB 10 2017
KLW/bsd
O: 12/13/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0075

LEANDRO SEGURA, BENJAMIN Case# **12WC021378**

Employee/Petitioner

SUPERIOR STAFFING INC-LOANING EMPLOYER
JUNO LIGHTING INC-BORROWING EMPLOYER

Employer/Respondent

On 2/3/2016, 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 0.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1922 SALK, STEVEN B & ASSOC LTD
DAMIAN R FLORES
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

0210 GANAN & SHAPIRO PC
MICHELLE L LaFAYETTE
210 W ILLINOIS ST
CHICAGO, IL 60654

ILLINOIS)
)SS.
TY 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

17IWCC0075

Benjamin Leandro Segura
Employee/Petitioner

v.

Superior Staffing, Inc. – Loaning Employer
Juno Lighting, Inc. – Borrowing Employer
Employer/Respondent

Case # **12WC 21378**

Consolidated cases: D/N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **January 14, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 _____

17IWCC0075

FINDINGS

On **5/8/2012**, Respondents were operating under and subject to the provisions of the Act.

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

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner established causation as to the need for the September 7, 2012 lumbar spine surgery and as to his current post-operative condition of ill-being.

Petitioner's average weekly wage was **$324.58.**

On the date of accident, Petitioner was **46** years of age, ***married*** with **2** dependent children.

Petitioner ***has in part*** received reasonable and necessary treatment.

Respondents have in part paid appropriate charges for reasonable and necessary medical services.

Respondents shall be given a credit of **$2,860.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$2,860.00**.

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

ORDER

Respondents shall pay Petitioner temporary total disability benefits of $319.00 per week for 67 2/7 weeks, commencing on **May 18, 2012 through August 31, 2013**, with Respondents receiving credit for the $2,860.00 in benefits paid prior to the hearing. Arb Exh 1.

For the reasons set forth in the attached decision, the Arbitrator declines to award temporary partial disability benefits in this claim.

Respondents shall pay Petitioner the sum of **$319.00** 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 a man as a whole**.

Respondents shall pay Petitioner the following reasonable and necessary medical expenses: 1) Marque Medicos, $6,472.96 in fee schedule charges; 2) Medicos Pain & Surgical, $408.96 in fee schedule charges; 3) Industrial Pharmacy, $1,605.10 (not subject to the fee schedule); 4) Ambulatory Surgical Care Facility, $65,968.00, $3,765.76 and $2,593.75 in fee schedule charges relating to the 9/7/12 surgery; 5) American Center for Spine & Neuro (Dr. Erickson), $35,828.00, per the fee schedule; 6) Lake County Neuromonitoring, $10,375.00 per the fee schedule; 7) IMS Experts, LLS, $2,085.00, per the fee schedule; 8) Metro Anesthesia, $2,792.50, per the fee schedule; 9) Hawthorne Works Medical Imaging, $4,544.00 per the fee schedule; and 10) Elite Physical Therapy, $10,694.35, per the fee schedule. See the attached decision for further explanation.

The Arbitrator declines to award penalties or fees, for the reasons set forth in the attached decision.

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

17IWCC0075

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

Molly C Mason

Signature of Arbitrator

2/3/16
Date

FEB 3 - 2016

Benjamin Leandro Segura v. Superior Staffing, Inc.
and Juno Lighting, LLC
12 WC 21378

Arbitrator's Summary of Disputed Issues

This claim involves a lending/borrowing employment situation, with Superior Staffing lending Petitioner to Juno Lighting. Petitioner named both Superior Staffing and Juno Lighting as respondents. Juno Lighting received notice of the hearing but did not appear. Superior Staffing stipulated Petitioner sustained a work accident on May 8, 2012 and provided timely notice of the accident. The disputed issues include causation, average weekly wage, medical expenses, temporary total disability (except for one period, to which Superior Staffing stipulated), temporary partial disability, nature and extent and penalties/fees. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner testified through an interpreter.

Petitioner testified he was 47 years old as of the May 8, 2012 accident. T. 16. He denied having any lower back or right-sided radicular pain before the accident. T. 24, 45.

Petitioner testified he was employed by Superior Staffing as of the accident. Superior Staffing sent him to work at Juno Lighting. As of the accident, he had worked at Juno for about three months. T. 16. Juno manufactures light fixtures. At Juno, he performed packing and distributed cables, rubber parts and screws to assemblers. T. 23-24. He regularly lifted items weighing up to 20 pounds. T. 23.

Petitioner testified he expected to work 40 hours per week for Superior Staffing. Specifically, he expected to work 8 hours per day, 5 days per week. T. 18. Before the accident, he never worked more than 8 hours per day. T. 18. He was paid $8.25 per hour. T. 18.

Petitioner identified PX 20 as a stub from a paycheck he received from Superior Staffing. PX 20 reflects an hourly rate of $8.25, regular earnings of $330.00 for the period ending April 28, 2012 and additional "retro" earnings of $66.00 for total earnings of $396.00.

Petitioner testified that, if an earnings statement produced by Respondent shows he worked only 8 hours his first week and 16 hours the second week, this would stem from the common practice of temporary agencies carrying earnings over from one week to the next. T. 20-21.

Petitioner testified his health was completely fine when he started working at Juno. He had no difficulty performing his assigned duties between the time he started at Juno and the accident. T. 23. He did not lose time from work due to back pain during that interval. T. 24.

Petitioner testified that, on May 8, 2012, he used both hands to reach into a metal container that was on the floor. He began lifting a box out of the container. At that point his knees were up against the container. The box weighed about 9 or 10 pounds. It was about as large as an accordion 9 x 13 legal file. The container was about one meter tall. It had short legs. As Petitioner began lifting the box, his knees pushed the container forward and his body twisted to the right. T. 29-30. He fell forward but did not fall all the way to the ground. He caught himself with his hands. He felt 10/10 pain in his lower back, right side and right leg. T. 33. He had never before experienced this kind of pain. T. 33.

Petitioner testified he was unable to resume working after this incident. He immediately reported the incident to a supervisor, Isidro Salinas. T. 33-34. [Notice is not in dispute.] Isidro Salinas was an employee of Juno. T. 35.

Petitioner identified PX 18 as a report he completed in connection with the accident. He wrote out this report [in Spanish] at 8:50 AM on May 8, 2012, about twenty minutes after the accident. T. 40. He signed the report and gave it to a supervisor, Candido Montalvo. T. 40. [The Arbitrator ultimately rejected PX 18 and thus did not consider the exhibit in reaching her conclusions.]

Petitioner testified that, shortly after the accident, someone affiliated with Superior Staffing drove him from Juno to a clinic, Advanced Occupational Medicine in Bellwood. At this clinic, he explained what had happened and complained of pain in his low back and right leg. T. 42-43.

The records from Advanced Occupational (PX 1) reflect that Petitioner saw Dr. Khanna on May 8, 2012. A handwritten history bearing that date reflects that Petitioner experienced the immediate onset of lower back pain when he picked up a 9-pound box and twisted his body to the right to put the box down. This history also reflects that Petitioner denied any fall or blunt trauma.

Dr. Khanna's typed report sets forth the same account of the accident. The doctor indicated that Petitioner complained of 7/10 lower back pain but denied "any numbness, tingling or lower extremity radiculopathy." On lower back examination, Dr. Khanna noted limited flexion, pain with lateral rotation and side bending, positive seated straight leg raising "for lower back pain only bilaterally," with "no radiculopathy elicited," and positive bilateral one-leg hyperextension testing.

Dr. Khanna obtained lumbar spine X-rays. He described the films as negative for any fracture and showing an anterior osteophyte at the L5 vertebrae.

Dr. Khanna diagnosed a lumbar strain, lumbago and paraspinal muscle spasm. He prescribed Ibuprofen, Cyclobenzaprine and ice applications. He released Petitioner to seated work only, with standing, stretching and walking as tolerated, and directed him to return on May 14, 2012. PX 1.

Petitioner testified that the records from Advanced Occupational are incorrect if they reflect he denied pain going down his leg. He began having leg pain after the accident. T. 43.

Petitioner acknowledged that Dr. Khanna released him to restricted work on May 8, 2012. He did not, however, report to work. He explained this as follows: "because of my pain, I couldn't do it." T. 45.

Petitioner returned to Advanced Occupational on May 10, 2012, earlier than directed. A handwritten note bearing that date reflects that Petitioner was still experiencing constant low back pain, rated 6-7/10, and had not returned to work because his symptoms increased with sitting. The note describes Petitioner as "listing" to the left. Dr. Khanna directed Petitioner to continue taking the medication and applying ice. He also directed Petitioner to return on May 14, 2012. PX 1.

The next note, dated May 14, 2012, reflects that Petitioner reported he did not work from May 7 through May 11, 2012 "because sitting for prolonged periods of time [was] too painful." The note also reflects that Petitioner denied numbness, tingling or radiation of his pain. Dr. Khanna discontinued the Ibuprofen. He prescribed a Medrol Dosepak and two weeks of physical therapy. He released Petitioner to light duty and directed him to return on May 22, 2012. PX 1.

Petitioner underwent an initial physical therapy evaluation at Advanced Occupational on May 15, 2012. The evaluating therapist recorded a consistent history of the accident. He noted that Petitioner reported feeling better "until this morning when he was getting out of the shower and his leg gave out on him and he fell. He started having more pain in his leg down to the knee on the anterior leg."

The therapist also noted that Petitioner was "currently on light duty doing only sitting work" and that an MRI was pending. He described Petitioner as exhibiting a forward flexed gait and a shortened step length on the left.

The therapist indicated that Petitioner's "symptoms may have been worsened by the fall in the shower today."

Petitioner acknowledged falling at home while coming out of the shower. He testified he fell "because of the pain" and because he "couldn't stand on [his] leg." He fell forward, catching himself with his hands. He was able to make it to the telephone. He denied striking his back when he fell. He testified the leg pain was present before he fell. T. 47-48.

The lumbar spine MRI, performed the same day, May 15, 2012, showed small right posterior osteophytes and a shallow, broad-based right lateral disc protrusion at L3-L4, along with a 6 mm structure that the radiologist described as "suspicious for a small extruded disc fragment" and "impinging on the right L3 nerve root." The radiologist also noted disc

desiccation and global disc bulging at L4-L5, a very mild disc bulge at L5-S1 and "congenital tapering and narrowing of the central canal involving the L4-L5 and L5-S1 levels." PX 1.

Petitioner returned to Advanced Occupational on May 17, 2012 and again saw Dr. Khanna. A handwritten note of that date documents the following complaints: "States his R leg feels numb for the [sic] 3 days. States he has difficulty walking. States he is currently not working. Taking MDP [Medrol DosePak] as directed."

On examination, Dr. Khanna noted reduced sensation in the lower right leg, low back pain with straight leg raising bilaterally and an inability to perform leg hyperextension testing. The doctor reviewed the MRI with Petitioner. He put physical therapy on hold and set up an appointment for Petitioner to see Jesse Butler, M.D., a spine specialist, on May 18, 2012. He released Petitioner to light duty and continued the medication. A separate "consultant referral form" documents the appointment with Dr. Butler and notes that the appointment was "approved by Herbie Valle" of Superior Staffing. PX 1.

Petitioner saw Dr. Butler on May 18, 2012. After examining Petitioner, Dr. Butler faxed a report to Valle. In his report, he indicated that Petitioner slipped while picking up heavy metal at work on May 8, 2012 and fell forward while continuing to hold onto the metal. He also noted that Petitioner complained of an immediate onset of low back pain and "pain running down the right leg into the shin with numbness of the shin." He stated that Petitioner complained of right leg weakness and difficulty holding his right leg in a comfortable position. He described Petitioner as having been off work since the accident.

On examination, Dr. Butler noted mild tenderness to palpation of the lumbar spine, positive straight leg raising in the back only, bilaterally, and no evidence of sensory loss.

Dr. Butler noted that the MRI images he reviewed "did not include L4-L5 or L5-S1." He also noted he had requested a new CD of the images "to include axial images of L4-L5 and L5-S1." He recommended an epidural steroid injection, to be scheduled pending workers' compensation approval, and a Medrol Dosepak. He directed Petitioner to remain off work and return in two weeks, following the injection.

On May 24, 2012, Dr. Khanna contacted Dr. Butler's office, seeking clarification of the Medrol Dosepak prescription and indicating he had previously prescribed a Medrol Dosepak for Petitioner. The Medrol Dosepak that Dr. Butler prescribed was subsequently discontinued.

Other records in Dr. Butler's chart reflect that Mark Mendenhall, a workers' compensation claims manager, approved the epidural steroid injection, that Dr. Butler reviewed the additional MRI images on May 25, 2012 and that an injection scheduled for June 5, 2012 was cancelled on June 4, 2012 due to "patient not returning phone calls." PX 2.

Despite Dr. Khanna placing therapy on hold, Petitioner continued attending therapy at Advanced Occupational after May 17, 2012. On May 29, 2012, the therapist indicated that

Petitioner "demonstrated poor tolerance" and was complaining of numbness in his right leg radiating down to his right knee by the end of the session. PX 1.

Petitioner testified he was willing to undergo the injection because he was told the injection would help him heal. Before he underwent the injection, he went to Marque Medicos for a second opinion. T. 49-50.

Petitioner first went to Marque Medicos on May 30, 2012, at which time he saw a chiropractor, Dr. Johnson. The doctor's lengthy history reflects that Petitioner experienced an acute onset of low back pain while trying to lift a box out of a container at work. The doctor indicated that Petitioner was resting his knees against the container, while leaning forward to lift the box, when the container "gave way," causing Petitioner to lose his balance as he was holding the box.

Dr. Johnson described Petitioner as currently complaining of "low back pain with referral into the right lower extremity." He described Petitioner's past medical history as non-contributory. He noted that Petitioner had difficulty walking and changing positions. On examination, he noted positive straight leg raising on the right at 20 degrees and 4/5 strength in the hip flexors and extensors, knee flexors and extensors and ankle flexors and extensors bilaterally. He also noted decreased sensation on the lower right leg at L4, L5 and S1. He obtained lumbar spine X-rays. He took Petitioner off work and recommended physical medicine care three times weekly. PX 3A.

On June 1, 2012, Petitioner saw another chiropractor, Dr. Perez, at Marque Medicos. Dr. Perez noted that Petitioner displayed an antalgic posture and was relying on a crutch while walking. He administered therapy, directed Petitioner to remain off work and referred Petitioner to Dr. Engel for pain management. PX 3A.

Petitioner saw Dr. Engel at Medicos Pain and Surgical Specialists on June 5, 2012. Dr. Engel recorded a consistent history of the work accident and noted that Petitioner reported feeling an "immediate pain in his low back" after the accident. Dr. Engel noted that Petitioner was currently complaining of constant right-sided lower back pain shooting down the right leg to the knee.

Dr. Engel noted he reviewed the MRI report.

On initial examination, Dr. Engel noted an antalgic gait, positive straight leg raising on the right at 30 degrees, 5-/5 lower extremity strength in the right L3 and L4 distribution and pain to palpation in the right lumbar paraspinous muscles.

Dr. Engel found a causal relationship between the work accident and Petitioner's current condition, based on Petitioner's history and denial of any pre-accident complaints. He directed Petitioner to stay off work, continue therapy, start Ultram and bring in his MRI films. PX 3A.

Petitioner returned to Dr. Engel on June 7, 2012, at which point the doctor reviewed the MRI films. The doctor described the films as "blurry and somewhat difficult to read." He indicated he did not agree with the radiologist. He interpreted the films as showing herniations at L3-L4 and L4-L5 causing neural foraminal and lateral recess stenosis. He indicated Petitioner appeared to be suffering from an L3, L4 and L5 radiculopathy. He prescribed an EMG along with continued therapy and medication. He directed Petitioner to remain off work. PX 3A.

Petitioner filed an Application for Adjustment of Claim on June 20, 2012. PX 16.

Petitioner underwent an EMG and nerve conduction testing on June 22, 2012. T. 52. Francis J. McCaffery, IV, DC, a chiropractor, conducted this testing.

On July 3, 2012, Petitioner returned to Dr. Engel. The doctor noted that Petitioner was now rating his pain at 3/10 rather than the previous 7/10. He indicated that Petitioner was still experiencing right-sided lower back pain, numbness from his right anterior thigh to his knee and numbness in his right calf. Dr. Engel's examination findings were unchanged. He recommended right L3 and L4 transforaminal epidural steroid injections, citing the EMG/NCV results and Petitioner's radicular symptoms. He prescribed Mobic and Omeprazole and directed Petitioner to stay off work and continue therapy. PX 3A.

On July 5, 2012, Jennifer Jacobs, R.N. of CorVel sent Marque Medicos a letter indicating that various physical therapy sessions had been certified as medically necessary. PX 27.

On July 6, 2012, Dr. Singh examined Petitioner and ordered an EKG and laboratory studies in anticipation of the injection. PX 4A.

Dr. Engel administered right L3 and L4 transforaminal injections on July 11, 2012. In his procedure report, he indicated he offered Petitioner round-trip, non-emergency, non-ambulance transportation since Petitioner "had an anesthetic during surgery." PX 3A, 4A.

On July 31, 2012, Dr. Engel noted that Petitioner "did not have noticeable improvement" from the injections. He referred Petitioner to Dr. Erickson, a neurosurgeon. PX 3A, 4A.

Petitioner first saw Dr. Erickson on August 3, 2012. The doctor recorded a history of the work accident, noting that Petitioner "slipped and caught himself while falling, twisting his back." He described the MRI as "significant for a small lateral disc herniation at L3-L4." He indicated the EMG "suggested abnormalities from L2 through L4." He conducted SSEP testing and described the results as suggestive of abnormalities from L3 through L5 "with the L4 nerve root being worst."

Dr. Erickson noted that Petitioner did not experience initial relief from the injection but had recently noticed that his pain had lessened and that he could walk more easily.

Dr. Erickson noted diminished quadriceps strength. He indicated that Petitioner reported falling occasionally when climbing stairs.

Based on Petitioner's recent improvement, Dr. Erickson suggested that he continue therapy for four more weeks to assess the need for surgery. He found a causal relationship between the work accident and Petitioner's current symptoms. He indicated he provided transportation for the visit. PX 3A.

Petitioner returned to Dr. Erickson on August 31, 2012, with the doctor again providing transportation. The doctor noted complaints of significant low back pain and pain radiating into the right leg as far as the knee. He presented Petitioner with a choice of another injection or a minimally invasive decompression at L3-L4 on the right. He described Petitioner as an "excellent surgical candidate at this point." PX 3A.

Petitioner testified he wanted to undergo surgery because he was unable to walk and wanted to get better. T. 55.

Petitioner returned to Dr. Engel on September 5, 2012, with the doctor ordering blood work in anticipation of surgery. On examination, the doctor noted a complaint of right anterior thigh numbness and positive straight leg raising on the right at 30 degrees. PX 4A.

On September 7, 2012, Dr. Erickson performed a minimally invasive decompression at L3-L4 on the right with foraminotomies over the L3 and L4 nerve roots. In his operative report, he indicated he removed the "far lateral disc herniation at L3-L4," placed an intervertebral device for repair of an annular defect at the same level and performed "continuous EMG monitoring of the lower extremities with motor and sensory evoked potential testing." He also indicated he offered Petitioner non-emergency, non-ambulance, round-trip transportation due to use of an anesthetic. PX 3A.

Petitioner filed a Petition for Penalties and Fees on September 12, 2012. The petition alleges, in a non-specific manner, that Respondent had refused to pay temporary total disability and medical benefits. PX 17.

Petitioner returned to Dr. Engel on September 26, 2012, with the doctor noting persistent right-sided greater than left-sided lower back pain, rated 5/10. The doctor indicated that Petitioner's radicular symptoms resolved with surgery. On examination, he noted negative straight leg raising bilaterally. He kept Petitioner off work and directed him to follow up with Dr. Erickson.

Dr. Engel indicated he reviewed Dr. Zelby's report. He described the doctor as "internally inconsistent," noting that the report documented both "no radicular findings" and "positive straight leg raising." He also described Dr. Zelby as "underplaying his reading of the MRI," noting that the radiologist who read the MRI documented nerve root impingement. He

responded to Dr. Zelby's criticism of concurrent physical therapy and chiropractic care by saying he did not believe Petitioner had simultaneous therapy and chiropractic care. PX 3A, 4A.

On October 4, 2012, Jennifer Jacobs, R.N. of CorVel sent Dr. Engel a letter indicating that retrospective therapy rendered between July 6 and July 31, 2012 had been certified as medically necessary. PX 27.

Petitioner returned to Dr. Erickson on October 9, 2012. The doctor noted complaints of residual back pain and "tingling affecting the right leg as far as the knee." He indicated that Petitioner reported "definite improvement overall." He recommended that Petitioner stay off work and begin therapy. PX 3A.

On October 11, 2012, a nurse reviewer associated with CorVel sent a letter to Dr. Erickson declining to retrospectively certify the September 7, 2012 surgery. In the letter, the nurse reviewer cited ODG guidelines, Dr. Zelby's report and an attached October 10, 2012 report from a peer consultant, Dr. Levy, a board certified neurosurgeon. In his report, Dr. Levy indicated he reviewed Dr. Zelby's report along with records covering treatment rendered from May 15, 2012 through September 5, 2012. RX 2.

Dr. Engel responded to the non-certification in a letter dated October 12, 2012. Dr. Engel indicated that Petitioner "easily met" ODG guidelines for surgery based on the EMG, MRI and lack of response to conservative care. He requested a conference with Dr. Levy. PX 4A.

On October 25, 2012, Dr. Engel noted persistent 5/10 low back pain, negative straight leg raising bilaterally and pain to palpation in the right lumbar paraspinous musculature. He prescribed Ultram and directed Petitioner to stop taking Hydrocodone. He directed Petitioner to stay off work and continue therapy. PX 3A.

Petitioner testified he returned to Dr. Erickson on November 20, 2012. By this time, he was able to walk "a little bit." T. 56.

A Marque Medicos physical therapy re-evaluation note of November 27, 2012 describes Petitioner as having some range of motion limitations but otherwise progressing quite well. PX 3A.

On December 4, 2012, Jennifer Jacobs, R.N. of CorVel sent a letter to Dr. Erickson referencing the doctor's peer-to-peer conversation with Dr. Levy on November 30, 2012 and confirming the previous non-certification of the surgery. In an attached report, Dr. Levy noted Dr. Erickson's intra-operative finding of free fragments in the foramina, compromising the nerve root, but stating that those findings could not be considered in a retrospective review "as that information was not available to Dr. Erickson at the time of the recommendation for surgery." Dr. Levy also indicated that his discussion with Dr. Erickson "did not result in new information" concerning Petitioner's pre-operative status and "did not clarify how the findings of the IME were so different from those documented by Dr. Erickson." RX 1.

On December 7, 2012, Dr. Engel wrote to CorVel Corporation, referencing the peer-to-peer conversation on November 30, 2012 and arguing that the surgery should have been certified based on Petitioner's MRI, EMG and failure to respond to conservative measures. Dr. Engel indicated that Dr. Levy should not have relied on Dr. Zelby because Dr. Zelby "under read the MRI." He requested a peer-to-peer conference. PX 4A.

On December 13, 2012, Dr. Engel noted that Petitioner complained of 4/10 right-sided low back pain and an increase in his right-sided radicular symptoms. On examination, he noted positive straight leg raising on the right at approximately 45 degrees. He recommended a lumbar spine MRI, with and without contrast, and Gabapentin. He directed Petitioner to stay off work and to stop physical therapy and start home exercises. PX 3A, 4A.

Petitioner returned to Dr. Engel on January 24, 2013 and complained of 4/10 low back pain and increased right thigh numbness. After reviewing the recent MRI, the doctor recommended a right L3 transforaminal epidural steroid injection. He directed Petitioner to stay off work and return to Dr. Erickson. He refilled the Gabapentin. PX 3A.

On January 25, 2013, Dr. Engel wrote to CorVel again, indicating his December 7, 2012 request for a peer-to-peer conference had not been allowed within 24 hours "as per URAC." He stated he was entitled to this conference as the representative of Ambulatory Surgical Care Facility. PX 4A.

On January 29, 2013, Dr. Erickson re-examined Petitioner and agreed with Dr. Engel's recommendation of an epidural steroid injection at L3. PX 3A.

Dr. Engel administered a right L3 transforaminal epidural steroid injection on February 14, 2013. PX 3A, 4A. Petitioner testified that this injection was "not really a success." T. 58.

On February 25, 2013, Dr. Engel noted persistent low back and right thigh complaints. On examination, he noted positive straight leg raising on the right at 45 degrees. He directed Petitioner to stay off work and return to Dr. Erickson. PX 3A. The same day, he wrote to CorVel again, indicating he had not been afforded the opportunity to talk with Dr. Levy, despite his previous requests, and theorizing that the surgery had likely been certified in the interim. PX 4A.

Petitioner returned to Dr. Erickson on March 4, 2013. The doctor indicated that the recent injection provided good relief for only one week. He indicated that Petitioner reported having to change positions frequently and being able to sit for only fifteen minutes at a time.

Dr. Erickson interpreted the December 21, 2012 MRI as showing "some darkening of the L4-L5 disc associated with moderate stenosis at that level, as well as a small, left-sided disc herniation at L5-S1." He performed SSEP testing of both legs. He interpreted the testing as showing mild delays present from L3 through S1, all on the right. He indicated that the L3 nerve

on the right side "retained significant improvement from the pre-operative value." He directed Petitioner to slowly increase his Neurontin intake and return in four to six weeks. PX 3A.

On April 11, 2013, Dr. Engel noted that Petitioner complained of 3/10 lower back pain and right anterior thigh numbness. On examination, he noted positive straight leg raising on the right at 45 degrees. He recommended a functional capacity evaluation, indicating Petitioner might be approaching maximum medical improvement "if he is not a candidate for repeat surgery." He directed Petitioner to remain off work and transition to over the counter medication. PX 3A.

Petitioner underwent a functional capacity evaluation at Elite Physical Therapy on May 3, 2013. The evaluator, David O'Connell, PT, rated the evaluation as valid. He described Petitioner as putting forth "full and consistent effort." He found Petitioner capable of functioning at a light physical demand level. He recommended that Petitioner participate in work conditioning five days per week for four weeks. Petitioner attended work conditioning from May 9, 2013 through July 15, 2013. PX 5.

Petitioner testified he went to Superior Staffing in July 2013 to see whether Superior Staffing would provide him with work within his restrictions. He talked with a secretary and was "supposed to report [to] a manager" but was unable to find the manager. He left a work status note with Superior Staffing. He visited Superior Staffing on three occasions but was never able to find the manager. T. 60-61.

Petitioner returned to Dr. Engel on July 31, 2013, with the doctor recommending an injection and imposing various restrictions. PX 21. Dr. Engel administered a right S1 transforaminal epidural steroid injection on August 28, 2013. PX 4A. Petitioner testified he noticed improvement after this injection, which was his last. T. 61. On August 28, 2013, Dr. Engel again imposed restrictions: sit/stand as needed, frequent lifting up to 25 pounds and occasional lifting up to 50 pounds. PX 21.

On September 3, 2013, Petitioner's counsel sent Respondent's counsel Dr. Engel's most recent work status notes and indicated Petitioner "has been able to return to work with light duty restrictions." Petitioner's counsel also indicated that Petitioner had requested light duty from Respondent on several occasions but had not received any offers of light duty to date. Petitioner's counsel asked Respondent's counsel to determine whether Respondent would accommodate Petitioner or, alternatively, begin paying temporary total disability benefits. PX 21.

Petitioner testified he last saw Dr. Engel on September 19, 2013. T. 68.

Petitioner testified he returned to Dr. Erickson on October 2, 2013. T. 68. On that date, the doctor indicated Petitioner had been doing well until two weeks earlier when he noticed right-sided sciatic pain which he associated with a return to light duty. He recommended that,

for the following month, Petitioner restrict occasional lifting to 50 pounds and frequent lifting to 25 pounds with no repetitive bending. PX 4A.

Petitioner testified that, in September 2013, he was able to find restricted duty through two temporary agencies, Debbie's Staffing and Elite Staffing. He continued working through Debbie's Staffing through the end of 2013. He identified PX 23 as a group of paycheck stubs showing he grossed a total of $758.44 from Debbie's Staffing in 2013. T. 62-64. He identified PX 24 as a W2 form showing he earned $2,165.65 from Elite Staffing in 2013. He did not work for any entities other than Debbie's Staffing and Elite Staffing in 2013. T. 65. He worked for two different agencies so as to maximize his job assignments. The agencies "only called [him] when they needed [him]." Neither agency was able to provide him with full-time work. The work he performed through Debbie's Staffing consisted of making boxes. The work he performed through Elite Staffing consisted of packing small spoons and other disposable items in a factory setting. T. 65-67. After he worked an 8-hour shift, he noticed pain. He "wasn't feeling 100% better" but he felt "a little bit" better than he had before the surgery. T. 68-69.

Petitioner testified he saw Dr. Kranzler, an associate of Dr. Erickson, in February 2014. The doctor's February 5, 2014 note reflects that Petitioner reported working three days per week for the past two months, with no lifting over 30 pounds. The note also reflects that Petitioner reported having pain after work and requested medication. Dr. Kranzler prescribed Tramadol and recommended that Petitioner return in three months. PX 4A.

On June 18, 2014, Petitioner returned to Marque Medicos and saw Dr. Perez. The doctor noted complaints of constant bilateral low back pain, rated 6/10, tingling in the posterior aspect of the right heel and a "painful, pulling sensation along the medial aspect of the right thigh." He also noted that Petitioner was having difficulty walking, sitting and sleeping "due to his pain worsening." He indicated that Petitioner reported being unable to work consistently.

On examination, Dr. Perez noted an antalgic gait, tenderness to palpation over the L3-L4, L4-L5 and L5-S1 spinal levels and positive straight leg raising on the right at 20 degrees. He recommended that Petitioner continue light duty and follow up with his neurosurgeon. PX 3A.

Petitioner testified he saw Dr. Erickson again on July 9 and September 17, 2014. On September 17, 2014, the doctor released him to unrestricted duty, noting he was taking over the counter Ibuprofen for continuing back pain. PX 4A. Petitioner testified he has not returned to the doctor since that date. T. 69.

On September 18, 2014, Dr. Perez of Marque Medicos discharged Petitioner from care, indicating that ongoing treatment was "no longer medically warranted." PX 3A.

Respondent's examiner, Dr. Zelby, testified by way of evidence deposition on January 21, 2015. RX 3.

Dr. Zelby testified he is a fellowship-trained, board certified neurosurgeon. RX 3 at 4-5. Zelby Dep Exh 1. He is an assistant professor of neurosurgery at Rush. RX 3 at 5.

Dr. Zelby testified he examined Petitioner on August 20, 2012. He does not independently recall Petitioner. RX 3 at 7. Petitioner related that he experienced a sharp onset of low back pain when he slipped forward while lifting a box out of a container that "gave a little." RX 3 at 8. Petitioner also related that he began experiencing bilateral buttock pain and pain down his entire right leg about four days after the accident. Petitioner indicated that his right foot and the bottom of his right foreleg were now fine. RX 3 at 8.

Dr. Zelby testified that Petitioner told him he felt that none of the treatment he had received was of any benefit and that his symptoms were unchanged, although his right leg pain now stopped at the knee. Petitioner denied any prior episodes of similar symptoms. RX 3 at 9.

Dr. Zelby testified he reviewed records from Advance Occupational and Marque Medicos, including Dr. Engel's notes. RX 3 at 10.

Dr. Zelby indicated that, on examination, he noted "no tenderness in a completely normal range of motion," negative sitting straight leg raising, positive lying and reverse straight leg raising on the right, normal toe and heel walking, normal strength and sensation and a normal gait. The only inconsistent finding was diminished pain on distraction "based on the disparity between sitting and lying straight leg raising." RX 3 at 10-11. His examination revealed no radicular complaints or findings. RX 3 at 12. To him, it was "not surprising" that Petitioner had no symptoms of impingement since there was no neural impingement demonstrated on MRI. RX 3 at 12.

Dr. Zelby testified he reviewed Petitioner's EMG. A chiropractor performed this EMG and he is not aware of knowledge, training or experience that would enable a chiropractor to correctly perform or interpret an EMG. Moreover, the EMG results suggested a "blunderbuss finding of denervation of the L2 through L4 nerve roots," with the chiropractor indicating it was more likely that the L3 and L4 nerve roots were affected, based on Petitioner's clinical presentation. RX 3 at 12-13. The symptoms Petitioner relayed to him were not radicular; rather they "encompassed the entire thigh." This is not a dermatomal distribution. The MRI of May 15, 2012 showed no neural impingement at any level and mild degeneration with well-maintained disc space heights. RX 3 at 14.

Dr. Zelby testified he diagnosed a herniated lumbar disc. Based on the examination and MRI, he did not view Petitioner as a candidate for any kind of surgery, irrespective of cause. Even with Petitioner's persistent low back pain and non-radicular thigh pain, there was no reason to pursue discography or consider either a discectomy or fusion. RX 3 at 15. Pursuit of a fusion in such a setting "exceeds any guidelines for treatment of the actual condition." RX 3 at 15-16. He thought a trial of epidural injections was reasonable, as was the decision to pursue no additional injections based on Petitioner's poor subjective response to the first injection. RX 3 at 16. The EMG was neither reasonable nor necessary. Physical therapy was excessive. RX 3

at 17. A complete laboratory panel and EKG were not needed in advance of the injection, which is pursued using sedation only. RX 3 at 16. He felt it would be reasonable to allow Petitioner up to ten visits of work conditioning before allowing him to resume full duty. RX 3 at 17. He anticipated that Petitioner would be at maximum medical improvement within two to three weeks. RX 3 at 16-17. In his view, there is a 50/50 chance that Petitioner's disc herniation is related to the work accident. However, "based on the minor degeneration that he had, a small herniated disc without neural impingement, this had been dragging on way too long." RX 3 at 18-19.

Dr. Zelby opined that, as of his examination, Petitioner could easily work at a light physical demand level. His prognosis for a return to full duty within two to three weeks was excellent. RX 3 at 19. Petitioner "absolutely did not" require permanent restrictions. RX 3 at 19. According to the job description he reviewed, Petitioner's job was at a medium physical demand level, occasionally lifting and moving up to 50 pounds. RX 3 at 20. A functional capacity evaluation was "absolutely not" needed. RX 3 at 21.

[The Arbitrator overruled Petitioner's hearsay objection to Dr. Zelby's report, dated August 20, 2012. Zelby Dep Exh 2. Petitioner's subsequent, Ghere-based objections to Dr. Zelby's criticism of the SSEP testing (RX 3 at 21-23) required admission and review of the report, in the Arbitrator's estimation.]

Dr. Zelby testified that his opinions are based on a reasonable degree of medical and surgical certainty. RX 3 at 23.

Under cross-examination, Dr. Zelby conceded he saw Petitioner only once and reviewed no records relating to treatment rendered after July 31, 2012. RX 3 at 23. Dr. Zelby testified he speaks Spanish fluently. He could not recall whether he conducted his examination in Spanish or English. RX 3 at 24. Petitioner told him he initially went to a company clinic and subsequently went to a different clinic at his attorney's direction. RX 3 at 24.

Dr. Zelby testified he has been performing independent medical examinations for at least 15 years. RX 3 at 24. He is not aware of any history of Petitioner having injured his back before the May 8, 2012 work accident. RX 3 at 25. Petitioner was able to perform work at a medium duty level before the accident. RX 3 at 25-26. He believes Petitioner did injure his back in the accident. RX 3 at 26. Petitioner rated his pain at 7-8/10 but exhibited no pain behaviors suggesting this rating was accurate. RX 3 at 26-27. Individuals have differing responses to pain. RX 3 at 27. He saw the actual MRI film. RX 3 at 27. He agrees that MRI films are not 100% accurate. RX 3 at 28. In Petitioner's case, however, it is not possible that the MRI showed impingement based on Petitioner's lack of neurologic symptoms. RX 3 at 28. It is possible the accident caused the herniated disc at L3-L4. RX 3 at 28. Pain caused by the L3 nerve root would typically come across the lateral buttock around the groin and into the front of the thigh, extending down toward the knee. RX 3 at 29. L4 nerve root irritation would typically cause pain "sort of along the lateral aspect of the thigh to the front of the knee and then the front of the proximal foreleg." RX 3 at 29. Radiculopathy is "pain in the nerve root

distribution." RX 3 at 30. Disc herniations are common causes of radiculopathy. RX 3 at 30. A physician can suspect radiculopathy based on straight leg raising but you would want confirmation via MRI and/or EMG. RX 3 at 31. Radicular symptoms can be constant or intermittent. RX 3 at 31. He reviewed Dr. Butler's note. He agrees with Dr. Butler's diagnosis of a disc herniation and his recommendation of an injection. RX 3 at 32. In his opinion, the MRI showed normal hydration of the L3-L4 disc. RX 3 at 32. There are certainly things that reasonable physicians can disagree on. RX 3 at 33. In Petitioner's case, post-operative reports showing relief of symptoms "would not by any means in retrospect justify pursuit of surgery." "Medicine in the 21st century isn't based on retrospective." RX 3 at 34. He did not review the operative report or any intra-operative photographs. RX 3 at 34. He would have to see those photographs in order to disagree with Dr. Erickson's noting of impingement. RX 3 at 34. He could not disagree with the doctor's other notation of fragments without looking at the photographs. RX 3 at 34-35. His opinions concerning surgery are based on the fact that Petitioner did not have symptoms in the front of his thigh. Petitioner had symptoms in his entire thigh. The L3 and L4 dermatomes are not represented in the back of the thigh. RX 3 at 37. Whether there were fragments or not, 85 to 90% of people who have disc herniations get better without surgery anyway. RX 3 at 37. The fact that Dr. Erickson found fragments retrospectively "seems more self-serving than truly representing pathology causing [Petitioner] any problems." RX 3 at 38. It was reasonable for Petitioner to undergo an injection, because such an injection could reduce the inflammation resulting from a disc herniation. RX 3 at 39.

Dr. Zelby testified he devotes 95% of his practice to patient care. He tries to adhere to ODG guidelines and believes they have "value in treatment." RX 3 at 39.

Dr. Zelby testified he conducts one or two independent medical examinations each week, during the weeks he works. He takes eight to ten weeks off per year. RX 3 at 40. As of 2012, he charged $1,350 for an examination. He charges $800 per hour for deposition time. RX 3 at 40. He has no agreements with PDM or Berkeley Risk as far as examination referrals. RX 3 at 41.

Dr. Erickson testified by way of evidence deposition on February 3, 2015. PX 19.

Dr. Erickson testified he attended medical school at Northwestern University and subsequently completed a five-year neurosurgery residency program at the University of Chicago in 1987. He held various teaching positions at the University of Chicago for 19 years before resigning to go into private practice. He currently practices in Lake County. He is a "general neurosurgeon excluding complex pediatric neurosurgery." PX 19 at 5. He specializes in both minimally invasive and large reconstructive procedures. He is board certified in neurosurgery and is on staff at various hospitals in Lake County. PX 19 at 6-7.

Dr. Erickson testified he first saw Petitioner on August 3, 2012, at Dr. Engel's referral. Petitioner provided a history of a May 2012 work accident and complained of severe lower back and right leg pain. PX 19 at 7-8. The fact that Petitioner complained of leg pain told him that Petitioner "might be harboring a lumbar nerve root problem." PX 19 at 7-8. The upper lumbar

nerve roots serve the area above the knee while the lower lumbar nerve roots serve the area below the knee. PX 19 at 8-9.

Dr. Erickson indicated that Petitioner described catching himself while falling and twisting his back in the course of the accident. Dr. Erickson also indicated that Petitioner immediately noticed severe low back pain "and began to have right-sided sciatica . . . about three days following the incident." Petitioner described his sciatica as residing mainly within the anterior thigh and the area just below his knee. PX 19 at 9.

Dr. Erickson testified that a twisting injury can result in tears of the fibers that contain the discs. He also testified that Petitioner denied any pre-accident injuries. PX 19 at 9-10.

Dr. Erickson testified that, based on Petitioner's reporting, he perceived Petitioner as deriving a delayed benefit from the injection Dr. Engel had administered. Petitioner's delayed response was "not atypical in any way." PX 19 at 11.

Dr. Erickson testified he documented some right quadriceps weakness on examination. He opined that this weakness meant there was involvement of the motor portion of one of the nerve roots or even compromise of more than one nerve root. A small disc herniation, if located off to one side, can pinch the nerve within the bony tunnel. PX 19 at 13. He reviewed Petitioner's MRI images, which showed a small disc herniation at L3-L4 in the lateral location. Based on the images alone, he could not determine with certainty whether the nerve root was compressed. Petitioner was old enough to have small disc herniations on MRI. Lateral disc herniations can be exquisitely painful. PX 19 at 14. Petitioner's EMG showed "possible abnormalities in the L2, L3 and L4 nerve roots." The EMG "raised the question of an upper lumbar disc herniation." The EMG correlated with the MRI and Petitioner's complaints. PX 19 at 15. An EMG is "always less specific" but, in Petitioner's case, it correlated with the side of the complaint and it localized the problem to one of the upper lumbar levels. PX 19 at 16.

Dr. Erickson testified he ordered SSEP testing when he first saw Petitioner because such testing is much more specific than EMG/NCV testing and can isolate a problem at a specific nerve root level. SSEP testing is newer and more sensitive than EMG/NCV testing. It is much more useful in the operating room. PX 19 at 17. He disagrees with Dr. Zelby's testimony that there is no data to suggest that SSEP tests provide any meaningful information. In his opinion, SSEP testing, while not to be used alone, helps avoid "wrong level surgery." PX 19 at 17-18. Petitioner's SSEP results did not suggest L2 involvement, as the EMG did. The results did, however, confirm that L2, L3 and L4 were somewhat abnormal. They also suggested that the L4 nerve root was the slowest. That nerve root "passes just inside the lateral disc herniation at L3-L4. PX 19 at 18-19. Petitioner's thigh complaints fell within an L3-L4 dermatomal pattern. PX 19 at 21.

Dr. Erickson testified that the studies and examination findings suggested that Petitioner might have an "important nerve impingement, probably at the location of the lateral disc herniation at L3-L4." PX 19 at 21. Impingement does not necessarily equate to radiculopathy.

Radiculopathy may or may not be due to nerve root impingement. A virus or a tumor can also cause radiculopathy. Impingement at the levels indicated in Petitioner's case could cause some degree of back, gluteal or thigh pain and some numbness and tingling. There is much individual variation. PX 19 at 22.

Dr. Erickson found a causal relationship between the work accident and Petitioner's condition, based on the mechanism of injury and Petitioner's statement that he was functioning well until the injury. PX 19 at 23. His causation opinion would not change if something showed that Petitioner's right leg complaints actually started on the day of the accident rather than three days later. PX 19 at 23-24.

Dr. Erickson testified he took a conservative approach on Petitioner's first visit due to Petitioner's report of recent improvement. He kept Petitioner off work because of the pain and so that Petitioner could pursue therapy and hopefully avoid surgery. PX 19 at 25. He viewed Petitioner as an "excellent candidate" for a minimally invasive decompression at L3-L4 on the right side. He attributed the need for this surgery to the work accident. PX 19 at 25-27. He performed the surgery on September 7, 2012. Several individuals, including a neurophysiology technician, were in the operating room with him. The technician obtained data for nerve monitoring. In Petitioner's case, this monitoring was "crucial because of the [small] size of the disc herniation." PX 19 at 27. Dr. Erickson testified that, during the surgery, he found and removed a far lateral disc herniation and repaired a defect in the annular layer. The monitoring showed that the nerve velocity improved during the surgery. PX 19 at 28-29. His operative findings correlated exactly with his pre-operative diagnosis. This signified a "probable good outcome." PX 19 at 29.

Dr. Erickson testified that Petitioner was improved overall at the first post-operative visit. Petitioner complained of tingling rather than pain in his right leg. This was normal, since, at this point, the nerve was still swollen. Numbness, which is part of radiculopathy, sometimes takes weeks and weeks to fade away. PX 19 at 31. Petitioner reported right leg pain at the next visit but the pain was "in a smaller zone." PX 19 at 32. By the visit of January 29, 2013, Petitioner was walking better than before the surgery but he could sit comfortably for only 15 minutes at a time. PX 19 at 33. At this point, he thought it was reasonable "but not mandatory" for Dr. Engel to administer an injection. PX 19 at 34. Petitioner experienced only one week of relief following the injection. PX 19 at 34-35.

Dr. Erickson testified that the findings shown on the post-operative MRI were "likely there all along." He did not believe Petitioner had a new incident or injury. He ordered repeat SSEP testing, which showed mild delays of multiple nerves but continued improvement of the L3 and L4 nerves. Nothing about the repeat testing prompted him to suggest more surgery. PX 19 at 36. He prescribed Neurontin. As of May 8, 2013, Petitioner still had some low back pain but had improved overall. PX 19 at 37.

Dr. Erickson testified he reviewed Dr. Zelby's report. He is unable to testify as to what complaints Petitioner voiced to Dr. Zelby but he is able to definitively state that Petitioner had a

clear radicular pattern of pain involving the thigh and the area below the knee on each of his visits. Petitioner also had "radicular weakness involving the quadriceps musculature." PX 19 at 38-39.

Dr. Erickson testified that, as of October 2, 2013, Petitioner had resumed light duty work. His "low back pain was much worse than his leg pain in a different manner than he had had before the surgery." PX 19 at 39. At this point, Petitioner was "not normal despite the successful results of the surgery." PX 19 at 40. As of July 2014, Petitioner had some back pain and pain radiating toward his right knee but his examination was negative for weakness. PX 19 at 41. Repeat SSEP testing showed only mild delays at the L4 nerve. When he last saw Petitioner, on December 17, 2014, he released Petitioner to full duty. He acknowledges that Petitioner was "not perfect" at that point. Petitioner did not return to him thereafter. PX 19 at 43.

Dr. Erickson had no recollection of having a peer-to-peer conversation with Dr. Levy in November 2012. PX 19 at 43.

Dr. Erickson testified that overall, he is satisfied with Petitioner's response to treatment. That treatment was causally related to the accident. PX 19 at 43-44.

Under cross-examination, Dr. Erickson testified he sees about 5 new patients per month at the referral of Marque Medicos and Medicos Pain. He sees about 20 patients per month under the umbrella of these providers. PX 19 at 44-45. Most likely, he saw Petitioner at one of the Marque Medicos offices. He operates on Marque Medicos referrals at the Ambulatory Surgical Care facility if they are appropriate for same-day discharge. PX 19 at 45. This facility is affiliated with Marque Medicos. He receives no portion of the facility fees. PX 19 at 46. With respect to his status at the American Center for Spine & Neurosurgery, he is a physician partner who functions as an employee of the corporation. PX 19 at 47.

Dr. Erickson testified that Petitioner had "one significant neurological deficit," i.e., a problem with quadriceps strength, when he first saw Petitioner on August 3, 2012. PX 19 at 47. He does not believe Petitioner had much numbness or tingling at that visit. PX 19 at 48. In his review of Petitioner's MRI, he noted a lateral disc herniation. He did not specifically note stenosis but Petitioner almost certainly had some degree of lateral recess or foraminal stenosis. PX 19 at 50.

Dr. Erickson testified he would have to look at Petitioner's EMG report to determine whether the EMG was performed by a chiropractor. In his own office, an EMG would usually be performed by a neurologist. He notices the status of the person conducting the study but he also looks at the data. PX 19 at 51. He trusts the chiropractic EMGs obtained through Marque Medicos sufficiently to not have them repeated by a neurologist. PX 19 at 52. He does not know the extent of the training of the chiropractors who conduct EMGs. PX 19 at 52.

Dr. Erickson testified there are various kinds of SSEP tests. Often when experts testify about these tests they are thinking of brain studies or brain recordings made during brain surgery. They do not always talk about dermatomal studies. PX 19 at 53. The SSEP tests conducted at his direction do not involve needle insertion. PX 19 at 54.

Under additional cross-examination by co-Respondent Superior Staffing, Dr. Erickson admitted Petitioner rated his pain at 6/10 in July 2014 and at only 4/10 at the initial visit in August 2013. Pain is very subjective and the rating should not be used for comparison purposes. PX 19 at 56.

On redirect, Dr. Erickson testified that it is not specified whether the 6/10 rating came from or what it related to. PX 19 at 59.

Petitioner testified he continues to work in a factory setting, packing small spoons and other disposable items into boxes. T. 69.

Petitioner testified his "butt" hurts with extended sitting and with cold weather. On a day when the weather is normal, he experiences 3/10 pain. At the end of an 8-hour shift, he feels very tired and his pain increases to a 5/10 level. T. 71-72. He takes 600 mg Tylenol as needed, depending on his pain. He typically takes this medication at the end of a workday. T. 72. He experiences 3-4/10 leg pain every day. The surgery helped him "a lot." Before he had the surgery, he was afraid he was not going to be able to walk. T. 73. The surgery was a success in the sense that it allowed him to resume walking but he continues to have some pain. T. 74. He is glad he underwent the injections and surgery. T. 75, 81. Before the surgery, he could not move and could not work. T. 75. He needed a heavier type of medication, which made him sleepy. The medication he takes now does not make him sleepy but he has to buy this medication on his own. T. 76. He has difficulty performing some routine activities, such as bending and reaching to wash his feet. He has to think about this motion ahead of time because of the pain he experiences. T. 77. He also has difficulty getting back to an upright position after he ties his shoes. T. 78. Before the surgery, he had trouble bending and moving his leg. If he had his leg in a straight position, it "stayed straight" and stiff. He felt tingling and "a very bad pain" from his knee downward. T. 80. These sensations improved, with time and medication, after the surgery. T. 80.

Under cross-examination, Petitioner testified he did not try to return to work after a doctor at Advanced Occupational imposed restrictions on May 8, 2012 because he felt he was unable to work in any capacity. T. 82. Superior Staffing told him it could accommodate the doctor's restrictions but he decided not to work. T. 83. Before the surgery, he had pain in his back and right leg. He still has pain in his back and right leg, although the pain is "not the same." T. 84-85. The medication he took before the surgery did not make him feel better. He did not like the way he felt when he took this medication but he had to take it "to control the pain." T. 85-86. He still takes medication to control pain but the medication he takes now is different. It does not make him feel sleepy or bad. T. 86.

Petitioner testified that the work he performed through Debbie's Staffing consisted of assembling and taping boxes. The boxes arrived at his work station in a package. He would remove the boxes one by one. T. 88-89. He assembled about 2,000 boxes per shift. T. 89. Debbie's Staffing did not send him to any other jobs. While working through Elite Staffing, disposable items such as plastic glasses and spoons would arrive in groups. He had to pack these items into boxes and run the boxes through a machine. The boxes would then move on to another worker who put them onto pallets. T. 91.

Petitioner testified he worked through a different agency, Star Staffing, in 2014. Through this agency, he worked in a factory, doing cleaning and sweeping the floor. T. 93.

On redirect, Petitioner testified he was unable to tolerate the leg pain he experienced before undergoing surgery. He would not wish this pain on anyone. T. 94. Dr. Engel prescribed Gabapentin and Tramadol for him. These medications made him very sleepy. He took Tramadol three times daily and Gabapentin twice daily. T. 95. The Tylenol he takes now is over the counter. He buys it on his own and takes it when he has pain. It does not make him sleepy. T. 96. His life now, after the surgery, is "fine" compared with what it was before. T. 96.

In addition to Dr. Zelby's deposition and the utilization review reports, Respondent offered into evidence a print-out of temporary total disability benefits and other expenses (medical, nurse case manager, IME, transportation, etc.) it paid in this claim. RX 4.

Arbitrator's Credibility Assessment

The Arbitrator finds credible Petitioner's testimony that he experienced right leg pain and weakness during the interval between the undisputed May 8, 2012 work accident and the shower-related incident of May 15, 2012. The Arbitrator makes this finding without giving any consideration to PX 18, a rejected accident report completed by Petitioner. The Arbitrator finds the testimony consistent with the described mechanism of injury and the post-accident records. Although Dr. Khanna of Advanced Occupational Health indicated that Petitioner denied radicular symptoms on May 8, 2012, a handwritten Advanced Occupational Health note dated May 10, 2012 reflects that Petitioner was "listing" to the left. The detailed therapy evaluation note of May 15, 2012 reflects that Petitioner attributed the shower incident to his leg giving out on him and that he was experiencing "more pain in his leg down to the knee" [emphasis added]. PX 1.

Also credible was Petitioner's testimony that his pre-operative leg symptoms were intolerable and that the surgery helped relieve those symptoms. The surgery was not entirely successful, as Dr. Erickson conceded, but it allowed Petitioner to move his leg more freely and resume walking.

Arbitrator's Conclusions of Law

Did Petitioner establish a causal relationship between his undisputed accident of May 8, 2012 and the need for the lumbar spine surgery? Did Petitioner establish a causal connection between his undisputed accident and his claimed current condition of ill-being?

The Arbitrator finds that Petitioner established a causal relationship between his undisputed work accident of May 8, 2012 and the need for the lumbar spine surgery Dr. Erickson performed on September 7, 2012. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible denial of any pre-accident lumbar spine or right leg conditions or treatment; 2) the fact that Petitioner was able to perform various duties at Juno Lighting for about six or seven weeks before the accident; 3) Petitioner's credible and detailed account of the accident and the symptoms he experienced thereafter; 4) the complaints and histories recorded in the May 10 and 15, 2012 notes (referenced in the Arbitrator's credibility assessment, above); 5) the radiologist's interpretation of the first lumbar spine MRI; 6) the right leg complaints noted by Dr. Butler in his communication to Heriberto Valle; and 7) Dr. Engel's and Dr. Erickson's examination findings and MRI interpretation.

Petitioner argues that Respondent's stipulation to a period of temporary total disability amounts to a binding stipulation to causation. Petitioner relies on Hector Fontalvo v. Food Team, 12 IWCC 565, in making this argument. The Arbitrator notes that Fontalvo has had, at best, a tortured procedural history, with the Commission issuing a third decision, on remand, in June 2014. Petitioner has not cited any appellate decision in support of the proposition that a party's stipulation to certain benefits (here, temporary total disability) amounts to a stipulation to causation. The Arbitrator also notes that Respondent clearly placed causal connection in dispute. Arb Exh 1.

The Arbitrator clarifies that she does not rely on the EMG findings since the EMG was performed by a chiropractor rather than a board certified neurologist. The Arbitrator agrees with Dr. Zelby's criticism of the EMG. The Arbitrator also notes Dr. Erickson's testimony that he uses EMGs conducted by neurologists in his own practice.

While Petitioner's right leg complaints clearly increased after the shower incident, the Arbitrator concludes that that incident resulted from right leg symptoms caused by the work accident. Petitioner's testimony that he lost his balance in the shower due to his already-existing right leg pain and weakness is supported by the physical therapy note of May 15, 2012.

Overall, the Arbitrator assigns greater weight to the examination findings and surgery-related causation opinions of Drs. Engel and Erickson than to those of Dr. Zelby. Dr. Zelby conceded that Petitioner had a disc herniation, positive straight leg raising (albeit inconsistent, in his opinion) and right thigh symptoms (albeit circumferential, in his opinion). He also conceded that radicular symptoms can be intermittent in nature. He saw Petitioner on only one occasion whereas Drs. Engel and Erickson saw him a number of times. In his report, (Zelby Dep Exh 2), he focused more on the idea that Petitioner did not require a fusion than on the notion that Petitioner required no surgery at all. He conceded he reviewed only pre-operative

records. He also conceded he performs one to two examinations per week during the weeks he works.

The Arbitrator further finds that Petitioner established causation as to his claimed current post-operative condition of ill-being. Petitioner testified to some ongoing difficulties with certain activities. He also testified to needing to use over the counter pain medication. He acknowledged, however, that he is able to perform various work activities and that he no longer experiences the kind of crippling leg symptoms he experienced before the surgery.

What was Petitioner's average weekly wage?

At the hearing, Petitioner claimed an average weekly wage of $330.00 ($8.25/hour x 40 hours) while Respondent claimed $252.31. Arb Exh 1. On direct examination, Petitioner testified he started working for Respondent in late March 2012 and earned $8.25 per hour. He also testified he had an expectation of working 40 hours per week. He acknowledged, however, that Respondent's wage statement (PX 26) shows he worked only 16 hours the first week of employment and 8 hours the second week. His explanation for this was that Respondent would sometimes defer paying him for work performed one week to the following week. T. 21. He introduced only one paycheck into evidence, with that paycheck (PX 20) confirming his testimony that "retro" earnings might be carried over from one week to the next. PX 26, a "statement of weekly earnings," does not show a hire date or the exact dates on which Petitioner worked but it does show the total hours he worked in each of seven weeks. It also shows his total non-overtime earnings in each of those weeks, with those earnings varying from $66.00 (for the week ending April 8, 2012) to $396.00 (for the week ending April 28, 2012, with the $396.00 including "retro" earnings of $66.00).

Respondent did not introduce any evidence contradicting Petitioner's testimony that he expected to work five days a week, eight hours a day, and made himself available to do so.

Section 10 of the Act provides that, where the employment prior to the injury extended over a period of less than 52 weeks, the method of dividing total earnings by "the number of weeks and parts thereof" shall be followed. The Arbitrator arrives at an average weekly wage of $324.58 by dividing Petitioner's total earnings of $1,622.88 by 5 weeks. The Arbitrator arrives at a divisor of 5 weeks by combining the hours Petitioner worked in each of the 7 weeks and assuming a "work week" of 8 hours per day, 5 days per week. In the instant case, an average weekly wage of $324.58 gives rise to a minimum temporary total disability and permanency rate of $319.00.

Is Petitioner entitled to reasonable and necessary medical expenses?

The Arbitrator has previously found that Petitioner established causation as to the need for the surgery. The Arbitrator further finds that the surgery was reasonable and necessary, based on the MRI, Petitioner's relatively consistent right leg complaints, the quadriceps atrophy

and intra-operative findings noted by Dr. Erickson and Petitioner's testimony that the surgery relieved his intolerable right leg pain and allowed him to resume walking.

In finding the surgery to be reasonable and necessary, the Arbitrator has given consideration to RX 3 and RX 4, the utilization review non-certifications. The Arbitrator recognizes that a retrospective review, such as the one conducted herein, is to be based solely on the information available to the ordering provider at the time the health care services were provided, per Section 8.7(e). The Arbitrator finds, however, that in the instant case, Petitioner showed, by a preponderance of the evidence, that a variance from the standard of care espoused by the reviewer was reasonably required to at least partially relieve the effects of his undisputed injury. The Arbitrator also notes that, while utilization review evidence must be considered, it is not dispositive.

At the hearing, Petitioner claimed numerous outstanding medical expenses, many of which relate to the surgery and post-operative care. Respondent disputed this claim, citing Dr. Zelby's opinions and the utilization review non-certification. Respondent offered into evidence a print-out (RX 4) showing it paid $24,047.98 in expenses relating to services rendered before the surgery. The Arbitrator notes that the $24,047.98 total includes a $75.00 IME-related transportation expense, Dr. Zelby's fees of $1,500 (presumably IME-related) and $750 (unknown expense of 8/28/12) and $3,420.15 in nurse case manager fees.] Respondent objected to Petitioner's various fee schedule calculations but did not offer any alternative calculations.

Petitioner claims $6,472.96 in outstanding fee schedule charges from Marque Medicos. PX 6. These charges relate to chiropractic care and physical therapy rendered after Respondent discontinued payment for this treatment. They do not include any transportation-related expenses. [RX 4 reflects that Respondent paid a substantial amount to Marque Medicos prior to Dr. Zelby's examination.] Based on the foregoing findings as to causation and reasonableness/necessity, the Arbitrator awards Petitioner the claimed $6,472.96.

Petitioner claims $5,029.06 in outstanding fee schedule charges from Medicos Pain & Surgical Specialists, S.C. PX 7. These charges relate to pre- and post-operative treatment rendered by Dr. Engel and various non-emergency transportation services. Of these charges, the Arbitrator awards only the $408.96 charges associated with Dr. Engel's September 5, 2012 surgical clearance examination. The Arbitrator declines to award any of the remaining outstanding charges. The Arbitrator declines to award the multiple transportation-related expenses (8/31/12 through 5/8/13) as there is no evidence supporting the need for transportation. Dr. Erickson did not address this need at any point during his deposition. The Arbitrator declines to award the remaining expenses as they relate to pain management and two largely unsuccessful injections rendered by Dr. Engel after Petitioner came under Dr. Erickson's care. The Arbitrator relies on Drs. Butler and Zelby in finding it was reasonable for Petitioner to undergo an initial injection. Respondent paid for this injection (administered by Dr. Engel on July 11, 2012), as evidenced in PX 7 and RX 4. The Arbitrator questions the need for Dr. Engel's ongoing involvement in Petitioner's care after the referral to Dr. Erickson. At no

point in his deposition did Dr. Erickson explain why he would have been unable to address Petitioner's medication needs on his own.

Petitioner claims outstanding charges of $1,605.10 from Industrial Pharmacy Management for pain and other medication prescribed between August 31, 2012 and September 19, 2013. PX 8. The Arbitrator, having found Petitioner's pain complaints to be credible, awards Petitioner the $1,605.10 in charges. Since these charges are prescription-related, they are not reduced per the fee schedule. Petitioner testified that the prescription medication he took made him sleepy but that he needed it due to the severity of his pain.

Petitioner claims $75,542.49 in outstanding fee schedule charges from Ambulatory Surgical Care Facility, LLC. PX 9. Of these charges, the Arbitrator awards only those relating to the surgery performed by Dr. Erickson on September 7, 2012, other than the $293.66 in transportation expenses. In summary, the Arbitrator awards the following: 1) $65,968.00 facility fee, 9/7/12; 2) $3,765.76, facility fee, 9/7/12; and 3) $2,593.75, prosthetic implant fee, 9/7/12. The Arbitrator declines to award the claimed $293.66 in transportation expenses because Dr. Erickson did not address the need for transportation at any point in his deposition. The Arbitrator declines to award the other claimed expenses, relating to the injections performed in February and August 2013. Petitioner testified the February injection was not successful and there is no evidence indicating the August 2013 injection provided lasting relief.

Petitioner claims $35,828.00 in outstanding charges from Dr. Erickson for treatment rendered between the initial visit of August 3, 2012 and the last visit of September 17, 2014. PX 10. Based on the foregoing findings as to causation and reasonableness/necessity, the Arbitrator awards Petitioner the $35,828.00 in outstanding charges, subject to the fee schedule.

Petitioner claims $10,375.00 in outstanding charges from Lake County Neuromonitoring for EMG and SSEP testing conducted at Dr. Erickson's direction on August 3, 2012 (the date of Petitioner's initial visit to Dr. Erickson), September 7, 2012 (the date of surgery) and July 9, 2014. Based on the foregoing findings as to causation and reasonableness/necessity, the Arbitrator awards Petitioner the $10,375.00 in charges, subject to the fee schedule.

Petitioner claims $2,085.00 in outstanding charges from IMS Experts. PX 12. These charges relate to a DVT pump and bilateral sleeves utilized during the September 7, 2012 surgery. Based on the foregoing findings as to causation and reasonableness/necessity, the Arbitrator awards these charges, subject to the fee schedule.

Petitioner claims various outstanding charges from Metro Anesthesia. PX 13. These charges relate to anesthesia administered during the September 7, 2012 surgery and the February 14, 2013 injection. Based on the foregoing findings as to causation and reasonableness/necessity, the Arbitrator awards the $2,792.50 in charges relating to anesthesia administered on September 7, 2012, subject to the fee schedule. The Arbitrator declines to award the charges relating to anesthesia administered in connection with the injection of February 14, 2013. Petitioner reported deriving no benefit from this injection.

Petitioner claims $4,544.00 in outstanding charges from Hawthorne Works Medical Imaging. PX 14. These charges relate to the post-operative repeat lumbar spine MRI performed on December 21, 2012. The Arbitrator finds it reasonable for Petitioner to have undergone this repeat MRI based on his post-operative complaints. The Arbitrator awards the claimed $4,544.00 in charges, subject to the fee schedule.

Petitioner claims outstanding charges of $10,694.35 from Elite Physical Therapy relating to the functional capacity evaluation of May 3, 2012 and subsequent work conditioning. PX 15. The Arbitrator finds it reasonable for Petitioner to have undergone a functional capacity evaluation and work conditioning, given the amount of time he was out of the workforce. The Arbitrator awards the claimed $10,694.35, subject to the fee schedule.

Is Petitioner entitled to temporary total disability benefits from May 9, 2012 through September 8, 2013?

At the hearing, Petitioner claimed he was temporarily totally disabled from May 9, 2012, the day after the accident, through September 8, 2013. Respondent disputed this claim but agreed Petitioner was temporarily totally disabled from May 18, 2012 (the date Dr. Butler took Petitioner off work) through August 20, 2012 (the date of Dr. Zelby's examination). Arb Exh 1. In its proposed decision, Respondent took a different position, maintaining Petitioner was entitled to benefits through September 6, 2012, the day before the disputed surgery.

The Arbitrator has previously found in Petitioner's favor on the issues of causation and reasonableness/necessity vis-à-vis the September 7, 2012 surgery.

The Arbitrator finds that Petitioner was temporarily totally disabled from May 18, 2012 (the date Dr. Butler took Petitioner off work) through August 31, 2013 (based on PX 21, with the wording of that letter seeming to indicate Petitioner was already back to work.) The Arbitrator declines to award temporary total disability benefits from May 9, 2012 through May 17, 2012, as requested by Petitioner, based on Dr. Khanna's light duty releases and Petitioner's admission that Respondent indicated it could provide light duty. Based on the previous average weekly wage calculation, the Arbitrator awards temporary total disability benefits at the applicable minimum rate of $319.00 per week. Respondent is entitled to credit for the $2,860.00 in benefits it paid prior to trial, in accordance with the parties' stipulation. Arb Exh 1.

Is Petitioner entitled to temporary partial disability benefits?

At the hearing, Petitioner claimed he was temporarily partially disabled from September 9, 2013 through July 9, 2014 (the date of Petitioner's second to last appointment with Dr. Erickson). Respondent disputed this claim. Arb Exh 1.

The Arbitrator declines to award temporary partial disability benefits in this case. Section 8(a) of the Act provides that an employee is entitled to such benefits when he is

"working light duty on a part-time basis 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 to performing light duty for two different staffing agencies in late 2013 and a third agency in 2014 but he did not establish that he earned less than he would have otherwise earned. He acknowledged that he worked when work was available but that the agencies only called him on an "as needed" basis. He did not claim that he declined any work because it was beyond his restrictions.

What is the nature and extent of the injury?

Since Petitioner's undisputed accident occurred after September 1, 2011, the Arbitrator looks to Section 8.1b of the Act for guidance in assessing the nature and extent of the injury. That section sets forth various factors to be considered in determining permanency. The first enumerated factor, i.e., any AMA Guides impairment rating, is not relevant as neither party offered such a rating into evidence. As for the second and third factors, Petitioner was a 46-year-old laborer as of his accident. With respect to the fourth factor, there is no evidence indicating that the injury has affected Petitioner's future earning capacity. Dr. Erickson released Petitioner to full duty in September 2014. As for the fifth factor, "evidence of disability corroborated by the treating medical records," the Arbitrator cites the MRI reports and Dr. Erickson's operative report, along with Dr. Zelby's concession that the accident possibly caused Petitioner's disc herniation.

The Arbitrator, having considered all of the foregoing along with Petitioner's credible testimony concerning his ongoing limitations, finds that Petitioner is permanently partially disabled to the extent of 12.5% loss of use of the person as a whole under Section 8(d)2 of the Act, equivalent to 62.5 weeks of benefits.

Is Respondent liable for penalties and fees?

In his proposed decision, Petitioner refines his claim for penalties and fees by arguing that Respondent is liable for $10,000.00 in Section 19(l) penalties, in part based on its failure to pay for all of the therapy sessions its utilization reviewer certified on October 4, 2012. PX 27. Petitioner essentially argues that Respondent is liable for $10,000.00 for failing to adhere to its certification of services costing a little under $300. The Arbitrator declines to award the requested $10,000. The Arbitrator notes that Respondent paid approximately $18,000 in medical expenses before discontinuing payment based on Dr. Zelby's report.

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

Kathy Westfield-Carter,

Petitioner,

17IWCC0076

vs.

NO: 12 WC 8489

United Airlines Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses, penaltiesand fees, 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 April 23, 2015 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 $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: FEB 10 2017
KWL/vf
O-12/13/16
42

Kevin W. Lamborn

Joshua D. Luskin

Thomas J. Tyrrell

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

17IWCC0076

WESTFIELD-CARTER, KATHY
Employee/Petitioner

Case# **12WC008489**

UNITED AIRLINES INC
Employer/Respondent

On 4/23/2015, 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 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0365 BRIAN J McMANUS & ASSOC, LTD
ROBIN FITT
30 N LASALLE ST SUITE 2126
CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
RAFAL DOBEK
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(a)

17IWCC0076

Kathy Westfield-Carter
Employee/Petitioner

v.

United Airlines, Inc.
Employer/Respondent

Case # **12 WC 08489**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **April 7, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ 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

17IWCC0076

FINDINGS

On the date of accident, **9/18/11**, 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 regarding her cervical spine ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$51,527.42**; the average weekly wage was **$990.91**.

On the date of accident, Petitioner was **54** years of age, ***single*** with **2** dependent children.

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

Respondent shall be given a credit of **$71,819.59** for TTD, **$0** for TPD, **$0** for maintenance, and **$5,945.40** for PPD advance, for a total credit of **$77,764.99**.

The Parties agreed that Respondent is entitled to a credit of **$11,668.98** for medical expenses under Section 8(j) of the Act.

ORDER

Petitioner's claim for prospective treatment is denied.

Petitioner's claim for temporary total disability benefits from September 19, 2011 through April 7, 2014 is denied. **TTD**, in the amount of **$660.61/week** is awarded from **September 19, 2011 to October 22, 2013**, a period of **109-2/7 weeks**.

Petitioner's claim for satisfaction of medical bills for services rendered after August 23, 2013 is denied.

Petitioner's claim for penalties and attorney's fees is denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for 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

April 23, 2015
Date

ICArbDec19(b)

APR 23 2015

FINDINGS OF FACT

Petitioner, Kathy Westfield-Carter, was employed by Respondent, United Airlines, Inc., as a flight attendant for about 35 years.

The Parties agreed that Petitioner sustained accidental injuries which arose out of and in the course of her employment by Respondent on September 18, 2011. The Parties noted for the Record that another body part was involved in the injury, but that would not be the subject of the §19(b)/8(a) hearing that was taking place. (Transcript @ P.10) The Arbitrator assumes that this involves a hernia injury.

Petitioner testified that she was trying to remove a bag from an overhead compartment on a plane. The bag was heavy and Petitioner thought that a co-worker was assisting, but she was not. Petitioner had to move the bag by herself and had to try to not drop the bag on a passenger. When Petitioner turned and set the bag down, she felt a pull in her stomach. Petitioner testified that, immediately, she felt a sharp pain in her naval and pain in her lower back and a strain in her upper back neck area. She felt bad pain in her stomach as the flight went on. Petitioner had a prior head /neck injury in 1997 when an overhead bin hit her head. She had a herniated disc. This condition had resolved before September 18, 2011.

The first medical treatment was at Concentra Occupational Medical Centers in Los Angeles on September 18, 2011. Petitioner was sent there by her supervisor. Petitioner gave a history of her naval and low back hurting after moving bags from an overhead compartment. The low back and abdomen were examined. The neck was said to be "supple". The low back exam was benign. Mild tenderness of the mid portion of the abdominal wall around the umbilicus was noted. The diagnosis was: "S/P Lumbar Back Strain and S/P Abdominal Wall Strain." Therapy, Ibuprofen, Extra-Strength Tylenol, cold packs and a lumbar support were recommended. There were no neck complaints noted and no treatment regarding the neck was given. Treatment at Concentra continued through October 5, 2011. Petitioner testified that her naval, lower back, upper and middle back hurt while she had treatment at Concentra. Petitioner was seen by physicians at Concentra on September 20 and September 27 without mention of the neck or cervical spine. The abdominal wall strain was said to have resolved by September 27. Stiffness in the midback was noted in a therapy note of September 30. The last therapy note of October 3 does not mention any midback complaints. Petitioner was last seen at Concentra, by Dr. Kay Hooshmand, on October 5, 2011. Upper back complaints with limited range of motion of the shoulders were noted. Dr. Hooshmand's diagnosis was: "Lumbar strain, Thoracic strain." (PetEx.1)

Petitioner was restricted to light duty/office work while receiving treatment at Concentra. Respondent could not accommodate these restrictions, so it began paying TTD benefits.

Petitioner then chose to begin treatment with Dr. Vernon Williams on October 10, 2011. Dr. Williams is a neurologist and pain management physician associated with Kerlan-Jobe Orthopaedic Clinic in Los Angeles. Petitioner filled out a Patient History form on October 10. The reason for visit was "Back injury." The part of body injured was lower back/stomach. Location of pain was low back, buttock, mid-back (right), upper back (right) and spine (nagging). Neither neck pain nor cervical spine pain were mentioned. Dr. Williams charted that Petitioner has had low back pain without radiation into the lower extremities and abdominal pain. The Assessment/Plan was: Lumbar Strain; Lumbar Myofascial Pain; R/O Annular Fissure; R/O HNP. Restricted work, medications and a lumbar MRI were recommended. (PetEx.2)

The MRI was done on October 24, 2011 and showed a slight pelvic tilt and minimal facet arthritis at L4-5 and L5-S1. The next visit was on November 4, 2011 and bilateral hip pain was noted. There was no mention of neck or cervical spine pain. The diagnosis was: Lumbar Strain/Sprain; SI Joint Athropathy; and Left Trochanteric Bursitis. Ultrasound guided injections to the SI joints and the left trochanteric bursa were performed with marginal improvement being noted. Lumbar facet blocks were recommended. (PetEx.2)

Petitioner was seen by Dr. Babak Lami for an IME on January 25, 2012. Petitioner had complaints of pain mainly in the lumbar spine, with some radiation to the buttocks. There were also right scapula and right flank pain complaints. There were no complaints or findings regarding the neck and cervical spine. Dr. Lami thought that the Petitioner had a normal orthopedic and neurologic exam, was at MMI and could return to work at full duty. (ResEx.1)

Petitioner followed up with Dr. Williams on January 27, 2012 and February 28, 2012. Dr. Williams continued to restrict Petitioner from full duty work and pain in the pelvic region and thigh and thoracic/lumbosacral neuritis were added to the Assessment. Cervical/upper extremity pain was charted on April 27, 2012, although there is no mention of the cervical spine in the Assessment/Plan.

Petitioner had a course of acupuncture treatments from June 29, 2012 through August 22, 2012 at Uchida Acupuncture. The treatment was for low back, hip and right neck pain. The neck pain appears to have involved the scapula. (PetEx.5)

On June 27, 2012, Petitioner was examined by Dr. Lawrence Miller for an independent medical exam, pursuant to a labor agreement. Petitioner's complaints were of right sided neck pain; right sided low back pain; lateral hip pain and periumbilical pain. Findings regarding the low back and cervical spine were noted. The lumbar MRI was said to be completely normal. The diagnostic impression was said to be: 1.) Chronic musculoligamentous sprain/strain of the lumbar spine; 2.) Chronic cervical musculoligamentous sprain/strain; and 3.) Reports of umbilical hernia/abdominal wall strain. Dr. Miller thought that Petitioner was at MMI and a trial return to work on flights of shorter duration than to Hawaii should be attempted. He did not think that the patient was capable of returning to work at full duty in January of 2012. Continued treatment with the pain specialist was endorsed, apparently for the lumbar spine. No recommendations for cervical/thoracic treatment were made. An FCE was recommended. (PetEx.6)

Petitioner continued to treat with Dr. Williams and also had treatment for the hernia. Dr. Williams recommended further injections and PT. Petitioner was able to receive PT via her group insurance. A further lumbar MRI was ordered, but was not approved by Gallagher Bassett. Dr. Williams offered Botox treatment, which Petitioner wanted, but could not afford.

A second IME by Dr. Lami took place on August 23, 2013. Dr. Lami noted no neurological deficits and full range of motion of all joints in the upper and lower extremities and the cervical and lumbar spines. He did not believe that Petitioner's subjective complaints were causally related to the accident of September 18, 2011 and were not supported by objective findings. The MRI was consistent with petitioner's age (minimal arthritic changes) and did not show any disc pathology. He again found Petitioner to be at MMI and recommended a release to full duty work, without restrictions. (ResEx.6)

Petitioner underwent another lumbar MRI on August 26, 2013. Multilevel mild disc desiccation was noted, along with mild bilateral facet arthropathy at L4-5 with a small 3mm synovial cyst arising from the dorsal aspect of the right facet joint at that level. At L5-S1, mild bilateral facet arthropathy was again

noted, with a 2mm disc bulge towards the left and a 3mm synovial cyst arising from the left facet joint. Petitioner continued to treat with Dr. Williams, who reviewed the new MRI and noted that there was no abnormality that correlates with Petitioner's complaints of severe radiating right leg pain. Because a diagnostic Piriformis block was said to provide dramatic improvement in the radiating right leg pain, a diagnosis of Piriformis syndrome was entertained and a Piriformis botox injection was recommended. (PetEx.2)

Dr. Lami reviewed the August 26, 2013 MRI and commented that it was essentially a 100% normal MRI for a patient of 55 years of age. There is no identifiable source of pain, given the benign MRI. Petitioner was at MMI and capable of full duty return to work. (ResEx.7)

Petitioner was seen by Dr. Elliott Gross for a second opinion regarding her neck pain complaints on October 16, 2013. The examination of the cervical and lumbar spine was completely benign. Some tenderness over the medial aspect of the trapezius muscle on the right was noted. Dr. Gross offered an injection to the right trigger point, but the patient declined. A home exercise program, with Aleve, Prilosec, Extrastrength Tylenol, Zanaflex as a muscle relaxer and analgesic cream were recommended. Return to work was deferred to Dr. Williams, who was treating Petitioner's low back. Petitioner insisted that Dr. Gross order an MRI of the cervical spine. Dr. Gross' impression was: 1.) C5-6 and C4-5 cervical spondylosis with disc space narrowing and foraminal stenosis; 2.) Pre-existing history of C5-6 cervical disc; 3.) Persistent lower back pain secondary to lumbar disc bulge; 4.) Status post umbilical hernia repair; and 5. Right trapezius trigger point tendinitis. (PetEx.7)

A cervical spine MRI was done on November 18, 2013. It was said to show severe spondylosis with marked narrowing of the C5-6 disc space and a Grade I retrolisthesis with a 3-4mm broad based disc/osteophyte complex compressing the thecal sac, more to the right. Moderate right neural foraminal stenosis at C5-6 and compression of the right C7 nerve root sleeve was noted. At C4-5 a small deep posterior right paricentral disc protrusion with minimal compression of the thecal sac was seen. A T4 vertebral body hemangioma was noted. (PetEx.2)

Dr. Williams' letter of November 22, 2013 states that Petitioner cannot perform her job duties as a flight attendant. His diagnosis as of that date was: Chronic Pain, Cervical DJD, Cervical Radiculitis, Cervical Myofascial Pain, Lumbar DJD, Lumbar Facet Arthropathy, Lumbar Radiculitis, Lumbar Myofascial Pain and Piriformis Syndrome. Dr. Williams sent a report to Petitioner's attorney on December 18, 2013 stating that he was treating Petitioner for low back and abdominal pain, as well as "...for her upper back and cervical condition; which in my medical opinion was caused from her work injury on September 18, 2011." When Petitioner was seen in follow-up by Dr. Williams on January 21, 2014, range of motion in the neck and low back was restricted in all directions. Cervical PT and Cervical ESI's were recommended. The Petitioner said that she could not afford the deductables for these procedures if they were put through group. It was charted that there was more right hand numbness/tingling, but not in the C7 distribution and not correlating with the C-spine foraminal narrowing. The last visit with Dr. Williams was on March 18, 2014, when the examination was unchanged and the recommendations for PT and ESI's continued, with the possibility of a surgical consult if there was no improvement. (PetEx. 2)

Dr. Stanley Simon, a consulting physician for United Airlines, authored a report of February 21, 2014 agreeing with Dr. Lami that the length of disability and duration of symptoms were prolonged, given the mechanism of the September 18, 2011 injury. Appropriate and timely treatment for the injury has been given. She was able to return to work at full duty as a flight attendant as of October 25, 2013. (ResEx.9)

Dr. Lami authored a final report of February 23, 2014 after reviewing further medical records and the C-Spine MRI. He interpreted the MRI as showing multilevel cervical spondylosis, without evidence of an acute traumatic finding. He did not believe that Petitioner's cervical condition was related to the injury. Petitioner was still at MMI and was capable of full duty work. (ResEx.8)

Petitioner is a stand-up comedian. After the injury, she completed 5 or 6 engagements that she committed to prior to the injury, with Respondent's permission. She also has done 6 or 8 complimentary shows. Basically, she is performing for 10 to 15 minutes. (ResExs.15-22)

Petitioner testified that she has constant, sharp, burning low back pain that goes down both buttocks. On the right side, it goes down her leg to her toes and the bottom of her foot. She still has pain from the hernia on her right side. She has sharp pain in her upper back (cervical), such that it's difficult to sleep at night. She can't turn her neck to check her blind spot when she drives. She has pain if she tries to run. She has pain if she tries to lift her right arm over her head. She can't do household chores, like vacuuming. She has constant headaches at the base of her neck. Her restrictions from Dr. Williams are "sedentary". She is not to lift more than 5 pounds, with no prolonged standing and no repetitive bending or twisting.

Respondent submitted surveillance evidence showing Petitioner driving and moving about without apparent limitation on August 5 and August 6, 2013. Petitioner is seen driving and backing her car up without limitation. ResEx.11,12)

Petitioner's claimed Medical Bills were submitted as Petitioner's Exhibit 8.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

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 with respect to her low back and neck/cervical spine is not causally related to the injury. Dr. Lami's opinion on this issue is credible and best comports with the evidence.

The lumbar MRI studies are benign and do not show any traumatic lesions. Further, Petitioner's subjective complaints are not supported by the MRI findings, as is documented by Dr. Williams and Dr. Miller.

Petitioner's cervical spine complaints are due to her prior herniated disc at C5-6 and degenerative joint disease in her spine, not as a result of the injury. Most importantly, there were no documented cervical spine findings or complaints in the initial records from Concentra or Dr. Williams. Petitioner's testimony that she somehow meant her "neck" when she complained regarding her "upper back" is not believable. She obviously knew that she had sustained a herniated disc in her neck from the 1997 accident. If she

had hurt her neck on September 18, 2011, cervical spine complaints and findings would have been documented. When Dr. Lami examined Petitioner on January 25, 2012, the cervical spine exam was benign. Dr. Lami's opinion that there is no causal connection between the injury of September 18, 2011 and Petitioner's condition of ill-being regarding her cervical spine is credible and best comports with the Record herein.

Dr. Williams' causation opinion is found to be not credible and does not comport with the evidence adduced. Clearly, Petitioner did not have cervical spine complaints at the time of the first visit with Dr. Williams in October of 2011.

The Arbitrator makes no finding regarding the hernia condition.

Giving Petitioner the benefit of the doubt, there is a causal connection between the injury and Petitioner's condition of ill-being as documented by Dr. Lami in his reports of August 23, 2013 and October 10, 2013 (status post lumbar strain/sprain, resolved to the point of MMI and full duty return to work) as supported by Dr. Simon's report. The current disability endorsed by Dr. Williams and the ongoing medical treatment regarding the low back and all treatment regarding the cervical spine is not causally related to the injury.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner's Exhibit 8 was the Bills Exhibit. There were twelve providers listed and the Arbitrator will address the claimed bills sequentially.

1. Concentra- This has a zero balance and is not awarded.

2. Kerlan-Jobe-The Arbitrator relies upon Dr. Lami's opinion that Petitioner was at MMI as of January 25, 2012 in denying these bills. All bills related to the cervical spine are denied, based upon the Arbitrator's findings above regarding the issue of causal connection. If there is liability for the bills based upon the labor agreement and third party medical opinions, then the Parties should address the bills pursuant to said agreement.

3. Moses J. Fallas, MD- This has a zero balance and is not supported by testimony or records and is, therefore, not awarded.

4. Saul Rosoff, MD- This has a zero balance and probably relates to treatment for the hernia. Not awarded.

5. Amanuuel Sima, MD- This has a zero balance and no supporting records were submitted. Not awarded.

6. Select Physical Therapy- This has a zero balance and is not awarded.

7. Diagnostic Health- This has a zero balance and is not awarded.

8. Physiotherapy Associates- This has a zero balance and is not awarded.

9. Uchida Acupuncture- Petitioner has the burden of proving reasonableness and necessity. Further, some treatment is related to the neck and is not causally related to the injury. Not awarded.

10. Dr. Elliott Gross- Petitioner's choice for a second opinion regarding her cervical spine condition. Not awarded based upon the finding above on the issue of Causal Connection.

11. Western Radiologic- This bill appears to be for the cervical spine MRI ordered by Dr. Gross and is not awarded.

12. Target Pharmacy- This is for medications prescribed by Dr. Williams on March 26, 2014 and is not awarded based upon the Arbitrator's finding regarding Causal Connection above.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

As the Arbitrator has found that there is no causal connection between the injury and Petitioner's current condition of ill-being, Petitioner's claim for prospective medical care is denied.

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

Petitioner has remained off work since September 19, 2011 and claimed TTD benefits through the date of the arbitration hearing.

The Arbitrator awards TTD benefits from September 19, 2011 through October 22, 2013, as paid previously by Respondent. This is a period of 109-2/7 weeks.

While the Arbitrator finds the opinions of Dr. Lami to be credible (Petitioner would be at MMI and capable of returning to work at full duty as of January 25, 2012), Respondent apparently paid TTD based upon the opinions of the "neutral" doctor, Dr. Miller. Further, the United consulting physician, Dr. Simon, saying that he agreed with Dr. Lami ,thought that Petitioner could return to work at full duty as of October 25, 2013. It does appear that Petitioner was released with restrictions by Concentra as of September 18, 2011 and Respondent did not accommodate the restrictions. Therefore, TTD benefits should commence September 19, 2011 and October 22, 2013 is an appropriate date to stop TTD benefits, given the proofs in this case.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner's claim for Penalties and Attorney's Fees is denied.

Respondent acted reasonably in relying upon the opinions of Dr. Lami. Respondent had a valid, reasonable and good faith basis for its disputes in this case.

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

Teresa Barbosa,

Petitioner,

vs.

NO: 15 WC 16773

City of Chicago,

17IWCC0077

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, notice, temporary total disability, medical, prospective medical, penalties, 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 June 9, 2016 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.

17IWCC0077

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: FEB 10 2017

Mario Basurto

David L. Gore

Stephen Mathis

MB/mas
o:1/19/17
43

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

BARBOSA, TERESA
Employee/Petitioner

Case# **15WC016773**

17IWCC0077

CITY OF CHICAGO
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:

1042 OSVALDO RODRIGUEZ PC
7704 W NORTH AVE
ELMWOOD PARK, IL 60707

0766 HENNESSY & ROACH PC
SEAN RYAN
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

17IWCC0077

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)

Teresa Barbosa
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **15** WC **16773**

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 **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **April 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 _____

FINDINGS

On the date of accident, **3/28/2015**, 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 **$27,540.76**; the average weekly wage was **$529.63**.

On the date of accident, Petitioner was **53** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $7,517.80 for medical benefits that have been paid.

Respondent is entitled to a credit of **$4,295.00** under Section 8(j) of the Act.

ORDER

Petitioner failed to prove, by a preponderance of the evidence, that she sustained an accident that arose out of and in the course of her employment by Respondent therefore no benefits are awarded, pursuant to the Act.

Respondent shall be given a credit of $7,517.80 for medical benefits paid to Petitioner and a credit of $4,295.00, pursuant to Section 8(j) of the Act.

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

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

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

17IWCC0077

FINDINGS OF FACTS

The disputed issues in this matter are: 1) Whether Petitioner sustained accidental injuries that arose out of and in the course of employment; 2) Whether the petitioner's present condition of ill-being was causally related to the injury; 3) Whether the medical services that were provided to the petitioner were reasonable and necessary and whether the respondent has paid all appropriate charges for all reasonable and necessary medical services; 4) What temporary benefits are in dispute; and 5) Whether the petitioner is entitled to any prospective medical care.

Petitioner's testimony

On March 28, 2015, Petitioner was employed by the City of Chicago and specifically by Alderman John A Pope. This is evidenced by Employee Earnings Records showing specifically that Petitioner, designated as Employee Number 108936, received net pay in the amount of $817.24, via ACH deposit on April 1, 2015 for the pay period starting on March 16, 2015 and ending on March 31, 2015. The net pay indicated on the Employment Earnings Record is in line with the previous five (5) Employment Earning Records covering each 2-week period from January 1, 2015 through March 15, 2015 in which Petitioner netted the exact same pay. RX1, pp.1-6.

As part of her duties for the City of Chicago Council, Petitioner was responsible for helping with communications between the City of Chicago ("City") and the 10th ward residents. On March 28, 2015, Petitioner was performing functions of her normal course of employment, and specifically, she was distributing Notices to Clean Up or Pay Up ("notice") to residents of Alderman Pope's 10th ward. The purpose of the notice was to advise 10th ward residents that the City would be stepping up enforcement of City of Chicago Ordinance 7-12-420, i.e., Removal of Excrement. PX1.

In order to distribute communications, including the aforementioned notice to 10th ward residents in an efficient and reasonable manner, Petitioner would drive her automobile to various locations within the ward, park her vehicle and walk house-to-house to distribute communication materials.

On March 28, 2015, in furtherance of her duties of distributing the notices pursuant to the direction of then-10th Ward Alderman John A. Pope, Petitioner parked her vehicle on East 104th street and N street and proceeded to walk around the area distributing notices. While returning to her parked vehicle, Petitioner attempted to traverse the sidewalk across the parkway to her parked automobile, via a broken concrete walkway running perpendicular to the sidewalk and street, nearest her vehicle.

In attempting to navigate the walkway, Petitioner lost her balance and fell due to the broken defective sidewalk, twisting her right ankle in the process. The broken defective sidewalk is depicted in the photos taken by Respondent's photographer. Petitioner testified that this route was the most direct route to her parked car. Petitioner experienced immediate pain and discomfort in her right ankle. RX5.

Petitioner's medical treatment

Petitioner testified that the next day, on March 29, 2016, she continued to experience pain and swelling in her right ankle and sought medical assistance at Franciscan Hammond Clinic. She reported to Franciscan Hammond Clinic Urgent Care complaining of ankle pain and discomfort, accompanied by swelling and a reduced range of motion in her right ankle/foot. As a result of these conditions, she was unable to walk well. Petitioner was diagnosed with an ankle fracture and injury and referred to a podiatrist for follow-up. She was prescribed Ibuprofen 600MG and Tramadol HCL, a narcotic pain-killer. The Arbitrator notes that while these medical records indicate that the petitioner's injuries were the result of a fall the previous day, nowhere in the records does it state that this fall was work-related. PX2.

On March 30, 2015, Petitioner returned to Franciscan Hammond Clinic for follow-up treatment, complaining of pain 5/10. She was diagnosed with soft tissue swelling over the right lateral malleolus and a non-displaced fracture of the distal tip of the right lateral malleolus; along with noting of a moderate size plantar calcaneal spur. She was given a boot to provide support and aid in the healing of the ankle fracture.

On April 13, 2015, Petitioner once again returned to Franciscan Hammond Clinic for follow-up treatment, complaining of pain 5/10 and unable to tolerate the medical boot. She was continuing with ibuprofen and Tramadol HCL. During that visit, Petitioner underwent a radiology examination in which she was diagnosed with an oval fracture of the distal fibular tip without change in alignment. She was prescribed Etodolac, a NSAID, in addition to her previous medications.

On April 27, Petitioner presented to Franciscan Hammond Clinic still complaining of pain on a scale of 5/10, as well as the onset of swelling and pain to her right lower extremity. At that time she also underwent a second radiology examination in which Petitioner was diagnosed with an avulsion fracture of the distal fibular tip. She was ordered to undergo an MRI to confirm the extent of her injury.

On April 29, 2015, Petitioner, continuing to experience pain and swelling, underwent an MRI of her right ankle. The MRI examination revealed that Petitioner suffered from avulsion fractures at the origin of the calcaneofibular and deltoid ligaments with associated disruption; a complete tear of the anterior talofibular tendon; mild tenosynovitis of the tibialis posterior tendon; and a plantar calcaneal spur.

On May 4, 2015, Petitioner returned to Franciscan Hammond Clinic for a follow-up examination, complaining of continued pain and swelling. Dr. Frederick Diel, DPM, reviewed the MRI reports and discussed various treatment options, including a cast and knee walker. At that time, Petitioner determined to continue with the boot.

On May 15, 2015, Petitioner returned to Franciscan Hammond Clinic, complaining of pain 6/10. At that time she was continuing her prescription treatment of ibuprofen and Tramadol HCL. As a result of her lack of improvement, Dr. Diel recommended the use of a Swede-o brace and advised that if Petitioner was unable to tolerate it, she would return in two (2) weeks for casting. The Arbitrator notes that through all this treatment, there is no mention that petitioner's injury is work-related. PX3.

On September 11, 2015, Petitioner sought treatment from Illinois Bone & Joint Institute. At that time she had continued to experience pain and discomfort and had developed an antalgic limp. Dr. Scott A. Rubinstein performed a physical examination and diagnosed Petitioner with a chronic unhealed ankle sprain which was "directly related to the injury she sustained while at work back in March". She was prescribed to undergo an MRI to determine the extent of her injury. The Arbitrator notes that this is the first mention of the mechanism of injury, i.e. tripping while "doing a survey" which is not what the petitioner testified that she was doing. The petitioner testified that she was handing out "clean up or pay up" fliers. PX1 & PX3.

On September 22, 2015, Petitioner underwent an MRI examination at Presence Saint Joseph Hospital, which found full-thickness tears of the deltoid ligament, with residual scarring. There was also evidence of remote avulsion injury at the medial malleolus at the insertion of the deltoid ligament. Dr. Liou also diagnosed a remote tear of the anterior talofibular ligament and a prior strain of the syndesmotic ligaments, along with mild bone edema anteriorly within the tibial plafond; likely the result of a residual bone contusion. PX3, pp.26-30.

On October 12, 2015, Petitioner returned to the Illinois Bone and Joint Institute and was seen by Ari J. Kaz, MD. She presented with continued ankle swelling, joint pain and weakness. Dr. Kaz diagnosed Petitioner with recalcitrant right ankle sprain and right posterior tibial tendon and FHL tendon tendonitis. He prescribed physical therapy ("PT") and asked Petitioner to return in six (6) weeks for follow-up.

On October 29, 2015, Petitioner was evaluated by Mohamed Moatzz, PT at United Rehab Providers, where she was prescribed PT 2x weekly for 12 weeks.

On November 23, 2015, Petitioner returned to Illinois Bone and Joint Institute for follow-up treatment from Dr. Kaz. He ordered her to continue with PT and to return for follow-up in four to six weeks.

On December 3, 2015, Petitioner was seen at Midwest Imaging Professionals to undergo an MRI. At that time, Nicholas W. Skezas, MD diagnosed Petitioner as having a torn Deltoid ligament; decreased echogenicity which may indicate fluid accumulation; a possible avulsed bony fragment; and a tear in tibiofibular ligament.

On January 7, 2016, Petitioner returned to Illinois Bone and Joint Institute for follow-up treatment. At that time, Dr. Rubinstein referred her to an orthopedic foot specialist. PX3, p.4.
On January 26, 2016, Petitioner was examined by Brian Burgess, DPM, who diagnosed her with mechanical and functional instability of the right lateral ankle with chronic distal fibular avulsion fracture. He found the majority of Petitioner's pain was due to distal fibular avulsion fracture and tears of the lateral ankle ligaments. Dr. Burgess recommended "extensive arthroscopic debridement, modified Brostrom right lateral ligament reconstruction, with excision of chronic fracture fragment and possible syndesmotic ligament repair PX6, pp.2-5.

Respondent's Witness
Lastly, John Pope, former alderman of the 10th ward was called by Respondent and testified that he was told, after the accident that the petitioner had fallen. Although he was in the office on the alleged date of accident, he could not remember if he saw Petitioner on that date; and that all attendance records had been discarded after he was not re-elected.

CONCLUSIONS OF LAW

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

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 v. 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 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 Arbitrator finds and concludes that the petitioner has not proven, by a preponderance of the evidence, that an accident occurred that arose out of and in the course of her employment by Respondent therefore, no benefits are awarded, pursuant to the Act. As the petitioner has not proven an accident, all other disputed issues are moot and will not be addressed.

17IWCC0077

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
15WC16773
SIGNATURE PAGE

17IWCC0077

Signature of Arbitrator

June 9, 2016
Date of Decision

JUN 9 - 2016

STATE OF ILLINOIS)
) SS.
COUNTY OF WINNEGAGO)

☒ 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

Sergio Puentes,

Petitioner,

vs.

NO: 08 WC 09390

17IWCC0078

Chrysler LLC,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the 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.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 17, 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: FEB 10 2017

Mario Basurto

David L. Gore

Stephen Mathis

MB/mas
o:1/26/17
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PUENTES, SERGIO
Employee/Petitioner

Case# **08WC009390**

17IWCC0078

CHRYSLER LLC
Employer/Respondent

On 3/17/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.51% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN EAGLE ET AL
DAVID M BARISH
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602-2983

0560 WIEDNER & McAULIFFE LTD
BRIAN J HINDMAN
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

17IWCC0078

STATE OF ILLINOIS)
)SS.
COUNTY OF Winnebago)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Sergio Puentes
Employee/Petitioner

v.

Chrysler LLC
Employer/Respondent

Case # 08 WC 09390

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Rockford**, on **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. ☒ Were the 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 _____

17IWCC0078

FINDINGS

On **November 28, 2007**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did 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 **$46,657.00**; the average weekly wage was **$897.25**.

On the date of accident, Petitioner was **26** 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 has paid **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$1,357.32** for other benefits, for a total of **$1,357.32**.

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

ORDER

BECAUSE PETITIONER FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT HE SUSTAINED ACCIDENTAL INJURIES ARISING OUT OF AND IN THE COURSE OF HIS EMPLOYMENT AND FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT HIS CONDITION OF ILL BEING IS CAUSALLY CONNECTED TO HIS EMPLOYMENT WITH RESPONDENT, THE CLAIM FOR COMPENSATION IS DENIED.

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

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

Signature of Arbitrator

March 16, 2016
Date

ICArbDec p. 2

MAR 17 2016

Statement of Facts

Petitioner Sergio Puentes testified that he began employment with Respondent Chrysler in 2006. He denied any problem or treatment for his low back prior to this employment. He testified that he had a spinal injury as a child. He went to the hospital but nothing came of it. He testified that he did not recall the injury.

Petitioner testified that in 2007 he was assigned to three tasks while working for Respondent: bezel and shifter knob installation, spare tire installation and battery installation. Petitioner testified that on the shifter installation job, he would lean into vehicles to install bolts and wires. He would rest his abdomen on the vehicle and lean far in to perform his work. He would rise up and bend far in every 30 to 40 seconds on that job. Petitioner testified that he was not concerned with the weight of items he was lifting/carrying, but just the motion and supporting his own weight that was the problem. The job was done on both the right and left side, so he would rotate but do the same job; just be doing the mirror image. Petitioner testified that the battery job was not as difficult. The job used an assisted arm. There were issues with the arm. He testified he did this job once every couple of days. He testified that on the spare tire job he pulled a spare tire off of a rack and carried it 10-15 feet to the line. He would wrestle it to the line and drop it into the trunk. He had to bend low over 90 degrees into the vehicle to place the tire. He could not drop the tire. The full size tire and rim weighed 50 to 60 lbs.

Petitioner testified that he began to notice pain in his back in the summer of 2007. It started like a sore muscle and got worse until it began to affect his work. He did not inform anybody at his place of employment. Petitioner was seen at the plant medical clinic on June 22, 2007, complaining of a 'migraine" headache. He notes he passed an accident on his way to work and is getting flashbacks when a friend was killed and he was in the car (PX 1, RX 1). Petitioner saw Dr. Miller on June 22, 2007 for headaches. He was given medication and advised to follow up with neurology (PX 2). Petitioner was seen at the plant medical clinic on June 26, 2007 with a sore right ankle (PX 1, RX 1).

Petitioner testified he went to the Beloit Clinic on July 26, 2007. The records of Dr. Merino were admitted as Petitioner's Exhibit 2. Petitioner was referred by Dr. Miller for his headache complaints. Petitioner reported a chief complaint of headache for at least the last two weeks. Petitioner reported he works in a factory all day and does multiple tasks requiring physical agility and he begins to get a little back pain. Then this climbs up his back. Eventually, it begins to get tight in his neck. From there the headaches eventually make it to the front of his head. Petitioner reported a spinal injury as a child. He reported he was at a quarry and jumped so that he sunk in the sand and hit his behind on the ground and felt a sensation of electricity going up the back. He was unable to walk or move very well for at least a couple of days. He complained of back pain that starts in the lumbar curve. He reported that prior to working for Chrysler he worked as a roofer and painter and spent the whole day crouching. Neurological examination noted pain on extension and twisting of the lower back. The impression was low back pain and headaches with a history of prior trauma to the back. Dr. Merino recommended cervical and lumbar MRI studies.

MRI studies of the cervical and lumbar spine were performed on August 13, 2007. The cervical examination was negative. The lumbar examination noted degenerative changes and disc protrusions attributable to a tear of the annulus fibrosis at L4-5 and less pronounced at L5-S1. The August 16, 2007 telephone message states that Dr. Merino would like Petitioner to see Dr. Zbedlick because the MRI doesn't show anything (PX 2).

On September 6, 2007, Petitioner presented to the University of Wisconsin Hospital referred by Dr. Merino. The note states that he has approximately 6 year history of back pain. Two years ago the pain increased and

the last two months the pain has increased to the point he is having difficulty sleeping. Petitioner again gives the detailed description of the fall into a sand pit 14 years before. Petitioner reported that he had worked for Chrysler for 5 years. Petitioner complained of low back pain increasing during his work day with left leg numbness. The impression was low back pain with an L4-L5 disc protrusion. Petitioner stated he was not interested in surgery. He was reluctant to participate in physical therapy (PX 5). A September 6, 2007 telephone message to Dr. Merino requested a referral to a different neurosurgeon for a second opinion (PX 2).

Petitioner testified that he sought treatment with Dr. Bautista, his personal physician. The records of Mercy Clinic East were admitted as Petitioner's Exhibit 3. The record includes hand written notes that Petitioner was seen on September 26, 2007 for back pain but no dictation is included in the exhibit. On October 9, 2007, Petitioner saw Dr. Bautista for a follow up on his low back pain. Dr. Bautista recommended physical therapy and prescribed Percocet (PX 3). Dr. Coe and Dr. Neal reference an October 17, 2007 record of Dr. Rust, a neurologist with a history of low back pain aggravated by prolonged bending at work, no recent significant injury, and a diagnosis of myofascial chronic back pain with possible facet arthritis and lumbar degenerative disc disease (PX 6, RX 2). On October 25, 2007, Dr. Bautista notes that a referral to neurosurgery indicated that Petitioner did not need surgery and recommended physical therapy and conservative pain management. The physical exam noted tenderness with full range of motion and no neurologic deficits. On November 19, 2007, Petitioner noted he was in physical therapy. He was still complaining of low back pain. On December 28, 2007, Dr. Bautista mentioned that Petitioner would be referred to a pain clinic after physical therapy in a month (PX 3).

On November 21, 2007, Petitioner presented to MedChoice. The records of MedChoice were admitted as Petitioner's Exhibit 4. The November 21, 2007 note from Dr. Baluga states that Petitioner complained of low back pain with numbness, tingling and weakness of the left leg since 2 years ago. Dr. Baluga provided Petitioner with work restrictions on November 28, 2007.

On November 28, 2007, Petitioner was seen at plant medical at Chrysler. He presented the work restrictions. He complained that he was having back pain for 1 year. He had been seeing his family medical doctor for this. Petitioner stated that the pain started around the 4th of July when he was working on a job of consoles which required him to bend in an awkward position and place a spare tire into a trunk by hand. Petitioner stated that all of the jobs he has worked for the last two years require bending. He stated that he cannot do any of the jobs on his rotation because the repetitive bending caused low back pain (PX 1, RX 1). On November 29, 2007 Petitioner reported starting pain when doing center consoles 8 months ago. He also described loading spare tires. He is recorded as stating, "I have a lower back problem for 8-12 months. I think it is repetitive movement. My jobs then were back breaking jobs, hanging in the car." On December 4, 2007 a job site evaluation was completed. It is recorded as positive for exposure leading to low back pain. Dr. Welch concurred. On February 20, 2008, Petitioner presented to the plant medical clinic after missing 3 appointments. He brought a note with him indicating that he would return to work with restrictions as of February 19, 2008 (RX 1).

Dr. Baluga's December 5, 2007 Medical Certificate lists the onset of the condition as 8-12 months ago. On December 12, 2007, Petitioner underwent an EMG/NCV. The test results were essentially normal. On December 28, 2007, Petitioner's history to MedChoice physical therapy is pain across his low back that started gradually one year ago. Petitioner underwent physical therapy treatment at MedChoice through April 8, 2008. The April 3, 2008 re-evaluation notes no radiating pain into the left leg on the pain diagram. Petitioner reports he is no longer taking his pain medication and he is not doing his home exercises. On April 8, 2008, Dr. Baluga notes no recurrence of pain down the lower extremities. Petitioner can do yard work with some pain at

the end of the day. Petitioner no longer takes strong pain medication. He has not kept up with physical therapy and comes when convenient (PX 4).

Petitioner continued to work light duty until he was terminated on March 4, 2008. Petitioner was terminated because all temporary enhanced employees lost their jobs at that time. Petitioner testified that he did not work for over a year. He went to truck driving school but could not pass the DOT physical and never obtained a job as a truck driver. He started his own business doing sales for construction and remodeling jobs. He hired others to perform these jobs. He intermittently saw his family doctor but did not get any treatment.

On May 31, 2013, Petitioner saw Dr. Ebert at the UW Hospital and Clinic. The Patient Questionnaire notes neck and back pain with tingling in the arm and leg for 6 years. Petitioner notes a slip and fall as a child. Dr. Ebert's correspondence to Dr. Bautista indicates that Petitioner's low back pain started in 2008 with work-related injury. The note also states that his had treatment until 2009 and that his symptoms improved. In the past year, his pain returned. Petitioner had an MRI in March of 2013 that showed three level degenerative disc disease. The impression is Mr. Puentes has axial low back pain without any radicular symptoms. He has some progression of his degenerative changes since 2007, but the degree of change is what we would typically expect of this amount of time. The reason for his increased pain in the last year is unclear (PX 5).

Petitioner testified that he has pain every day. If he pushes the pain gets worse. On some days the pain is a dull ache and on others the pain is sharper. He has sharper pain four days per week. Petitioner does not do physical activities and works as a salesman. He has not had medical care in a number of years. If he avoids heavy activity he does not have intolerable pain, but he always has pain.

Petitioner was evaluated at his attorney's request on October 18, 2011 by Dr. Jeffrey Coe. Dr. Coe testified by evidence deposition on July 18, 2014 (PX 6). Dr. Coe opined that Petitioner suffered repetitive strain injuries which were a factor aggravating degenerative disc disease and degenerative arthritis. Dr. Coe found that the jobs installing tires and doing shifter installation contributed to Petitioner's low back condition. The doctor found that Petitioner had a permanent light duty restriction and needed to limit repetitive bending and twisting. Dr. Coe testified that the medical records contain different histories. The fall could be a factor in the development of the arthritic component of his back condition. Petitioner has degenerative disc findings. The MRI findings are not changes of a few months. The opinion of aggravation is based upon the subjective symptoms reported.

Petitioner was initially scheduled for a Section 12 exam with Dr. Bryan Neal on May 7, 2012. Dr. Neal prepared a record review on May 10, 2012 (RX 2, Ex. 2). The examination took place on September 11, 2013. Dr. Neal testified by evidence deposition taken April 10, 2015 (RX 2). Dr. Neal testified to the records reviewed. He testified that Petitioner history did not clearly state whether his symptoms were brought on gradually or occurred as a result of a specific trauma, with elements of both. Dr. Neal found him a poor historian. Dr. Neal opined that Petitioner's low back condition was secondary to degenerative lumbar spondylosis. He opines that Petitioner's condition was not causally related to his work for Respondent. He opined that the job did not aggravate his symptoms. He testified that Petitioner did not have a repetitive strain injury that caused any physiological injury to Petitioner. He did not find any neurologic condition. He notes the history of a spinal trauma at a young age. Dr. Neal testified that Petitioner seems to have a variable job. He would not consider it repetitive. He testified that he had an understanding of Petitioner's job tasks, but cannot state exactly what he did for each and every assembly line job that he did.

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident, (D) Date of Accident and (F) Causal Connection, the Arbitrator finds as follows:

Petitioner is seeking compensation alleged a repetitive trauma injury to his low back as a result of his job activities as an assembler for Respondent. Petitioner is alleging a date of manifestation of November 28, 2007, when Petitioner reported his complaints to Respondent's company medical clinic.

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of the his employment and that his condition of ill being is causally connected to his employment. An employee who suffers a repetitive-trauma injury still may apply for benefits under the Act, but must meet the same standard of proof as an employee who suffers a sudden injury. If the claimant had health problems prior to a work-related injury, he bears the burden of showing that the preexisting condition was aggravated by the employment, and that the aggravation occurred as a result of an accident which arose out of and in the course of his employment. In cases relying on the repetitive-trauma concept, the claimant generally relies on medical testimony establishing a causal connection between the work performed and claimant's disability.

Petitioner testified that he began to notice pain in his back in the summer of 2007. Petitioner testified that in 2007, he was assigned to three tasks while working for Respondent: bezel and shifter knob installation, spare tire installation and battery installation. He described the physical nature of these duties including the lifting and bending required. The June, 2007 plant medical notes confirm that he was in fact doing these duties, among other job duties such as engine decking. Petitioner reported that these tasks were the source of his back pain when he returned to Respondent's plant medical on November 29, 2007. Respondent's December 4, 2007 job site evaluation was recorded as positive for exposure leading to low back pain. The November 28, 2007 plant medical note reflects that Petitioner was doing multiple other jobs at that time.

Petitioner's initial medical records do not focus on back pain or his work activities. His testimony of onset of his complaints in the summer, 2007 is contradicted by the June, 2007 company medical notes where he complaints of headaches and discusses flashbacks from seeing a motor vehicle accident. Petitioner saw Dr. Miller on June 22, 2007 for headaches. In the records of Dr. Merino, Petitioner reported a chief complaint of headache for at least the last two weeks. Petitioner reported he works in a factory all day and does multiple tasks requiring physical agility and he begins to get a little back pain. He reported that prior to working for Chrysler he worked as a roofer and painter and spent the whole day crouching. When cross examined as to his prior employment, Petitioner discussed working cleanup in a foundry and driving a dump truck, but did not mention either of these occupations.

When Petitioner did specify low back symptoms during his medical treatment, the onset varied from history to history. On September 6, 2007, Beloit Clinic recorded a 6 year history of back pain. On November 21, 2007, Petitioner presented to MedChoice with complaints of back pain since 2 years ago. On November 28, 2007, Petitioner complained that he was having back pain for 1 year to the plant medical clinic. Later that same day, he described a specific incident while lifting a spare tire around July 4th. Dr. Baluga's December 5, 2007 Medical Certificate lists the onset of the condition as 8-12 months ago. On December 28, 2007, Petitioner presented to MedChoice physical therapy stating he had pain across his low back that started gradually one year ago.

At trial, petitioner said he did not recall his back injury as a child. On July 27, 2007, at Beloit Clinic, Petitioner provided a detailed history involving a childhood injury to his back. He reported he was at a quarry and jumped so that he sunk in the sand and hit his behind on the ground and felt a sensation of electricity going up the back. He was unable to walk or move very well for at least a couple of days. On September 6, 2007, Petitioner again gives the detailed description of the fall into a sand pit 14 years before. Petitioner denied any childhood injury history at Dr. Neal's Section 12 examination. Dr. Coe's report describes the childhood incident as a contusion in a fall. At trial, Petitioner testified he had no problems with his back before starting at Respondent, but told Dr. Coe he experienced occasional pain in his lower back, but not as severe or persistent until the work activities described.

Based upon the findings of a preexisting degenerative disc disease and these numerous inconsistencies in Petitioner's testimony and medical histories, the Arbitrator finds Petitioner's testimony as to his job duties and onset of his symptoms not credible.

Dr. Coe opined that Petitioner suffered repetitive strain injuries which were a factor aggravating degenerative disc disease and degenerative arthritis. Petitioner has degenerative disc findings. The MRI findings are not changes of a few months. The opinion of aggravation is based upon the subjective symptoms reported. Dr. Coe found that the jobs installing tires and doing shifter installation contributed to Petitioner's low back condition. His history describes the shifter installation and spare tire jobs with reported symptoms beginning in June, 2007. He admits at his deposition that this history is not consistent with the medical histories recorded. Petitioner did state to Dr. Coe that prior to the alleged date of onset, he experienced occasional pain in his lower back, but not as severe or persistent until the work activities described. There is no information of prior employment in roofing and painting as described in the treating records. Dr. Coe's report describes the childhood incident as a contusion in a fall. Dr. Coe concedes that the fall could be a factor in the development of the arthritic component of his back condition.

Dr. Coe also relies on Petitioner's history to him that he has had persistent symptoms since the date of injury. This history and Petitioner's trial testimony to that fact are contradicted by the medical records. The April, 2008 notes from MedChoice confirm improvement and the lack of complaints into the leg. Petitioner can do yard work with some pain at the end of the day. Petitioner no longer takes strong pain medication. He has not kept up with physical therapy and comes when convenient. Dr. Ebert's states that Petitioner had treatment until 2009 and that his symptoms improved. In the past year, his pain returned. Petitioner had an MRI in March of 2013 that showed three level degenerative disc disease. Dr. Ebert's impression is Mr. Puentes has axial low back pain without any radicular symptoms. He has some progression of his degenerative changes since 2007, but the degree of change is what we would typically expect of this amount of time. The reason for his increased pain in the last year is unclear.

The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts. Dr. Coe's opinions are based upon the descriptions, subjective complaints and histories provided by Petitioner. Upon review of the entire record, the Arbitrator finds the opinions of Dr. Neal more persuasive.

Based upon the record as a whole, the Arbitrator finds that 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 November 28, 2007 and further failed to prove by a preponderance of the evidence that his condition of ill being in the low back was causally connected to his employment with Respondent.

In support of the Arbitrator's decision with respect to (E) Notice, (J) Medical and (N) Credit, (K) Temporary Compensation, and (L) Nature and Extent, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Accident and Causal Connection, the remaining issues of Notice, Medical and Credit, Temporary Compensation, and Nature and Extent are moot.

Petitioner's claim for compensation is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ 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

Stanley Molda,

Petitioner,

vs.

NO: 13 WC 28855

17IWCC0079

EMTECH,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, extent of temporary total disability, nature and extent of permanent disability, medical expenses and §8(j) credit and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission modifies the Arbitrator's Decision finding that Respondent is entitled to §8(j) credit of $231.31, the amount of medical bills for chiropractor Dr. Grennell prior to maximum medical improvement on May 30, 2013 paid by the group health carrier. The medical records and testimony of treating Dr. Amine indicates Petitioner sustained new and different symptoms on July 25, 2013 than he had before. Petitioner's treatment with chiropractor Dr. Grennell shows a steady improvement of his diagnosed sprain/strain and Petitioner was released from his care on May 30, 2013. The Arbitrator's finding of maximum medical improvement on that date is supported. According to the medical records, Petitioner had no radicular symptoms until after the July 24, 2013 cereal box incident where he jerked his head backwards. The Commission affirms the Arbitrator's finding that the July 24, 2013 neck jerking incident constituted an intervening accident that broke the chain of causation between the work related

17IWCC0079

injury of December 27, 2012 and his current condition of ill-being. The Commission notes that Dr. Amine did not review Dr. Grennell's records, while Dr. Mirkovic reviewed all of the medical records. The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.55 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 permanent disability of the person as a whole to the extent of 5%.

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 that Respondent paid $3,562.75 as an advance of TTD benefits.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $231.31 for medical expenses that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in §8(j) of the Act.

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $14,100.00. 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: FEB 10 2017
MB/maw
o01/19/17
43

Mario Basurto

Stephen J. Mathis

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MOLDA, STANLEY
Employee/Petitioner

Case# **13WC028855**

17IWCC0079

EMTEC
Employer/Respondent

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:

1067 ANKIN LAW OFFICE LLC
JOSHUA E RUDOLFI
10 N DEARBORN ST SUITE 500
CHICAGO, IL 60602

4136 ADELSON TESTAN & BRUNDO
NANCY RUNDIN
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CHICAGO, IL 60606

17IWCC0079

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

STANLEY MOLDA,
Employee/Petitioner

v.

EMTEC,
Employer/Respondent

Case # 13 WC 28855

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 **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **Chicago**, on **5/16/16**. 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 ____

17IWCC0079

FINDINGS

On **12/27/12**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$101,876.74**; the average weekly wage was **$1,959.17**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **2** dependent children.

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

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.
Respondent shall be given a credit of **$3,562.75** as an advance in TTD, **$0** for TPD, and **$0** for maintenance benefits, for a total credit of **$3,562.75**.

Respondent shall be given a credit of **$22,187.09** for medical benefits that have been paid.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$712.55/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, for the **lumbar spine**.

Respondent shall be given a credit of **$3,562.75** as an advance in TTD, **$0** for TPD, and **$0** for maintenance benefits, for a total credit of **$3,562.75**.

Respondent shall be given a credit of **$22,187.09** 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.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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

6-20-2016
Date

JUN 20 2016

FINDINGS OF FACT

Stanley Molda ("Petitioner") alleged injuries arising out of and in the course of his employment on December 27, 2012 with EMTEC ("Respondent"). Ax1. The parties proceeded to arbitration on May 16, 2016 on the following disputed issues: casual connection, liability for unpaid medical bills, temporary total disability and nature and extent of the injury. Ax1.

Petitioner testified he worked for Respondent on December 27, 2012 as a software engineer whose duties included design and development of software for various clients. On that date, Petitioner injured his neck/cervical spine as a result of a motor vehicle accident, which occurred while leaving a client site. Petitioner testified he had immediate symptoms of pain in the neck, extreme pressure traveling down his shoulder area. He said his neck area tingled and felt "electrical impulses." He said pain would travel down the back of the right arm. Petitioner had no prior neck problems.

Petitioner began treating on January 8, 2013 with Dr. Grinnell, a chiropractor. Px2. The history noted Petitioner's motor vehicle accident. Px2. Complaints included: stiffness, headache, tingling in the hands, shoulder and neck pain. Px2. Symptoms interfered with Petitioner's abilities and daily routine, computer work, concentration, lifting, exercise and sleep. Past medical history was positive for lumbar discectomy and left elbow surgery. Px2. After an exam, the doctor diagnosed moderate to severe posttraumatic cervical sprain/strain associated with myofascitis, cervical subluxation at multiple sites, cervicalgia and general headache, cervical radiculitis and muscle spasm. Px2. He was given light-duty restrictions of no lifting over 15 pounds. The plan was for chiropractic treatment. Px2. On January 27, 2013 x-rays of the cervical showed biomechanical changes with cervical hypo lordosis, diminished sagittal mobility on extension in early degenerative disc disease at C-5. Px2. Petitioner continued chiropractic care. Petitioner continued working during this time and said treatment helped for about ½ hour and would not go away. During this time, most treatments involved subjective complaints to the cervical and trapezius areas.

On January 22, 2013, Petitioner underwent a progress exam with Dr. Grinnell. Px2. He complained of cervical pain primarily on the right side of the neck and into the right muscle and shoulder area. Px2. On exam, he was tendered in the neck, trapezius and suboccipital areas. Px2. The doctor noted decreased sensitivity in the right C6 (lateral forearm) and right C7 (little finger and posterior forearm). Px2. Diagnosis was unchanged and light-duty restrictions of no lifting over 20 pounds were issued. Px2. On April 15, 2013, Petitioner underwent progress exam with Dr. Grinnell. He complained that the pain was in the lower neck area and into the upper back more on the right side. Px2. He was given restrictions of no lifting over 25 pounds. Px2. On May 30th, Petitioner was reevaluated by Dr. Grinnell. Px2. He complained of mild stiffness and some difficulties in the right shoulder. Cervicalgia was resolved. Petitioner rated his pain discomfort level at 1/10. Exam showed no compression abnormalities and normal spinal postures. The doctor determined that Petitioner was at pre-accident status. Petitioner was released from care. Petitioner testified he did not feel good that date. He stopped seeing Dr. Grinnell because he was not getting better and had done everything asked of him. The doctor's bills were paid under his auto insurance.

On July 9, 2013, Petitioner began treating for the neck with Dr. Amine. Px3. The doctor noted pain and discomfort in the back of the neck and the right scapular region. Radiating pain was negative. The doctor noted improvement with chiropractic manipulation but discomfort had persisted. It did not interfere with his work. Exam of the upper extremities failed to note any weakness, reflexes were symmetric bilaterally; flexion and extension was within normal range but painful when flexed forward to the left side. Impression was possible foraminal narrowing at C5-6 or C6-7 causing a partial nerve root impingement. The plan was for home cervical

traction followed by possible epidural steroid injections followed by possible MRI. Px5. Petitioner testified Dr. Amine took him off work that day but he continued working anyway. Petitioner testified that during this time, he was in a lot of pain, had enormous pressure in the back of the neck and sneezing caused electrical impulses in the back of his neck, traveling into right arm and all the way to the right hand.

Petitioner testified that on July 24, 2013, while at home he jerked his head back instinctively when a box of cereal fell off a shelf and onto his face. He said the pain and electrical impulses became constant then.

On July 25, 2013, Petitioner returned to Dr. Amine reporting little benefit with traction. Px3. He also related that a cereal box fell on his head and he instinctively jerked his neck back and he immediately felt electrocuted from his neck all the way down. Px3. The pain traveled to both knees and hands. Px3. The doctor was hoping to eliminate Petitioner's new symptom and hoped Petitioner had not ruptured a disc with his neck jerk. Px3.

On August 1, 2013, Dr. Amine opined that cervical MRI showed C5-6 disc protrusion with extensive cord compression requiring surgical intervention. Px3. On August 14, 2013, Petitioner underwent and Dr. Amine performed a C5-6 discectomy with excisions of acute fresh extruded disk, bilateral foraminotomies and fusion. Petitioner continued to follow up with Dr. Amine periodically and on October 23, 2014, Petitioner was to return PRN. Px3.

On February 24, 2014, Dr. Amine issued a narrative report. Px4. He said Petitioner was frustrated with persistency of symptoms and he returned to him in July 2013 for the motor vehicle accident. He said the symptoms from the neck jerking back had reproduced all the symptoms he experienced before. He said the cereal box could not produce such a large cervical disc herniation, cord compression or cervical myelopathy. He concluded that "cervical herniated must have preexisted the incident of the cereal box and likely related to the incident of the motor vehicle accident December 2012." Px4.

On December 2, 2014, Dr. Mirkovic was deposed. Rx4. He previously performed a record review. The doctor testified Petitioner sustained a cervical sprain/strain as a result of the motor vehicle accident, based upon the history provided in his review of medical records. Specifically, the doctor relied on Dr. Grinnell's notation that Petitioner was neurologically intact no evidence of radiculopathy or myelopathy. Further, Dr. Mirkovic noted Petitioner had normal reflexes, negative Spurling, no documented weakness, only localized pain to the upper neck and back and most importantly following chiropractic treatments, Petitioners symptoms improved.

Dr. Mirkovic pointed out that the 37 diagrams in Dr. Grinnell's medical records did not demonstrate evidence of radiculopathy. Dr. Mirkovic noted that as of May 30, 2013, Petitioner had only localized pain with resolution of neck and upper back pain consistent with acceptable recovery time of a cervical sprain/strain.

Dr. Mirkovic opined Petitioner's diagnosis on July 9, 2013 was consistent with a cervical sprain/strain perhaps with some residual symptoms. Neither MRI nor surgery was indicated on July 9, 2013 based on Petitioner's clinical presentation on that date.

The doctor further testified records indicated a change in Petitioner's symptoms sometime after July 9, 2013. Specifically, the doctor testified that on July 25th, Petitioner presented to Dr. Amine with a completely different clinical picture and new symptoms. Dr. Mirkovic noted the neck jerking incident the day before when a cereal box fell toward Petitioner.

Dr. Mirkovic opined that the medical records suggested an immediate onset of symptoms following this incident. He opined that hyper reflexia was consistent with positive neurologic findings or potentially significant irritation to the spinal cord. No such symptom existed previously and prior exam showed normal reflexes bilaterally.

The doctor opined that the symptoms and exam findings on July 24th and July 25th signified a change in the nature of Petitioner's condition. The doctor opined that Petitioner "presented with suggestion of severe acute irritation of the spinal cord," more likely than not related to a herniated disc. He believed the mechanism of injury described as occurring on July 24th is a possible cause.

He did not believe that the motor vehicle accident was the cause of Petitioners new condition, as Petitioner was doing reasonably well with isolated symptoms to the neck and upper back. The doctor admitted the herniation may have existed prior to July 24th but he would expect to see symptoms similar to those Petitioner had related on July 24th and July 25th given the size of the disc herniation on MRI. The doctor further testified that surgery and subsequent work restrictions were necessitated by the July 24th incident and not the motor vehicle accident.

On September 8, 2014, Dr. Amine was deposed. Px6. He said Petitioner presented complaining of neck pain shoulder pain. He did not find any focal deficits and reflexes were normal. The doctor stated that in the absence of any significant muscle atrophy or any neurological deficits he wanted to try nonsurgical options first.

The doctor testified that Petitioner returned and related that a cereal box had fallen on his nose so he jerked his neck and immediately felt electrocutions going down to his body through the knees down to the feet and hands. On exam, Petitioner had hyperreflexia, which was a sign of pressure on the spinal cord. The doctor testified it was not a sign of pressure on the nerve. Given the severity of findings, the doctor testified he sent Petitioner for an MRI. He was asked whether Petitioner's symptoms on the 25th were consistent with his symptoms on July 9th, he responded "it's a little more than what it is." The doctor testified that he believed he sustained a herniated disc six months before he first saw him.

The doctor opined that he believed the herniated disc began at the time of the accident, which may have been aggravated by the jerking of the neck. He based this on Petitioner's continuation of his symptoms. He believed the condition began with the motor vehicle accident and was aggravated by the cereal box incident.

On the cross, the doctor agreed that acute as used in his operative report was referring to the rupture detected on MRI. He agreed that the rupture to which he was referring possibly occurred in July 2013 following the incident with the cereal box. Regarding the MRI, the doctor testified that he typically would not order an MRI until more debilitating symptoms were noted. To that extent, he agreed that he ordered the MRI only after learning of the cereal box incident. He agreed that there was a change in symptoms specifically citing "new additional symptoms," one such symptom included hyperreflexia. The doctor agreed that there was no evidence of hyperreflexia prior to the date of that physical exam on July 25th.

The doctor agreed that prior to Petitioner reporting to him on July 9th, the symptomology that he was reporting had never radiated into the hands or the fingers. He also agreed that the condition had not interfered with his work. The doctor agreed that in his initial report there is no mention of a motor vehicle accident. On redirect, the doctor distinguished between elements of an old injury and a fresh injury in the operative report. The doctor concluded that the fresh injury was superimposed on an old injury at the desk.

Petitioner testified he feels about 75% better. He still has pain, finds it hard to work; looking at angles is difficult and has cold weather sensitivity. He is not comfortable driving. He said he has outstanding Christ Hospital bills. He returned to work and while has not missed pay, believes he is missing out on opportunities. He testified he missed bonus, which are part of his wages.

Regarding his activities, he cannot wrestle with his son, cannot practice football with him, cannot do volleyball with his daughter, and cannot do heavy stuff around the house. He does not feel like I am the man he used to be and feels fragile. On cross, he said he still drives to and from work and has no driving restrictions.

Regarding bills, Respondent admitted its "claims payment list." Rx5. The following amounts were claimed as paid by Respondent in relation to the instant claim, along with alleged corresponding dates of service: Porter Capital $1,050.00 (DOS: 8/8/14-8/25/14); First Script Network $169.04 (DOS: 11/13/13, 11/21/13, 12/1/13) Christ Medical Center $154.15 (DOS: 8/5/13). Thus, Respondent alleged workers' compensation medical benefits totaling $1,373.19. Petitioner alleged outstanding medical bills as part of Respondent's liability. Ax1, Px1. They include: Trover Solutions/Blue Cross Blue Shield $22,133. 47 (DOS: 4/26/13-10/23/14); Christ Medical Center/DNL Healthcare Services $1,970.47 (DOS: 7/9/13, 8/5/13, 8/14/13); Chicago Ridge Radiology $10.26 (DOS 7/30/13, 9/25/13); Dr. Abdul Amine $10,229.60 (DOS: 7/9/13 – 6/23/14). Thus, Petitioner alleged remaining unpaid medical bills totaling $34,351.80. A statement from Trover Solutions, which referred to group health benefits provided to Petitioner, were for various dates of service beginning April 26, 2013 through October 27, 2015 benefits totaling $22,187.09. Rx3. Dates of service correspond to Petitioner's chiropractic treatments, Dr. Amine, the cervical fusion along with pre-and post-operative care.

CONCLUSIONS OF LAW

ISSUE (F) ***Is Petitioner's current condition of ill-being causally related to the injury?***
ISSUE (J) ***Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?***
ISSUE (K) ***What temporary benefits are in dispute?***

The Arbitrator concludes that Petitioner's current condition of ill-being was not caused by nor is a natural consequence of the December 27, 2012 work injury and that the neck jerking incident of July 24, 2013 constituted an independent, intervening accident that broke the chain of causation. As such, the Arbitrator finds that Respondent's liability for temporary total disability benefits and medical expenses ceased on May 30, 2013, the date in which Petitioner last sought medical treatment for his work accident and the same date in which he was released from care for same.

In order to establish causation under the Act, an employee must prove that some act or phase of his employment was a causative factor in his ensuing injury. *Land & Lakes Co. v. Indus. Comm'n*, 834 N.E.2d 583, 592, 296 Ill. Dec. 26 (2005). "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." *Nat'l Freight Indus. v. Ill. Workers' Comp. Comm'n*, 993 N.E.2d 473, 373 Ill. Dec. 167, 169 (2013). Under an independent intervening cause analysis, compensability for an ultimate injury or disability is based upon a finding that the employee's condition was caused by an event that would not have occurred "but for" the original injury. *Int'l Harvester Co. v. Indus. Comm'n*, 46 Ill. 2d 238, 245, 263 N.E.2d 49 (1970).

Applying these principles to the instant case, the evidence shows that: 1) Petitioner's work-related motor vehicle

accident resulted in a cervical sprain/strain for which he treated conservatively with chiropractic care; 2) Petitioner was released from care in May 2013 and did not seek any further treatment for his neck until July 9, 2013; 3) On July 9, 2013 Petitioner presented with no neurological deficit, no complaints of radiating pain/symptoms, no hyper-reflexia, no evidence of disc rupture and did not relate any work injury; 4) the presence and absence of such symptoms were acknowledged by Drs. Amine and Mirkovic; 5) following the July 24, 2013 incident involving Petitioner jerking his neck back in response to a falling cereal box resulted in new symptoms, including neurological deficit, spinal cord compromise/compression and hyper-reflexia; 6) Drs. Amine and Mirkovic admitted and agreed that Petitioner's symptoms changed significantly following the incident at home; 7) both doctors testified that the need for immediate MRI and fusion surgery was based on ruptured disc, new symptoms that compromised the spinal cord and were not based on nerve injury.

The Arbitrator is not persuaded by Dr. Amine's conflicting opinions. For example, Dr. Amine's narrative report states that Petitioner presented to him in July 2013 for the motor vehicle accident however the initial note makes no mention of a motor vehicle accident. In another example, the doctor's narrative report said that the symptoms from the neck jerking incident had *reproduced* all of the symptoms Petitioner had experienced before. However, Dr. Amine's deposition testimony suggested that the neck jerking incident produced *new* symptoms, such as suspected spinal cord compression, hyper-reflexia and disc rupture/herniation. Px6:36:3-9. Further, Dr. Amine's narrative report said that the cereal box incident could not produce such a large cervical disc herniation and would not produce cord compression. However, the doctor testified that neck jerk ruptured the disc, causing a new acute injury and cord compression, all superimposed on an older injury. Px6:38:10-18. Finally, Dr. Amine attempted to testify that Petitioner's C5-6 herniation was caused by Petitioner's weakened cervical ligaments, which he attributed to the motor vehicle accident. However, this testimony stands in conflict with Dr. Amine's other opinions that the herniation likely was caused by the motor vehicle accident and was later aggravated by the neck jerking incident. The Arbitrator declines to adopt the opinions of Dr. Amine.

Instead, the Arbitrator is persuaded by Dr. Mirkovic's compelling and succinct medical opinions in this case, which support a conclusion that Petitioner's C5-6 disc herniation and spinal cord compression was not caused by his work accident, which resolved as of July 9, 2013. Dr. Mirkovic's opinions, along with Dr. Amine's medical record and deposition testimony, suggest, by a preponderance of the evidence, that Petitioner's neck jerking incident of July 24, 2013 constituted an intervening accident that broke the chain of causation between the work related injury of December 27, 2012 and his current condition of ill-being. It cannot be said that Petitioner's event of the neck jerking incident would have occurred but-for the work accident.

Further, the Arbitrator is not persuaded by Petitioner's testimony as it relates to his symptoms. Petitioner testified that at the time of his auto accident, he felt electrical impulses; but no such corroborating evidence exists in Dr. Grinnell's medical record. In fact, none of Dr. Grinnell's records demonstrate radiation to any extremity. Dr. Grinnell only documented that subjectively, Petitioner complained of tingling in the hand. Further, as Dr. Mirkovic correctly pointed out, much of the pain diagrams in Dr. Grinnell's record show localized pain in the neck and trapezius area. Petitioner also testified he did not feel well and stopped seeing Dr. Grinnell because he was not getting better. However, Dr. Grinnell's medical record on May 30th demonstrated 1/10 pain, resolved cervicalgia and no abnormalities. Diagram for that date demonstrated trap and shoulder pain only. No mention is made of C5-6. Petitioner's testimony in this regard is contradicted by his medical record. Further, Petitioner did not seek any medical treatment for 40 days after his last visit with Dr. Grinnell, suggesting to the Arbitrator that Dr. Grinnell's record is accurate as to Petitioner's symptoms as they existed on May 30, 2013.

For the foregoing reasons, the Arbitrator concludes that Petitioner's current condition of ill-being is not causally related to the work accident of December 27, 2012, which resolved itself by July 9, 2013 and that the July 24, 2013 incident constitutes an intervening cause.

Regarding the disputed issue of medical bills, having found Petitioner's work related cervical condition resolved as of May 30, 2013, Respondent's liability is limited to those medical bills incurred as a result of the December 27, 2012 work accident up to and including May 30, 2013. For those dates, the Arbitrator notes Petitioner submitted charges from Dr. Grinnell totaling $0.00 but for which Trover Solutions/Blue Cross Blue Shield issued payment for dates of services from April 26, 2013 through May 30, 2013, for which Respondent is entitled to a credit under Section 8(j). Ax1, Px1, Rx3. Respondent shall be given a credit of **$22,187.09** 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. The Arbitrator finds all medical treatment after May 30, 2013, which includes treatment with Christ Medical Center, Chicago Ridge Radiology, Dr. Amine and Advocate Medical Group, is unrelated to Petitioner's December 27, 2012 work accident and Respondent shall not be held liable for same. The Arbitrator declines to award any amounts listed in Rx5, as they are not supported by any medical record and the dates of service listed occur after May 30, 2013. Respondent also did not seek any credit for these amounts. Ax1.

Regarding the disputed issue of temporary total disability, having found Petitioner's work related cervical condition resolved as of May 30, 2013, Respondent's liability is limited to any temporary total disability for which Petitioner may be entitled to from December 27, 2012 through May 30, 2013. At trial, Petitioner only alleged entitlement to temporary total disability from August 13, 2013 through October 17, 2013. Ax1. Having found Petitioner's work-related cervical condition of ill-being resolved on May 30, 2013, the Arbitrator declines to award Petitioner's request for additional temporary total disability for the period sought. Respondent shall be given a credit of **$3,562.75** as an advance in TTD, **$0** for TPD, and **$0** for maintenance benefits, for a total credit of **$3,562.75**.

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The evidence established that Petitioner last treated for his cervical sprain/strain on May 30, 2013, at which time he was determined to be at pre-accident status by Dr. Grinnell and was released from care. Dr. Mirkovic opined this was acceptable recovery time for a cervical sprain/strain. Petitioner did not return to Dr. Grinnell. The evidence does not support any further treatment for his work-related injuries beyond this date, as Petitioner's first visit with Dr. Amine, forty days later, made no mention of a work injury. Therefore, the Arbitrator finds Petitioner's cervical sprain/strain reached maximum medical improvement and otherwise stabilized on May 30, 2013 and relies on the medical record of Dr. Grinnell, as well as the credible medical opinions of Dr. Mirkovic in reaching this conclusion. Thus, the nature and extent of Petitioner's work related cervical sprain/strain is ripe for adjudication.

Consistent with the Act, the Arbitrator considers the following factors and makes the following corresponding findings: With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no AMA impairment rating was submitted into evidence. Dr. Grinnell noted no permanent restriction, however. The Arbitrator therefore gives 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 software engineer at the time of the accident and returned to work following his release from Dr. Grinnell. Petitioner did not testify his occupation suffered as a result of this injury. The Arbitrator therefore gives no weight to this factor. With regard to subsection (iii) of

§8.1b(b), Petitioner was 50 years old at the time of the accident. Petitioner's age suggests a short work life remaining but also suggests Petitioner may experience the effects of his injury to a greater degree than a younger person. The Arbitrator therefore gives some weight to this factor. With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes no doctor or expert has opined Petitioner's future earnings to be impaired or that Petitioner has permanent restrictions as a result of his work related injuries. The Arbitrator therefore gives no weight to this factor. With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Dr. Grinnell's records and adopts same. Petitioner testified extensively as to his limitations but that testimony was as to his current condition, which the Arbitrator has found to be unrelated. The Arbitrator therefore gives the greatest weight to this factor. Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of **5%** loss of use of **man as a whole** pursuant to §8(d)(2) of the Act. Respondent shall pay Petitioner permanent partial disability benefits of **$712.55/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, for the **lumbar spine**.

Signature of Arbitrator

6-20-2016
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brian DiCristofano,
Petitioner,

vs.

NO: 13 WC 30298

17IWCC0080

Ingersoll Rand Co.,
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, reasonableness and necessity of current and future medical expenses, temporary total disability, penalties and attorneys' fees and evidentiary issues and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 agrees with the Arbitrator's findings in regard to placing more weight on Dr. Zelby's opinions than on Dr. Hennessey's opinions. In doing so the Commission discounts Dr. Zelby's flawed position that Petitioner had a pre-existing symptomatic cervical condition leading into the June 2, 2011work accident, but otherwise adopts the remainder of Dr. Zelby's opinions over those of Dr. Hennessey. The Commission further holds all of the appropriate temporary total disability benefit and temporary partial disability benefit payments have been made by the Respondent. Lastly, the Commission places no weight on the utilization reports authored by either Drs. Wyatt or Ciochetty. The Commission finds that it is abundantly clear in reviewing the depositions of these two doctors along with their reports and the correctly

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rejected RX12 exhibit that any material generated via the Claims Eval Co. that pertains to this case should be assigned no weight.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,243.00 per week for a period of 15-3/7 weeks, that being the period of temporary total incapacity related to Petitioner's low back condition injured while at work on June 2, 2011 under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit in the amount of $249,157.04 for all amounts paid for workers' compensation benefits and $1,434.14 per §8(j) credit 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: FEB 10 2017

MB/jm

O: 1/26/17

43

Mario Basurto

David L. Gore

Stephen Mathis

NOTICE OF 19(b) ARBITRATOR DECISION

DI CRISTOFANO, BRIAN
Employee/Petitioner

Case# **13WC030298**

INGERSOLL RAND COMPANY
Employer/Respondent

17IWCC0080

On 7/25/2016, 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 0.43% 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:

0391 HEALY SCANLON
KEVIN T VEUGELER
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

1408 HEYL ROYSTER VOELKER & ALLEN
BRAD ANTONACCI
120 W STATE ST 2ND FL
ROCKFORD, IL 61105

17IWCC0080

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)

BRIAN DICRISTOFANO
Employee/Petitioner

v.

INGERSOLL RAND COMPANY
Employer/Respondent

Case # **13** WC **30298**

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 **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **01-15-16**. 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. [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. [x] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [x] Other **Admissibility of Respondent's Exhibit No. 11 into evidence.**

FINDINGS 17IWCC0080

On the date of accident, **06-02-11**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being *is not* causally related to the accident regarding his left hand/wrist and cervical spine, and *is* causally related regarding his lumbar spine.

In the year preceding the injury, Petitioner earned **$99,840.00**; the average weekly wage was **$1,920.00**.

On the date of accident, Petitioner was **45** years of age, *married* with **2** dependent children.

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

Respondent shall be given a credit of **$22,455.99** for TTD, **$63,686.39** for TPD, **$0.00** for maintenance, **$4,616.87** for a PPD advance, and **$158,398.39** for medical benefits, for a total credit of **$249,157.64**.

Respondent is entitled to a credit of **$1,434.14** under Section 8(j) of the Act.

ORDER

Credits
Respondent shall be given a credit of **$22,455.99** for TTD, **$63,686.39** for TPD, **$0.00** for maintenance, **$4,616.87** for a PPD advance, and **$158,398.39** for medical benefits, for a total credit of **$249,157.64**.

Medical Benefits
Respondent *has* paid all reasonable and necessary charges for all reasonable and necessary medical services. Petitioner has received medical services that are unreasonable, unnecessary, and unrelated to the injury, as noted in the Attachment. Respondent is not liable for that treatment.

Causal Connection
The Arbitrator finds causal connection for the Petitioner's lumbar spine condition. However, the Arbitrator finds no causal connection for the Petitioner's bilateral carpal tunnel syndrome, nor his current cervical spine condition.

Prospective Medical Benefits
Petitioner is not entitled to cervical spine fusion as prescribed by Dr. Hennessy.

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits of **$1,243.00**/week for **15 & 3/7** weeks, commencing **12-02-11** through **03-19-12**, as provided in Section 8(b) of the Act.

Penalties
Respondent shall pay to Petitioner penalties of **$0.00**, as provided in Section 16 of the Act; **$0.00**, as provided in Section 19(k) of the Act; and **$0.00**, as provided in Section 19(l) of the Act.

Evidence
Respondent's Exhibit No. 11 is admitted into evidence.

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.

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STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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

07-25-16
Date

JUL 25 2016

ICArbDec19(b)

17IWCC0080

ARBITRATION DECISION 19(b)
ATTACHMENT

Brian Dicristofano v. Ingersoll Rand Company
Case No. 13 WC 30298

FINDINGS OF FACT

On 6/02/11, Petitioner was working as a field foreman/field technician for the Respondent in the commercial heating and air conditioning industry. His duties included overseeing a group of individuals, and they would service multiple buildings. They would also perform preventive maintenance work and major repair work on commercial air conditioning and heating equipment. He would also perform factory certified startups. See Petitioner's Exhibit No. 7; Respondent's Exhibit No. 4.

On 6/02/11, Petitioner was heading to work at the Chicago Board of Exchange to perform a running inspection, but before he arrived, he was involved in a motor vehicle accident. He was driving through an intersection in a Chevy Astro Minivan when the driver of the other vehicle failed to stop his/her vehicle at a red light and impacted Petitioner's vehicle. Petitioner testified he felt "jolted." Petitioner went to Respondent's office and then proceeded to Concentra Occupational Health Center (Concentra). (Petitioner's Exhibit No. 22.)

Petitioner presented to Concentra on 6/02/11 complaining of soreness and tightness primarily in the mid back and left shoulder region. (Petitioner's Exhibit No. 22.) Dr. John assessed Petitioner with a thoracic strain, noted Petitioner to have no functional limitation, and allowed him to return to regular work duties. He was prescribed Extra-Strength Tylenol and Flexeril. On 6/06/11, Dr. John at Concentra assessed Petitioner with lumbar and thoracic strain. Petitioner noted mid and lower back pain with significant stiffness both in the left mid back and lower back and left side of his neck. Petitioner denied radicular symptoms. Dr. John provided restrictions of no lifting more than 20 pounds or reaching over shoulder level. Respondent accommodated the restrictions. He was to follow up at Concentra following X-rays. Physical therapy began on 6/09/11 at Accelerated Rehabilitation Centers. (Petitioner's Exhibit No. 6.) Petitioner began performing clerical or office-type work for the Respondent after the accident on a part-time basis. He testified that his job duties varied, and he was not lifting any heavy weights. He was paid temporary partial disability benefits. (Respondent's Exhibit No. 1.)

Rather than follow up at Concentra, Petitioner presented to Dr. Weiss, his primary care physician, who referred Petitioner to Dr. Hennessy at Orthopedic Associates, S.C. (Petitioner's Exhibit No. 3.) Dr. Hennessy reviewed a lumbar MRI from 7/01/11, which revealed an 8 mm fragmented

right central disc herniation at L4-5. A cervical spine MRI of the same date revealed disc herniations at C3-4 and C5-6 with no cord compression or compression of the nerve roots. (Respondent's Exhibit No. 8.) Petitioner advised Dr. Hennessy on 7/06/11 that he experienced dull ache on the left arm with activity that began one week after the accident. Petitioner noted right leg pain began the weekend after the accident. His neurological exam appeared to be within normal limits. Dr. Hennessy diagnosed lumbar disc displacement without myelopathy and cervical disc disorder. Dr. Hennessy recommended physical therapy. Physical therapy continued at Accelerated Rehabilitation Center in July 2011, with noted improvement in Petitioner's complaints. (Petitioner's Exhibit No. 6.)

Dr. Hennessy noted improvement in Petitioner's cervical condition on 8/05/11, and his lumbar spine and right L4-5 radiculopathy were essentially the same. (Petitioner's Exhibit No. 3.) He was taking Norco and Flexeril. He continued working light duty four hours per day. Petitioner agreed to proceed with an L4-5 epidural injection, and this procedure was performed on 8/09/11 by Dr. Zaffer. (Petitioner's Exhibit No. 3.) A second injection was performed on 9/06/11. Petitioner noted minimal relief with the injections.

Petitioner was treated by Dr. Singh for a second opinion on 9/22/11. (Respondent's Exhibit No. 16.) Dr. Singh noted Petitioner's primary pain complaints were relegated to his lumbar spine. He diagnosed degenerative disc disease at L4-L5 status post prior L4-L5 laminectomy and discectomy, L4-L5 disc protrusion with bilateral foraminal stenosis, and degenerative disc disease at C3-C4, C4-C5. He recommended a revision L4-L5 laminectomy and posterior spinal fusion with instrumentation. Petitioner specifically noted his neck symptoms and arm symptoms were improving. Dr. Singh believed some of Petitioner's cervical pain complaints were postural. (Respondent's Exhibit No. 16.)

Dr. Zaffer performed an EMG on 9/27/11, which revealed bilateral median neuropathy at or to the distal wrist as in carpal tunnel syndrome, moderately severe on the left and mild in severity on the right. There was no electrical evidence of a left-sided C8 radiculopathy. (Respondent's Exhibit No. 9.) The Arbitrator notes that the Petitioner is right-hand dominant.

Dr. Hennessy reviewed the EMG results on 10/03/11 and mistakenly indicated the EMG revealed left C8 radiculopathy. (Petitioner's Exhibit No. 3.) During his deposition, he testified he did not appreciate any significant left C8 radiculopathy or nerve impingement on the cervical MRI. (Petitioner's Exhibit No. 16, p. 11.) He recommended a decompression and fusion surgery to the Petitioner's lower back. Dr. Hennessy felt cervical surgery was not recommended to the cervical spine on 10/14/11 but thought Petitioner should consider a carpal tunnel release surgery. Petitioner stopped working his part-time office work on 12/02/11 due to the lumbar spine surgery.

Dr. Hennessy performed lumbar spine surgery on 12/02/11 in the form of an L5-S1 decompression and fusion. (Petitioner's Exhibit No. 1.) Following surgery, while still at the hospital, Petitioner noted significant resolution of his leg radiculopathy. Petitioner continued to treat with Dr. Hennessy postoperatively and noted marked improvement in back pain and radicular leg symptoms in the spring of 2012. (Petitioner's Exhibit No. 3.) Petitioner noted complaints of left arm radiculopathy in the C7 dermatome that were improving but still present. His carpal tunnel symptoms were not improving and getting worse. Physical therapy took place at Athletico following surgery. He noted improved mobility and flexibility in his lower back and legs in physical therapy. (Petitioner's Exhibit No. 5.) He remained off work until 3/19/12, when Dr. Hennessy released the Petitioner to seated work only and no lifting more than ten pounds. He was to limit his work to 4 hours per day and was to stand 15 minutes every hour. The Petitioner returned to work within these restrictions on 3/19/12, performing office work, and the Respondent began paying temporary partial disability benefits. (Respondent's Exhibit No. 1.) He was noted to be neurologically intact, and X-rays showed the fusion to be in good alignment and apparent bridging bone. (Petitioner's Exhibit No. 3.) Petitioner underwent another EMG/NCV on 3/27/12. (Respondent's Exhibit No. 10.) This study revealed bilateral carpal tunnel syndrome again, and, again, there was no electrical evidence of a left-sided cervical radiculopathy.

Petitioner continued to note that he was able to walk longer distances, perform more activities at work, and perform daily activities with less difficulty in April 2012. (Petitioner's Exhibit No. 5.) Dr. Hennessy increased his weight restriction to 30 pounds of lifting. Work conditioning began in April 2012 and discontinued in May of 2012 as Petitioner plateaued. (Petitioner's Exhibit No. 5.) Dr. Hennessy recommended a home-exercise program for the lumbar spine. He continued to recommend a left carpal tunnel release. (Petitioner's Exhibit No. 3.) A 6/04/12 lumbar spine CT scan (Petitioner's Exhibit No. 1) revealed spotty fusion, according to Dr. Hennessy. (Petitioner's Exhibit No. 3.) Dr. Hennessy performed a left carpal tunnel release on 6/21/12. (Petitioner's Exhibit No. 1.) Petitioner stopped performing his part-time office work. Petitioner underwent physical therapy following the carpal tunnel release at Athletico. (Petitioner's Exhibit No. 5.) An updated cervical MRI was performed on 6/01/12, which revealed degenerative disc disease at C7-T1 with left-sided asymmetric disc protrusion and asymmetric narrowing left of the midline, mild bulging discs at C5-6 and C3-4 with mild superimposed bony spondylotic changes, and no evidence for compression fracture or destructive lesions. (Petitioner's Exhibit No. 3.) There was no compression or impingement of the spinal cord noted.

Dr. Hennessy recommended a C8 cervical epidural injection. For the lumbar spine, Dr. Hennessy recommended continued use of a bone stimulator, calcium, and vitamin pills on 6/25/12. (Petitioner's Exhibit No. 3.)

In the summer of 2012, following carpal tunnel release surgery, Petitioner reported to Dr. Hennessy decreased numbness and tingling in his left hand. Dr. Hennessy continued to recommend a C8 epidural injection and potentially future surgery to the cervical spine. (Petitioner's Exhibit No. 3.)

Petitioner first treated with Dr. Glaser, a pain management physician from Pain Specialists of Greater Chicago, on 8/09/12. (Petitioner's Exhibit No. 2.) Dr. Glaser performed a left transforaminal epidural steroid injection at C7-T1 and a selective nerve root block at C8 on 8/10/12. Petitioner noted 25 percent relief, according to Dr. Hennessy. (Petitioner's Exhibit No. 3.) Petitioner also advised Dr. Hennessy that his lumbar spine pain was improved 50 to 75 percent with no more shooting pains down his legs. Petitioner had a normal lumbar examination, according Dr. Hennessy, on 8/20/12. Petitioner began physical therapy at ATI on 8/23/12 with treatment directed to his lumbar, thoracic, and cervical spine. (Petitioner's Exhibit No. 4.) On 9/18/12, Dr. Glaser performed a second round of injections noted to be a left C7-T1 transforaminal epidural steroid injection. (Petitioner's Exhibit No. 2.)

On 9/24/12, Dr. Hennessy noted Petitioner was basically only taking Tylenol two to three times per week for pain. (Petitioner's Exhibit No. 3.) Petitioner's numbness and tingling in the median nerve distribution had resolved with respect to his carpal tunnel release. He had normal hand strength and a normal hand/wrist examination. Due to continued neck and left arm radicular complaints, Dr. Hennessy recommended a third left C8 nerve root block. Petitioner was discharged from physical therapy to his left hand/wrist on 10/31/12 after meeting all of his goals and returning to his previous functional status. (Petitioner's Exhibit No. 5.)

Petitioner underwent another CT scan of the lumbar spine on 11/14/12. (Petitioner's Exhibit No. 3.) Dr. Hennessy noted on 11/19/12 that the CT scan revealed a solid interbody fusion as well as apparently good solid posterior lateral graft. He considered Petitioner's lumbar fusion successful. Petitioner noted occasional back pain and bilateral hip area pain but no radiation into the thigh or legs. Petitioner's carpal tunnel issues were noted to be resolved. Dr. Hennessy placed Petitioner at MMI for his carpal tunnel on 12/17/12. He noted the Petitioner's lower back would be at MMI following an FCE, but the FCE would be artificially low due to the Petitioner's cervical spine condition, which required further treatment. Although Dr. Hennessy recommended the left C8 nerve root block, he noted that Dr. Glaser was now recommending multilevel facet injections. On 11/19/12, Dr. Hennessy noted that Dr. Glaser would have to supply the necessary rationale for treatment.

At the request of the Respondent, Dr. Zelby performed an independent medical examination on 12/03/12. (Respondent's Exhibit No. 6.) Dr. Zelby also testified with respect to this report in his 6/11/14 evidence deposition. (Respondent's Exhibit No. 5.) Dr. Zelby noted a normal cervical

spine examination except for a small amount of diminished hyperextension. The thoracic spine examination was normal. Lumbar spine examination was normal except for evidence of his previous surgery. He noted diminished sensation in the left fifth finger and the entire right foot. Dr. Zelby noted markedly diminished Achilles reflexes bilaterally. He also reviewed the diagnostic studies as well. After obtaining a history, performing the examination, and reviewing Petitioner's medical records, Dr. Zelby diagnosed cervical spondylosis, cervical strain, lumbar degenerative disc disease, a herniated lumbar disc, history of lumbar fusion, history of carpal tunnel release, and history of morbid obesity.

Dr. Zelby opined that Petitioner sustained a cervical strain in the context of mild underlying and previously symptomatic cervical spondylosis. On cross-examination, he admitted the Petitioner was symptomatic previously but not at the time right before the 6/02/11 motor vehicle accident. (Respondent's Exhibit No. 5, p. 38.) He also testified Petitioner sustained a right herniated L5-S1 disc. Petitioner's exam revealed no evidence of cervical radiculopathy, and his MRI study revealed no evidence for cervical radiculopathy. He did not believe Petitioner required any additional medical treatment to his cervical spine, and there was no medical indication to pursue the cervical facet injections suggested by Dr. Glaser. (Respondent's Exhibit No. 5, p. 23.) Petitioner had easily reached maximum medical improvement for any condition in his cervical spine associated with the motor vehicle accident. (Respondent's Exhibit No. 5, p. 24.) The evidence was consistent with a cervical strain from the motor vehicle accident and nothing more, regarding the cervical spine. Any other cervical findings were degenerative in nature and part of the natural aging process. (Respondent's Exhibit No. 5, p. 26.)

With respect to Petitioner's lumbar spine, Dr. Zelby found a solid arthrodesis at L5-S1, and Petitioner required no additional diagnostic studies or further directed treatment for his lumbar spine. (Respondent's Exhibit No. 5, p. 24.) He believed Petitioner could safely return to work in a medium physical-demand level, lifting up to 50 pounds occasionally and 25 pounds frequently. He anticipated these restrictions would be permanent. He did not believe Petitioner required any restrictions for his carpal tunnel condition. Furthermore, Dr. Zelby did not believe Petitioner's carpal tunnel condition was causally related to the motor vehicle accident on 6/02/11.

Dr. Hennessy reviewed Dr. Zelby's IME report on 1/21/13 and disagreed with Dr. Zelby's opinion that the Petitioner has not always had C8 radiculopathy. (Petitioner's Exhibit No. 3.) Dr. Hennessy did note Petitioner remains neurologically intact with regard to motor strength. He agreed with Dr. Zelby that there is no impairment with respect to Petitioner's carpal tunnel syndrome. Dr. Hennessy noted he did not believe further injections were necessary. He recommended a posterior cervical decompression and noted there was the possibility Petitioner may require a fusion if too much of the facet has to be removed. He recommended that

physical therapy be discontinued. Petitioner was discharged from physical therapy at ATI on 1/30/13 after 58 sessions. (Petitioner's Exhibit No. 4.) Dr. Hennessy recommended independent performance of a home-exercise program.

Petitioner continued to treat with Dr. Hennessy and Dr. Glaser in 2013. Dr. Glaser continued to recommend and perform injections. In 2013, he performed bilateral intra-articular facet joint injections at C5 through T1 on 2/26/13, bilateral intra-articular facet joint injections at C2 through C5 on 4/02/13, bilateral intra-articular facet joint injections at T6 through T9 on 10/03/13, a C8 selective nerve block and C7-T1 transforaminal epidural steroid injection on 10/11/13, and bilateral intra-articular facet joint injections at T3 through T6 on 10/31/13. (Petitioner's Exhibit No. 2.) Petitioner would note decreased neck and upper back pain following the injections, if he noticed any improvement at all, but no change in his symptoms down his left arm. Dr. Hennessy noted Petitioner had not reached a decision as to whether he wanted to pursue cervical spine surgery. (Petitioner's Exhibit No. 3.) On 4/19/13, Dr. Hennessy noted the Petitioner was finding much more benefit with a home-exercise program. Petitioner continued to work part-time and continued to receive temporary partial disability benefits in 2013. On 6/26/13, Dr. Hennessy noted he agreed with Dr. Zelby's assessment of Petitioner's lumbar spine and carpal tunnel syndrome but disagreed with regard to the left C8 radiculopathy. Dr. Hennessy eventually began recommending cervical injections followed by surgery if the injections were unsuccessful in August of 2013. He continued to defer treatment to Dr. Glaser in October of 2013. He also recommended a trial of acupuncture. Petitioner also returned to full-time, light-duty work in September of 2013 and noted an increase in his symptoms. (Petitioner's Exhibit No. 3.)

Dr. Zelby performed a second independent medical examination on 7/01/13. (Respondent's Exhibit No. 7.) He also provided testimony regarding this report as well. (Respondent's Exhibit No. 5.) Petitioner advised Dr. Zelby that the facet injections helped his back slightly, but he had no improvement in his neck. Dr. Zelby performed another physical and neurologic examination, which was essentially the same as the examination from 12/03/12. (Respondent's Exhibit No. 5, pp. 27-28.) Petitioner did make nonanatomic complaints of diminished sensation in his entire left upper extremity. Dr. Zelby's impression at this time was cervical spondylosis, history of carpal tunnel release, and history of lumbar fusion. His recommendations were essentially the same. He did not believe there was any reason for another CT scan of the lumbar spine because the previous CT scan showed a solid fusion. (Respondent's Exhibit No. 5, p. 29.) Petitioner required no restrictions and needed no treatment to his cervical spine as a consequence of his work injury. (Respondent's Exhibit No. 5, p. 29.) He did not require any additional medical treatment for his back and required a medium-duty restriction. This included no additional injections. (Respondent's Exhibit No. 5, p. 30.) The injections were not reasonable and

necessary, irrespective of cause. On cross-examination, Dr. Zelby noted there were no herniated discs on the cervical spine MRI from 7/01/11. (Respondent's Exhibit No. 5, p. 37.)

During continued treatment with Dr. Glaser in 2014, Dr. Glaser performed additional injections. (Petitioner's Exhibit No. 2.) He performed bilateral L5-S1 intra-articular facet joint injections on 1/13/14, bilateral T3 through T6 medial branch nerve blocks and bilateral L5 dorsal rami nerve block on 2/24/14, bilateral C3 through C5 intra-articular facet joint injections on 6/02/14, and bilateral C3 through C5 medial branch nerve blocks on 8/07/14. Although the Petitioner would occasionally note temporary, decreased pain in his spine following injections, he continued to note radicular complaints down his left arm. (Petitioner's Exhibit No. 3.) Dr. Glaser then performed a bilateral T3 through T6 medial branch radiofrequency ablation procedure on 4/28/14 and another radiofrequency ablation on 10/19/14 at the bilateral C3 through C5 levels. (Petitioner's Exhibit No. 2.) Petitioner noted initial decreased mid and upper back pain but no change in his symptoms down his left arm following the 4/28/14 procedure. Dr. Glaser noted Petitioner's neck pain and left shoulder pain increased following the 10/19/14 procedure, and Dr. Hennessy noted this as well on 12/15/14. Dr. Hennessy treated Petitioner on four occasions in 2014 and noted Petitioner was working full-time, performing essentially light work in that he would travel to work sites but not perform any lifting. (Petitioner's Exhibit No. 3.) He noted the Petitioner had improvement but still noted some radicular-type symptoms. He did note on 5/30/14 that Petitioner was taking no medications and had lost a significant amount of weight. On 8/29/14, Dr. Hennessy noted Petitioner's left arm symptoms in the C8 dermatome were getting worse. He discussed the possibility of a cervical fusion, but Petitioner was not ready to proceed. He indicated Petitioner could return to work 8 hours per day, 5 days a week, limited to lifting no greater than 30 pounds with limited bending, crouching, and squatting. Petitioner continued to contemplate cervical surgery on 12/15/14. (Petitioner's Exhibit No. 3.) Dr. Hennessy recommended another cervical spine MRI.

Petitioner presented Dr. Hennessy for his evidence deposition on 2/05/14. (Petitioner's Exhibit No. 16.) Dr. Hennessy provided a brief summary of his treatment of Petitioner up to that point. The Arbitrator notes that Dr. Hennessy erroneously testified that the 9/27/11 EMG showed left C8 radiculopathy. (Petitioner's Exhibit No. 16, pp. 10, 16.) Dr. Hennessy testified that the need for Petitioner's lumbar surgery was a result of the injuries that were sustained in the 6/02/11 motor vehicle accident. (Petitioner's Exhibit No. 16, p. 12.) He attributed the Petitioner's carpal tunnel syndrome to the 6/02/11 accident. (Petitioner's Exhibit No. 16, p. 17.) He then testified, after being questioned about Petitioner's clerical work following 6/02/11, that Petitioner's symptoms worsened, as repetitive motion is a well-documented cause of carpal tunnel syndrome. (Petitioner's Exhibit No. 16, p. 17.) On cross-examination, he testified that the more likely cause of the carpal tunnel syndrome was the light-duty work, and the motor vehicle accident did not cause the left carpal tunnel syndrome. (Petitioner's Exhibit No. 16, pp. 40-41.)

He then admitted he did not have any details about the nature of Petitioner's office work, such as the frequency, nature of the work, or hours worked. (Petitioner's Exhibit No. 16, p. 41.) Dr. Hennessy testified that the likely cause of the C8 radiculopathy was a bone spur and disc protrusion. He testified it was an aggravation of a pre-existing asymptomatic problem. (Petitioner's Exhibit No. 16, pp. 23-24.) The osteophyte was present prior to 6/02/11. (Petitioner's Exhibit No. 16, pp. 38-39.) Dr. Hennessy testified he had to rely on Dr. Glaser's expertise regarding the appropriateness of the facet injections. (Petitioner's Exhibit No. 27, p. 27.) He noted Dr. Glaser's injections did not change the left C8 radiculopathy, even though it helped his neck pain. (Petitioner's Exhibit No. 27, p. 34.) He testified that his treatment to Petitioner's low back, cervical spine, and left carpal tunnel had been reasonable and necessary to treat injuries that were sustained or aggravated in the 6/02/11 motor vehicle accident,, and the treatment performed by Dr. Glaser to treat Petitioner's cervical condition had been reasonable and necessary for Petitioner's cervical condition that was aggravated by the 6/02/11 accident. (Petitioner's Exhibit No. 27, p. 35.) On cross-examination, Dr. Hennessy noted Petitioner did not want to undergo a cervical spine surgery as of the time of his deposition in 2014. (Petitioner's Exhibit No. 27, p. 45.)

On 8/18/14, Dr. Ciochetty completed a utilization review at the request of the Respondent regarding Dr. Glaser's pain management treatment. (Respondent's Exhibit No. 11.) Dr. Ciochetty also testified during evidence deposition on two occasions with respect to his utilization review, the first time being on 1/06/15 (Respondent's Exhibit No. 15), and the second evidence deposition taking place on 12/17/15 (Respondent's Exhibit No. 19). After reviewing Petitioner's medical records personally, the same records Dr. Glaser had while performing pain management treatment, as required for retrospective utilization review, Dr. Ciochetty found numerous injections to be unreasonable and unnecessary, utilizing the ODG evidence-based treatment guidelines.

According to Dr. Ciochetty, the 8/10/12 left C8 selective nerve root block and left C7-T1 transforaminal epidural steroid injection were denied because on Dr. Glaser's 8/09/12 note, there is no mention of radicular pain or neurologic symptoms in a specific dermatomal distribution, and the recent cervical imaging did not show any evidence of nerve root impingement. (Respondent's Exhibit No. 15, pp. 23-25.) He found the 9/18/12 left C7-T1 transforaminal epidural steroid injection to be unreasonable and unnecessary because Petitioner did not receive substantial relief from the previous injections. (Respondent's Exhibit No. 15, pp. 25-26.) Dr. Ciochetty testified the bilateral T6 through T9 intra-articular facet joint injections on 10/03/13 were not reasonable and not necessary because the thoracic spine MRI made no mention of facet arthropathy or facet hypertrophy. (Respondent's Exhibit No. 15, pp. 27-28.) He testified the 10/10/13 C8 selective nerve root block and C7-T1 transforaminal epidural steroid injections were not reasonable or necessary because Petitioner did not receive significant relief

from the prior injections, and there was no evidence of a worsening of radicular symptoms. Dr. Ciochetty testified the 10/31/13 bilateral T3 through T6 intra-articular facet joint injections were not reasonable or necessary because the prior thoracic MRI did not reveal facet hypertrophy or facet arthropathy. (Respondent's Exhibit No. 15, p. 29.) He found the 1/13/14 bilateral L5-S1 intra-articular facet joint injections to be unreasonable and unnecessary based on a lack of MRI evidence of facet arthropathy or facet hypertrophy. (Respondent's Exhibit No. 15, pp. 29-30.) Finally, Dr. Ciochetty testified the Petitioner's Norco and Flector medications were unreasonable and unnecessary due to noncompliance with ODG evidence-based treatment guidelines as well as a lack of compliance with standards accepted by the Illinois Department of Professional Regulation. (Respondent's Exhibit No. 15, pp 30-31.) The Flector patch was found to be unreasonable and unnecessary because there was no clinical documentation of failure of any oral medications, according to Dr. Ciochetty. (Respondent's Exhibit No. 15, pp. 31-32.)

On cross-examination, Petitioner's counsel questioned Dr. Ciochetty regarding his involvement in the drafting of his report. There was confusion with respect to the report Dr. Ciochetty referenced as his utilization review report during the telephonic evidence deposition, compared to a prior utilization review report prepared by Jonathan Wyatt. (Petitioner's Exhibit No. 17.) Petitioner's attorney moved to strike Dr. Ciochetty's opinions due to not being provided a true and accurate copy of his report during his deposition. (Petitioner's Exhibit No. 17, pp. 82-83.)

Dr. Ciochetty then prepared an affidavit dated 2/02/15 to address the confusion during his 1/07/15 evidence deposition. (Respondent's Exhibit No. 14.) He also testified regarding this affidavit on 12/17/15. (Respondent's Exhibit No. 19.) He testified he received a template report from Claims Eval along with Petitioner's medical records to review. He made numerous corrections to the template to reflect his professional opinions, which eventually became his 8/18/14 report. However, he errantly brought the template report, dated 8/14/14, to his first deposition and began referencing the 8/14/14 template as his own, even though this was not his report. (Respondent's Exhibit No. 19, pp. 7-8.) Petitioner's attorney was provided with Dr. Ciochetty's 8/18/14 utilization review report. Dr. Ciochetty rescinded his prior testimony in which he previously claimed the 8/18/14 report was not his own. He clarified that the 8/18/14 report is his final report and contains the entirety of his written opinions regarding the utilization review performed on Petitioner's medical treatment. He noted that Claims Eval provided him the incorrect report for preparation for his first deposition. The 8/18/14 report contains his utilization review opinions to a reasonable degree of medical certainty. (Respondent's Exhibit No. 19, pp. 10-11.) He testified that his report may contain lines that are contained in the prior utilization review report from Jonathan Wyatt because he borrows verbatim phrases from the ODG paragraphs. (Respondent's Exhibit No. 19, pp. 14-15.)

In 2015, Petitioner followed up with Dr. Hennessy on 2/23/15 following a 2/16/15 cervical spine MRI. (Petitioner's Exhibit No. 3.) Dr. Hennessy noted the MRI revealed C7 through T1 protrusions and recommended cervical spine surgery. He also referred Petitioner to Dr. Pelinkovic for a second opinion. On 3/13/15, Dr. Pelinkovic recommended an EMG to rule out ulnar nerve compression. (Petitioner's Exhibit No. 25.) If Petitioner had recalcitrant symptoms, Dr. Pelinkovic noted he might undergo an anterior cervical discectomy and fusion. The 3/19/15 EMG revealed moderate left ulnar neuropathy at the left elbow with denervation and severe left-sided C6-C7 radiculopathy with ongoing denervation. The EMG also revealed moderate chronic carpal tunnel syndrome at the left wrist with no ongoing denervation. After reviewing the EMG, Dr. Hennessy recommended cervical spine surgery. Dr. Glaser performed another medial branch radiofrequency ablation procedure at the bilateral T3 through T6 levels on 10/01/15. (Petitioner's Exhibit No. 2.) Petitioner's pain levels remained about the same following the procedure. He then performed bilateral C5 through C8 medial branch nerve blocks on 11/30/15.

Petitioner testified that he is currently experiencing pain in his neck, lower back, feet, hands, arms, and extremities. He continues to work for the Respondent performing mainly supervisory work. He testified that he now wishes to proceed with the cervical surgery, and he admitted on cross-examination that he previously did not wish to proceed with the cervical surgery. On cross-examination, Petitioner testified that he is currently working as a field foreman/technician, the position he held with the Respondent before 6/02/11, although he is working within his current work restrictions. On cross-examination, Petitioner testified that he would continue to experience symptoms in his left shoulder and down his left arm following the numerous injections and radiofrequency ablations performed by Dr. Glaser.

Petitioner experienced neck and low back pain prior to 6/02/11. He was involved in a motor vehicle accident in 1994, which caused low back pain with pain radiating down the right leg. A 6/29/94 MRI revealed an L4-L5 disc herniation, and he underwent a lumbar epidural steroid injection. (Petitioner's Exhibit No. 1.) He also underwent an L4-L5 discectomy in 1994. He was also involved in a motor vehicle accident in 1995 in which he injured his back and cervical spine. (Petitioner's Exhibit No. 1.) He was involved in another motor vehicle accident in July 1998 in which he experienced low back, mid back, and neck pain. A 9/03/98 lumbar spine MRI revealed a degenerated L4-5 disc with slight posterior bulging. (Petitioner's Exhibit No. 1.) He noted continued low back complaints in November 1998 and underwent trigger-point injections. The last notation from 11/30/98 indicates Petitioner only received minimal relief with treatment up to that point. According to Dr. Hennessy, Petitioner had another accident in 2002. Following that accident, Dr. Hennessy noted Petitioner had neck pain and left arm radiculopathy. (Petitioner's Exhibit No. 16, pp. 6, 37.) Petitioner testified he did not receive any medical treatment to his neck or back in the ten years prior to 6/02/11.

CONCLUSIONS OF LAW

In support of the Arbitrator's decision relating to (C), whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

Petitioner's 6/02/11 motor vehicle accident occurred as he was heading to a work site in his work vehicle. Because he was heading directly to a work site, the Arbitrator finds that the accident occurred in the course of employment. Because of this, the Arbitrator finds that a compensable accident took place.

In support of the Arbitrator's decision relating to (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

LEFT HAND/WRIST

The Petitioner failed to prove that his left carpal tunnel syndrome is in any way causally connected to the 6/02/11 motor vehicle accident. If the Petitioner is attempting to claim that his left carpal tunnel syndrome is causally related to a specific trauma on 6/02/11 during the accident, this argument must fail, based on the evidence. First, the Arbitrator notes the initial Concentra medical records do not note any complaints or symptoms in the Petitioner's left hand/wrist. (Petitioner's Exhibit No. 22.) Petitioner advised Dr. Hennessy on 7/06/11 that he experienced a dull ache on the left arm with activity that began one week after the accident. There is no diagnosis with respect to the left hand/wrist in Dr. Hennessy's initial records. (Petitioner's Exhibit No. 3.)

In his deposition, Dr. Hennessy initially claimed Petitioner's left carpal tunnel syndrome was caused by the 6/02/11 accident. (Petitioner's Exhibit No. 16.) He later testified that the motor vehicle accident did not cause the left carpal tunnel syndrome. (Petitioner's Exhibit No. 16, pp. 40-41.) Therefore, Petitioner's own expert denied a causal connection between the work accident and a specific trauma to the left hand/wrist, which caused carpal tunnel syndrome. Based on all of the evidence, the Arbitrator cannot causally connect the Petitioner's left carpal tunnel syndrome to any specific trauma during the 6/02/11 motor vehicle accident.

Petitioner attempts to causally connect his left carpal tunnel syndrome to his light-duty, office-type work he performed after the motor vehicle accident. This work began in June of 2011. Petitioner admitted that he only performed this work on a part-time basis and that his job duties varied, with no lifting of any heavy weights. He then stopped performing this light-duty work when he underwent a 12/02/11 lumbar spine surgery. He only worked this light-duty position for a period of six months, clearly not enough time for a light-duty position to cause carpal tunnel syndrome, especially considering that it was part-time work.

The 9/27/11 EMG revealed bilateral evidence of carpal tunnel syndrome, severe on the left and mild in severity on the right. (Respondent's Exhibit No. 9.) At that point, Petitioner had been working the office-type position for only three months on a part-time basis. Further, Petitioner is right-handed, and the Arbitrator can only assume that if the carpal tunnel syndrome was indeed related to the light, part-time job duties, it would have been more severe in the right hand/wrist instead of vice versa.

The Petitioner's carpal tunnel symptoms did not improve when he was not working. Petitioner was completely restricted from work following the 12/02/11 lumbar spine surgery. Dr. Hennessy

noted in January of 2012, while the Petitioner was completely off work, that the Petitioner's symptoms did not improve. It stands to reason that if his carpal tunnel symptoms were related to the light-duty work, his symptoms should have improved when he was off work following the lumbar surgery.

Petitioner then again worked the part-time office work from March 2012 up until his carpal tunnel release surgery on 6/21/12. Combining this period of light-duty work with his prior light-duty work, the Petitioner only worked a total of nine months of part-time office work before the surgery.

Based on the evidence, the Arbitrator finds Dr. Zelby's opinions regarding the carpal tunnel syndrome to be more credible than Dr. Hennessy's opinions. Dr. Zelby testified that the Petitioner's carpal tunnel condition was not causally related to the motor vehicle accident on 6/02/11, which is consistent with the evidence. (Respondent's Exhibit No. 5.) Dr. Hennessy failed to credibly rebut this opinion when Dr. Hennessy claimed that the left carpal tunnel syndrome was caused by Petitioner's light-duty, part-time work. Dr. Hennessy had no foundation for his opinion. He did not have any details about the nature of Petitioner's office work, such as the frequency, nature of the work, forces involved, or hours worked. (Petitioner's Exhibit No. 16, p. 41.)

Petitioner's own treating physician, Dr. Hennessy, testified that Petitioner's left carpal tunnel syndrome was not directly caused by the motor vehicle accident. Dr. Hennessy's opinion regarding the left carpal tunnel syndrome and Petitioner's light-duty work duties lacks foundation and is not supported by the evidence. The evidence shows the light-duty work was limited in duration, contained varied duties with no lifting of any heavy weights, and was only performed on a part-time basis. Based on the above, the Petitioner failed to prove that his left carpal tunnel syndrome is causally related to the 6/02/11 motor vehicle accident. All benefits related to the carpal tunnel syndrome are hereby denied.

LUMBAR SPINE

The Petitioner proved that his lumbar spine condition of ill-being is causally connected to the 6/02/11 motor vehicle accident. He was initially assessed with a lumbar and thoracic strain at Concentra on 6/02/11. (Petitioner's Exhibit No. 22.) Petitioner sought continuous medical treatment with Dr. Hennessy for his lower back since the time of the motor vehicle accident. Dr. Zelby noted Petitioner suffered a herniated right L5-S1 disc as a result of the motor vehicle accident. (Respondent's Exhibit No. 5.) Dr. Hennessy testified that the need for the lumbar surgery was a result of the injuries sustained in the 6/02/11 motor vehicle accident. Petitioner testified to some ongoing lower back symptoms. Based on the above, the Arbitrator finds that

Petitioner's condition of ill-being with respect to his lumbar spine is causally connected to the motor vehicle accident from 6/02/11.

The Petitioner has a solid fusion and is at maximum medical improvement with respect to his lumbar spine, pursuant to Dr. Zelby's opinions. (Respondent's Exhibit No. 5.) Petitioner can safely return to work in a medium physical-demand level, lifting up to 50 pounds occasionally and 25 pounds frequently. He requires no additional medical treatment to his lumbar spine, pursuant to Dr. Zelby's opinions.

CERVICAL SPINE

The Arbitrator finds that the Petitioner suffered a cervical strain, but his ongoing cervical complaints and left upper extremity complaints are not causally related to the 6/02/11 motor vehicle accident. This finding is based on numerous factors. First, when Petitioner initially treated at Concentra, his primary complaints did not involve the cervical spine. (Petitioner's Exhibit No. 22.) He was assessed with a thoracic strain, and there were no assessments with respect to his cervical spine. Although the Petitioner began making complaints on the left side of his neck on 6/06/11, Dr. John did not assess the Petitioner to have any cervical condition. Additionally, Petitioner denied radicular symptoms in his cervical spine at that time.

The 7/01/11 cervical spine MRI revealed disc herniations at C3-4 and C5-6. However, there was no cord compression or compression of the nerve roots to explain or substantiate any of the Petitioner's left upper extremity radicular symptoms. (Petitioner's Exhibit No. 3.) Petitioner's cervical condition was improved by 8/05/11, according to Dr. Hennessy. Dr. Singh even noted on 9/22/11 that Petitioner's primary pain complaints were relegated to his lumbar spine, and his neck symptoms and arm symptoms were noted to be improving. (Respondent's Exhibit No. 16.) He noted the Petitioner's cervical spine to have degenerative disc disease, and he never specifically causally connected Petitioner's cervical condition to the motor vehicle accident. He also noted some of Petitioner's cervical spine complaints appeared to be related to posture or kyphosis (excessive outward curvature of the spine, causing hunching of the back).

Additional objective testing confirmed a lack of any cord compression or nerve root impingement from the 7/01/11 cervical MRI. The EMG from 9/27/11 showed no evidence of a left-sided C8 radiculopathy (Respondent's Exhibit No. 9), and Dr. Hennessy's testimony is clearly erroneous in that regard. Even still, Dr. Hennessy did not believe cervical surgery would be recommended, after his review of the EMG on 10/03/11. (Petitioner's Exhibit No. 3.) Petitioner's medical treatment then primarily focused on his lumbar spine following the 12/02/11 lumbar spine surgery. Petitioner was noting continued improvement in his left arm symptoms, although they were still present. (Petitioner's Exhibit No. 3.) Yet another EMG/NCV performed on 3/27/12 showed no evidence of left-sided cervical radiculopathy. Another cervical MRI from

6/01/12 failed to show any compression or impingement on the spinal cord to explain Petitioner's cervical and left upper extremity symptoms, contrary to Dr. Hennessy's testimony. (Petitioner's Exhibit No. 3.) The MRI showed mild disc bulging from C7-T1 with asymmetric bulge left of the midline with degenerative changes. In another section of the MRI report, there is noted to be a disc protrusion but, again, nothing regarding any compression or impingement of the spinal cord. Dr. Zelby confirmed there was no interval change from the 7/01/11 MRI. It is not until an MRI performed 2/16/15, almost four years after the motor vehicle accident, that an MRI revealed left nerve compression at C7-T1. It is also almost four years later where the 3/19/15 EMG revealed a C6, C7 radiculopathy. (Petitioner's Exhibit No. 25.) These findings are too far removed from the motor vehicle accident to be causally connected to the motor vehicle accident.

The Arbitrator finds Dr. Zelby's opinions regarding the cervical spine to be more credible than Dr. Hennessy's opinions. As Dr. Zelby noted, Petitioner's cervical spine examination was normal, on both occasions on which he examined Petitioner, except for a small amount of diminished hyperextension. (Respondent's Exhibit Nos. 5 and 6.) There were no findings of any left upper extremity radiculopathy. This is consistent with all of the objective radiological testing up to this point. He also found that Petitioner's complaints of diminished sensation in his entire left upper extremity were nonanatomic and unsupported by any objective evidence. His opinion that the Petitioner suffered a cervical strain in the context of a mild underlying cervical spondylosis is well reasoned and supported. Petitioner had easily reached maximum medical improvement for any condition in his cervical spine associated with the motor vehicle accident. Any other cervical findings or symptoms were related to Petitioner's degenerative cervical spinal condition, a part of the natural aging process. The Arbitrator adopts Dr. Zelby's opinions. Petitioner's current condition of ill-being with respect to his cervical spine is causally unrelated to the 6/02/11 motor vehicle accident.

In support of the Arbitrator's decision relating to (J), 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 finds the following:

LEFT HAND/WRIST

Based on section (F) above, the Arbitrator denies all medical treatment and medical bills related to the Petitioner's left carpal tunnel syndrome as causally unrelated to the 6/02/11 motor vehicle accident. Petitioner failed to prove causal connection regarding the left carpal tunnel syndrome, and the Respondent is not liable for any medical bills related to the left carpal tunnel syndrome. Respondent is entitled to a credit for any medical benefits paid related to the left carpal tunnel syndrome.

LUMBAR SPINE

Regarding the lumbar spine, the Arbitrator finds that Petitioner's medical treatment was reasonable and necessary up to Dr. Zelby's 12/03/12 independent medical examination. As Dr. Zelby noted, the Petitioner had a solid arthrodesis at L5-S1 at that time and required no additional diagnostic studies or further directed treatment for his lumbar spine. (Respondent's Exhibit No. 5, p. 24.) He felt Petitioner was at MMI at that time, pursuant to his performance of an AMA impairment rating and as noted in his later report. Dr. Hennessy even noted on 6/26/13 that he agreed with Dr. Zelby's assessment of Petitioner's lumbar spine. (Petitioner's Exhibit No. 3.) With respect to Petitioner's lumbar spine, Dr. Hennessy also noted, "I do agree there is not much more we can do . . . ." Dr. Hennessy found on 11/19/12 that the Petitioner would be considered at MMI for his lumbar spine following an FCE, but he did not proceed with that FCE due to Petitioner's cervical spine condition. (Petitioner's Exhibit No. 3.) Based on the above, the Arbitrator therefore denies any low back medical treatment incurred after Dr. Zelby's 12/03/12 independent medical examination as unreasonable and unnecessary.

CERVICAL SPINE

As noted above in section (F), the Petitioner's current condition of ill-being with respect to his cervical spine is not causally connected to the motor vehicle accident. As Dr. Zelby noted in his 12/03/12 report, Petitioner did not require any additional medical treatment to his cervical spine. (Respondent's Exhibit Nos. 5 and 6.) He specifically noted there was no medical indication to pursue the cervical facet injections suggested by Dr. Glaser. (Respondent's Exhibit No. 5, p. 23.) Dr. Zelby again noted in his supplemental report from 7/01/13 that the Petitioner's injections were not reasonable or necessary, irrespective of cause. (Respondent's Exhibit Nos. 5, 7.)

Dr. Hennessy initially recommended epidural injections at C8 and then recommended a C8 nerve root block on 11/19/12. (Petitioner's Exhibit No. 3.) Despite this recommendation, Dr. Glaser began recommending multilevel facet injections. Dr. Hennessy noted on 11/19/12 that Dr. Glaser would have to supply necessary rationale for this treatment. What is clear is that Dr. Hennessy was not recommending facet injections. Petitioner never presented Dr. Glaser to explain the reasonableness and necessity of the facet injections.

Then on 1/21/13, Dr. Hennessy specifically noted he did not believe further injections were necessary. (Petitioner's Exhibit No. 3.) Despite this statement, Dr. Glaser continued to recommend and perform multiple injections to Petitioner's cervical, thoracic, and lumbar spine, including multiple facet joint injections, and radiofrequency ablation procedures in 2013, 2014, and 2015, all of which the Arbitrator finds to be unreasonable and unnecessary. He also continued to perform injections into the Petitioner's thoracic spine, and no doctor appears to be relating Petitioner's thoracic spine condition to the motor vehicle accident.

Despite the fact that Petitioner was not receiving any significant pain relief from the injections, Dr. Glaser continued to perform them. Petitioner would note transient, decreased neck and upper back pain following injections, if he noticed any improvement at all, but no change in his symptoms down his left arm. The injections and the radiofrequency ablation procedures were not achieving the desired results. Dr. Hennessy even noted on 4/19/13 that the Petitioner was finding much more benefit with a home-exercise program. (Petitioner's Exhibit No. 3.) Although Dr. Hennessy eventually began recommending cervical injections again, it is clear that the previous injections were not achieving the desired results and were therefore unreasonable and unnecessary. Dr. Hennessy also testified he had to rely on Dr. Glaser's expertise regarding the appropriateness of the facet injections.

Finally, the Arbitrator relies on the opinions of Dr. Ciochetty, the utilization review physician. (Respondent's Exhibit Nos. 15, 19.) Dr. Ciochetty provided cogent explanations and bases for his opinions that the numerous injections were unreasonable and unnecessary. This is noted in the Findings of Fact above. This included Petitioner's lack of radicular pain or neurologic symptoms in a specific dermatomal distribution, the lack of imaging studies showing any evidence of nerve root impingement, Petitioner's failure to receive substantial relief from previous injections, and a lack of facet arthropathy or facet hypertrophy. Although Dr. Ciochetty was initially confused and referred to the wrong template report during his initial deposition, he clarified that his report was the 8/18/14 report, which was provided to Petitioner's attorney prior to his depositions.

The Arbitrator in no way relies upon the opinions of Dr. Jonathan Wyatt. (Petitioner's Exhibit No. 17.) Dr. Wyatt lacks credibility based on his deposition testimony that he did not review the

medical records and that he signed his utilization review report without reviewing the opinions contained therein.

Despite a clear lack of reasonableness and necessity, Dr. Glaser continued to provide Petitioner pain management treatment to the staggering amount of $224,289.74, after combining the two surgical center invoices and Dr. Glaser's invoice. (Petitioner's Exhibit Nos. 9, 10, and 15.) As noted above, there is no causal connection regarding the Petitioner's left carpal tunnel syndrome, and all bills related to that condition are denied. Any lumbar medical treatment following Dr. Zelby's initial independent medical examination on 12/03/12 is hereby denied as unreasonable and unnecessary. All injections performed by Dr. Glaser were unreasonable and unnecessary. Finally, all medical treatment to the cervical spine following Dr. Zelby's independent medical examination is hereby denied based on a lack of causal connection and a lack of reasonableness and necessity for the multiple reasons stated above.

In support of the Arbitrator's decision relating to (K), whether Petitioner is entitled to any prospective medical care, the Arbitrator finds the following:

Petitioner seeks authorization for the cervical spine surgery as recommended by Dr. Hennessy. The Arbitrator denies the requested treatment due to a lack of causal connection and a lack of reasonableness and necessity. As noted above in section (J), the Petitioner failed to prove that his current condition of ill-being with respect to his cervical spine is causally connected to the motor vehicle accident. Again relying on the opinions of Dr. Zelby, the Arbitrator further finds the Petitioner required no additional medical treatment to his cervical spine. Even assuming, for the sake of argument, that the Petitioner's recommended cervical surgery is reasonable and necessary, the Petitioner's current cervical condition is causally unrelated to the motor vehicle accident. The Arbitrator therefore finds Petitioner is not entitled to any prospective medical treatment.

In support of the Arbitrator's decision relating to (L), whether the Petitioner is entitled to any temporary total disability benefits, the Arbitrator finds the following:

According to the request for hearing, Petitioner is first demanding temporary total disability benefits for the period from 12/02/11, the date of his lumbar spine surgery, through 3/19/12, the date on which he returned to part-time, light-duty work for Respondent. (Arbitrator's Exhibit No. 1.) Petitioner was entitled to TTD benefits during that period and was paid TTD benefits by the Respondent for that period. (Respondent's Exhibit No. 1.) Petitioner then demanded an additional 3 5/7 weeks of TTD benefits, but there is nothing specified on the Request for Hearing regarding the period in which he is claiming to be entitled for this additional TTD. Presumably, the Petitioner is demanding TTD benefits for the dates on which he took off work to attend doctor appointments. Petitioner testified he was paid his regular salary when he attended these medical visits with Dr. Glaser. He then testified he was using vacation or sick time in order to attend those appointments. He referred to Petitioner's Exhibit No. 24. In reviewing Petitioner's Exhibit No. 24, the Arbitrator notes that the dates on which Petitioner claims he used vacation or sick time in order to attend appointments were for dates of treatment which have been found to be unreasonable, unnecessary, and/or causally unrelated to the Petitioner's motor vehicle accident. Therefore, the Arbitrator denies Petitioner's request for TTD benefits for the dates listed in Petitioner's Exhibit No. 24.

In support of the Arbitrator's decision relating to (M), whether penalties or fees should be imposed upon Respondent, the Arbitrator finds the following:

Section 19(k) of the Act requires an ". . . unreasonable or vexatious delay of payment or intentional underpayment of compensation, or proceedings have been instituted or carried on by the one liable to pay the compensation, which do not present a real controversy but are merely frivolous or for delay," in order for the Commission to award compensation pursuant to that section. Section 19(l) requires a finding that the ". . . employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse, or unreasonably delay the payment of benefits under Section 8(a) or 8(b)" in order for compensation to be awarded under that section. In order for attorney's fees to be awarded pursuant to Section 16, there must be a finding of compensation pursuant to Sections 19(k) and 19(l). "Generally, an employer's reasonable and good faith challenge to liability does not warrant the imposition of penalties. When the employer acts in reliance upon reasonable medical opinion or when there are conflicting medical opinions, penalties ordinarily are not imposed." *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, at 763 (4th Dist. 2003).

For the reasons stated in Sections (F) and (J) and (L) above, the Respondent acted reasonably in denying Petitioner's ongoing medical treatment and demand for temporary total disability benefits. The Respondent reasonably relied upon the opinions of its experts in denying Petitioner's ongoing benefits. The Arbitrator denies all requests for penalties or attorney's fees.

In support of the Arbitrator's decision relating to (M), whether Respondent is due any credit, the Arbitrator finds the following:

The Respondent is entitled to credits for all benefits paid to date, according to Respondent's Exhibit No. 1 and Respondent's Exhibit No. 2. Respondent is additionally entitled to an 8(J) credit for any medical bills paid on behalf of Petitioner by the Respondent's group insurance carrier, as noted on Petitioner's medical bills exhibits. Finally, Respondent is entitled to an additional credit of $4,616.87 in the form of a PPD advance, as stipulated by the parties. (Arbitrator's Exhibit No. 1.)

In support of the Arbitrator's decision relating to (O), the admissibility of Respondent's Exhibit No. 11, the Arbitrator finds the following:

Respondent offered into evidence Respondent's Exhibit No. 11, the utilization review report of Dr. Ciochetty. Petitioner objected to the exhibit's admission at the time of trial and during the depositions of Dr. Ciochetty. The Arbitrator finds, after reviewing the deposition transcripts of Dr. Ciochetty (Respondent's Exhibit Nos. 15, 19), and the affidavit of Dr. Ciochetty (Respondent's Exhibit No. 14), that Petitioner was provided a copy of Dr. Ciochetty's 8/18/14 utilization review report prior to the deposition, the Respondent laid the appropriate foundation for Dr. Ciochetty's 8/18/14 utilization review report, and the confusion that occurred during Dr. Ciochetty's initial telephonic evidence deposition was due to Dr. Ciochetty inadvertently referring to a template report rather than his final 8/18/14 utilization review report. Dr. Ciochetty cleared the confusion and issues caused by this inadvertent error in his affidavit and his subsequent evidence deposition, during which the appropriate foundation was again laid for his 8/18/14 utilization review report. Based on this, the Arbitrator overrules Petitioner's objection to Respondent's Exhibit No. 11, and the exhibit is admitted into evidence.

29550010_1

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Leonel Ortiz,

Petitioner,

17IWCC0081

vs.

NO: 14 WC 34886

Ethio Café Inc,

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, notice, wages and rates, causal connection, and temporary total disability and being advised of the facts and law, affirms the Decision of the Arbitrator which is attached hereto. In a Decision filed May 24, 2016, the Arbitrator denied Petitioner's claim for benefits under the Workers' Compensation Act for an alleged accidental injury arising out of and in the course of his employment by Respondent.

The evidence shows that Petitioner worked as a busboy and bar-back for Ethio Café from September 4, 2014 through September 20, 2014. On October 3, 2014, Petitioner sought medical treatment for complaints of left knee pain he related to an injury at work. Petitioner was examined by Dr. Ma, a chiropractor at M&R Rudra New Life Medical. Dr. Ma took Petitioner's history of injuring his left knee at work on September 7, 2014. Dr. Ma recorded that Petitioner was carrying four heavy garbage containers down the stairs "when he slipped and hurt his left knee." Petitioner complained of intermittent sharp pain in his left knee that increased with carrying and prolonged sitting or standing. Dr. Ma noted that Petitioner had a history of left knee surgery 30 years earlier. Dr. Ma diagnosed a left knee sprain or strain and recommended physical therapy. We note that the examination report of Dr. Ma repeatedly states an accident date of September 7, 2014. We further note that a handwritten "Comprehensive Examination" form and the off-work slip accompanying Dr. Ma's report of October 3, 2014 both state a date of accident of September 10, 2014.

On October 14, 2014, Petitioner filed an Application for Adjustment of Claim alleging "multiple injuries while working" on September 7, 2014. At the 19(b) hearing on April 28, 2016, the parties signed a Request for Hearing form stipulating that Petitioner was claiming an accidental injury on September 7, 2014. Petitioner further alleged that he gave notice of the injury to "Octavio" whose job title was "Supervisor" on September 7, 2014. The parties stipulated that on September 7, 2014 an employee and employer relationship existed between Respondent and Petitioner but Respondent disputed Petitioner's claim of accident and notice on September 7,

2014 and all remaining issues.

At arbitration, Petitioner repeatedly denied that any injury occurred on September 7, 2014. Instead, Petitioner testified that the accident occurred on September 19, 2014, the day before his last day of work for Respondent. Petitioner testified that any medical records stating September 7, 2014 as the date of accident are incorrect. Petitioner testified with respect to his alleged accident on September 19, 2014, "I was bringing down the garbage cans, five empty garbage cans. I was lowering them to take them to the restaurant, and I slipped; and then my knee – my left knee banged against the stair, the step." Petitioner testified that he talked to his "supervisor," Octavio Mexicano. On further questioning, Petitioner explained that he told Mr. Mexicano "That I had fallen. I showed him my knee." Petitioner further testified that the cook, Abigail, asked him if he was alright. Petitioner finished work at 3:30-4:00 a.m. and took the bus home.

Respondent's "President," Mr. Latino, also testified at arbitration. Mr. Latino oversees three restaurants, including Ethio Café. Mr. Latino testified that Petitioner never reported to him that he was injured at work. Mr. Latino further testified that Mr. Mexicano was not Petitioner's supervisor; Mr. Mexicano was another bar-back who no longer works for Respondent. Mr. Latino testified that Petitioner's actual supervisor at Ethio Café was "Pete Mazzone."

The Arbitrator found that Petitioner failed to prove that he sustained an accident arising out of, and in the course of his employment by Respondent on the alleged date of accident, September 7, 2014. After considering all of the evidence, we agree with the Arbitrator's finding. The employee bears the burden of proof of establishing elements of his right to workers' compensation benefits. The Arbitrator correctly noted that Petitioner himself denied that an accident occurred on the alleged date of accident, September 7, 2014. Petitioner did not move to amend his Application for Adjustment of Claim or Request for Hearing at any point during arbitration to comport with his testimony that the accident occurred on September 19, 2014. Petitioner did not offer the testimony of Mr. Mexicano nor "Abigail" to corroborate his claim of accident occurring on September 19, 2014 and no other evidence supports that date of accident. Petitioner's alleged accident was unwitnessed, and Petitioner's testimony with respect to his discussions with Mr. Mexicano and Abigail was vague. There was no testimony that Petitioner told them that he fell on the stairs at work, only that he told them he hurt his knee. Based on Petitioner's failure to show proof of an accidental injury we find that the Arbitrator correctly denied Petitioner's claim.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 24, 2016 is hereby affirmed.

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

DATED: FEB 10 2017
RWW/plv
o-1/18/17
46

Ruth W. White

Joshua D. Luskin

Charles J. DeVriendt

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

17IWCC0081

ORTIZ, LEONEL
Employee/Petitioner

Case# **14WC034886**

ETHIO CAFÉ INC
Employer/Respondent

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:

4069 LAW OFFICE OF JONATHAN SCHLACK
200 N LASALLE ST
SUITE 2830
CHICAGO, IL 60601

0210 GANAN & SHAPIRO PC
JULIE SCHUM
210 W ILLINOIS ST
CHICAGO, IL 60654

☐	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)

17IWCC0081

ILLINOIS WORKERS' COMPENSATION COMMISSION

19(b) ARBITRATION DECISION

LEONEL ORTIZ
Employee/Petitioner

Case #14 WC 34886

V.

ETHIO CAFÉ, INC.,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on April 28, 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 September 7, 2014, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- At the time of injury, the petitioner was 42 years of age, married with three children under 18.
- The parties agreed that the respondent paid $1,184.00 in medical benefits and is allowed a credit under Section 8(j) of the Act.

ORDER:

- The petitioner's request for benefits is denied and the claim is dismissed.

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

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

Robert E. Williams

Signature of Arbitrator

May 24, 2016

Date

MAY 24 2016

FINDINGS OF FACTS:

The petitioner, a busboy/bar-back, seeks benefits for an injury to his left knee on September 7, 2014, due to a fall. His last day of work was September 20th. The petitioner sought chiropractic care with Dr. Irene Ma at New Life Medical on October 3, 2014, and reported falling on stairs on September 7, 2014, while carrying four heavy garbage containers and injuring his left knee. The diagnosis was a knee sprain/strain and chiropractic modalities and a brace were provided. He reported a prior left knee surgery. The petitioner received chiropractic modalities for his knee approximately three to four times a week without any reported improvement. A left knee MRI on November 13th showed postsurgical changes in the patellar and peripetallar regions, intact collateral and cruciate ligaments and medial meniscus and subtle blunting of the apical free edge of the mid-body of the lateral meniscus. Dr. Silver evaluated the petitioner on November 26, 2014, and noted lateral jointline tenderness, a positive McMurry's test, a limited ROM past 90^0 and moderated effusion. On January 7, 2015, Dr. Silver recommended surgery for a torn lateral meniscus. The petitioner followed up with Dr. Silver approximately once a month through February 3, 2016, and received chiropractic modalities for his knee through April of 2016.

Daniel Latino, the president of respondent, testified that he had not been advised by the petitioner of a work injury. Also, he further testified that Octavio Mexicano was a bar-back and not a supervisor, boss or manager. The petitioner worked three weeks for the respondent.

FINDING REGARDING WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that he sustained an accident on September 7, 2014, arising out of and in the course of his employment with the respondent. Even though the records of his initial medical care and his Application for Claim indicated an injury date of September 7, 2014, the petitioner was adamant that his injury occurred on September 19, 2014. He was queried several times regarding the accident date but remained resolute in his testimony that his work injury did not occur on September 7, 2014. There was no motion to amend the accident date. The petitioner's request for benefits is denied and the claim is dismissed.

FINDINGS REGARDING WHETHER TIMELY NOTICE WAS GIVEN TO THE RESPONDENT:

A copy of the petitioner's Application of Claim was sent to the respondent's place of business on October 14, 2014. The respondent received timely notice of the petitioner's injury.

FINDING REGARDING THE AMOUNT OF WAGES:

In the three weeks that the petitioner worked for the respondent, the petitioner earned $888.00. The petitioner's average weekly wage was $296.00.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner for his left knee by Dr. Silver through January 2015, was reasonable and necessary. The chiropractic modalities rendered the petitioner for his left knee by Dr. Irene Ma for six weeks was reasonable and necessary.

The monthly medical care rendered the petitioner for his left knee by Dr. Silver after January 2015, was not reasonable or necessary. Dr. Silver had recommended

surgery and did not provide any therapeutic care. His continued practice of re-evaluations and providing prescriptions for pain and other medications did not provide any benefits to the petitioner and was detrimental to his well-being.

The chiropractic modalities rendered the petitioner after six weeks was not reasonable or necessary. The chiropractic modalities provided no benefits to the petitioner. The medication prescribed the petitioner by Dr. Silver after January 7, 2015, was not reasonable or necessary.

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 failed to prove that his current condition of ill-being is causally related to the work injury on September 7, 2014. The petitioner's claim is dismissed.

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

Randall Clover,
Petitioner,

17IWCC0082

vs.

NO: 14 WC 29717

Chester Mental Health Center,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, 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 July 9, 2015, is hereby affirmed and adopted.

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

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

DATED: FEB 10 2017
o1/31/17
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0082

CLOVER, RANDALL
Employee/Petitioner

Case# **14WC029717**

CHESTER MENTAL HEALTH CENTER
Employer/Respondent

On 7/9/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1167 WOMICK LAW FIRM
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CARBONDALE, IL 62903

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

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

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

1745 CMS - RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JUL 9 - 2015

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

17IWCC0082

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

Randall Clover
Employee/Petitioner

v.

Chester Mental Health Center
Employer/Respondent

Case # **14** WC **029717**

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 **Herrin**, on **June 12, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **January 28, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner N/A 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 **$65,854.00**; the average weekly wage was **$1,266.45**.

On the date of accident, Petitioner was **50** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

The Arbitrator finds that the Petitioner has not met his burden of proving by a preponderance of the evidence that his injury is causally connected to his alleged accident on January 28, 2014.

Petitioner's claim for compensation is denied. All other issues are moot.

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

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

D. Dee McCarthy
Signature of Arbitrator

July 7, 2015
Date

JUL 9 - 2015

Randall Clover v. Chester Mental Health Center
Case No. 14 WC 29717

17IWCC0082

Petitioner filed an application for adjustment of claim with the Illinois Workers' Compensation Commission. Petitioner alleged that he sustained injuries to his right knee as a result of physically restraining a patient while working for Chester Mental Health Center. Petitioner has alleged the date of accident as January 28, 2014. The issues in dispute are accident, causal connection, extended benefits, credit for overpayment of extended benefits, medical bills, prospective medical, credit for 25% of the right leg, and nature and extent.

Petitioner previously injured his right knee on July 27, 2008 while working at Chester Mental Health Center. (RX10) Dr. Richard Lehman performed an arthroscopic partial medial menisectomy on September 3, 2008. (RX5, RX10) Post-operatively Dr. Lehman diagnosed Petitioner with severe degenerative joint disease patella, severe degenerative joint disease medial femur, small degenerative joint disease lateral femur, and degenerative joint disease patellofemoral joint. (RX5) Following surgery Petitioner underwent physical therapy and returned to work light duty. Petitioner returned to Dr. Lehman with complaints of pain in his knee in December 2008. Petitioner received injections through February 2009. On April 15, 2009, Petitioner underwent a partial medial and lateral menisectoomy, debridement of all three joint surfaces, and a large scar tissue debridement inferomedial. (RX5) On June 23, 2011, Dr. Lehman testified that Petitioner had been unwilling to undergo a total knee replacement. (RX10)

The claim, 09 WC 35546, involving Petitioner's previous right knee injury proceeded to a 19(b) hearing on October 17, 2011. (RX10) The Arbitrator denied Petitioner's proposed treatment of a right total knee replacement as it was not related to his July 27, 2008 injury.

That matter, 09 WC 35546, proceeded to final hearing on January 15, 2014. (RX13) At that hearing Petitioner testified to his complaints regarding to his right knee. (RX13) Petitioner testified that he had constant pain and difficulty sleeping at times. Petitioner testified that the condition of his right knee affected his hobby of hunting because he could not do a lot of pushing off with his right leg, and that when climbing down from a tree stand his right leg tended to give out and not hold his weight up. (RX13) Petitioner testified that he had to sleep with his knee bent hanging off the bed or he would be up pacing the house continually. Petitioner testified that when he was at work, after he would sit for an hour when he got up to walk the first three to five steps were "stumble steps" because he didn't have much support on the right knee. Petitioner testified that if he had to drive long distances he had to continue moving his leg to different positions or the pain would shoot down to his foot and then up to his hip while driving and/or sitting in a car. Petitioner testified that he had difficulty getting out of a low riding vehicle because it was difficult to push off with his right leg. Petitioner testified that it was very difficult for him to walk up and down hills in the woods like he used to. Petitioner testified going up a hill was sometimes not that hard but going down a hill was very difficult because of the pressure.

On January 29, 2014, Petitioner completed Chester MHC Information Report. (RX4) The information described the incident where staff had to place a patient in a physical hold to stop self-injurious behavior. Under staff injuries it listed: "Randall Clover = outside right knee". (RX4)

On January 30, 2014, Petitioner presented to his primary care physician with complaints of ear pain. (PX1) Petitioner reported that his symptoms began one day prior. Petitioner was prescribed ciprodex to use on both ears.

On March 13, 2014, Petitioner presented to Gerald Cameron, PA with complaints of right knee pain. (PX1) Petitioner reported that he had suffered a fall that occurred at work on January 28, 2014. Petitioner reported his pain was aggravated by movement and standing to sitting. Petitioner reported decreased mobility, joint tenderness, locking, nocturnal awakening, nocturnal pain and popping. Oh physical examination Petitioner's right knee had tender joint spaces with Positive Apley, pain with full extension or flexion greater than 50 degrees, and pain with flexion and internal rotation. Petitioner was given Naproxen, Hydrocodone, and an x-ray was ordered. Mr. Cameron noted he anticipated Petitioner needing physical therapy or possible MRI with referral to ortho.

On March 13, 2014, Petitioner underwent an x-ray of the right knee. (PX1) The findings noted where: 1) medial compartment osteoarthritis, 2) small joint effusion, and 3) no acute bony findings.

On March 13, 2014 Petitioner completed an Employee's Notice of Injury. (RX1) Petitioner reported he felt his right knee pop and had some tenderness that would not get better after he physically restrained a violent patient on January 28, 2014.

On March 20, 2014, Petitioner followed up with Mr. Cameron for his right knee. (PX1) Petitioner reported that his pain was the same as his last appointment, and that he had pain with weight bearing starting on the lateral then medial aspect of his knee. Petitioner reported pain with active hyperflexion and flexion beyond 90 degrees. On physical examination Mr. Cameron noted Petitioner's right knee was still very tender on the joint spaces, especially the lateral. No peripatellar edema or pain was noted. Petitioner's pain was aggravated by flexion past 100 degrees and extension to 170, and by plantar flexion. Mr. Cameron noted the x-ray showed no acute bony injury, and advised he wanted Petitioner to attend physical therapy three times a week for three weeks.

On April 9, 2014, Petitioner presented for his right knee. (PX1) Petitioner reported that his knee was feeling worse, and worsened after therapy. Petitioner advised he would go to physical therapy on Friday and seek evaluation on Monday as to whether he was making progress. Mr. Cameron advised if Petitioner was not progressing he would consider an MRI.

On April 24, 2014, Petitioner underwent an MRI without contrast. (PX1) The impression of Petitioner's right knee was: 1) tricompartmental osteoarthritis with most severe changes involving the medial compartment, overall increased in extent compared to the previous study, 2) there was evidence of interval partial meniscectomy. Hyperintense signal involving the posterior horn/root remnant which may in part represent scarring related to previous surgery with irregularity of the meniscal remnant suggesting progressive degenerative type tear. Correlate with physical examination., 3) complex popliteal cyst with evidence of cyst leakage/rupture. Small joint effusion. Ganglion/synovial cyst adjacent to the femoral attachment of the lateral head gastrocnemius., 4) Extensive mucoid degeneration versus sequel of a partial/interstitial tear involving the anterior cruciate ligament with intact fibers identified. There was some sagging of the ligament fibers., 5) Scarring related to a chronic sprain/partial tear of the medial collateral ligament., 6) Sclerotic lesion within the anterior portion of the distal femur, favoring a benign fibrous lesion or bone island, and 7) Patellar/quadriceps tendinosis.

On April 30, 2014, Petitioner presented to Mr. Cameron in follow up to his MRI. Mr. Cameron advised he was referring Petitioner to Dr. Lehman an orthopedic surgeon in Kirkwood, MO. (PX1)

On May 22, 2014, Petitioner presented to Dr. Richard Lehman. (PX2) Petitioner reported to Dr. Lehman that he had been injured on January 28, 2014, during an altercation with a patient that caused Petitioner to twist his right knee. Petitioner advised Dr. Lehman that he initially treated conservatively but had consistent pain, soreness, and discomfort in the knee. Dr. Lehman noted that Petitioner had undergone treatment for problems with his right knee before, but that Petitioner reported to him that prior to Petitioner's new injury he only had occasional soreness and that he was able to do his job without difficulty. Petitioner reported to Dr. Lehman that prior to his new injury he had very few problems with his right knee. On physical examination Dr. Lehman noted Petitioner had mild swelling in his right knee, pain over the medial joint line, and significant tenderness over the lateral joint line. Dr. Lehman noted that Petitioner's range of motion in his right knee was full although it was very tight in full extension and Petitioner was having pain with hyperextension. Dr. Lehman noted Petitioner's radiographs showed mild to moderate degenerative arthritis in both the medial and lateral compartments. Dr. Lehman's note contains a review of Petitioner's previous treatment medical records as well as a review of his current medical records.

Dr. Lehman noted that due to Petitioner's symptoms he felt that Petitioner had significant degenerative changes and an acute component in his knee. (PX2) Dr. Lehman stated that it appeared Petitioner was doing quite well until January 28, 2014, and now he appeared to have symptoms which were significant laterally and posteriorly. Dr. Lehman advised he recommended Petitioner undergo a cortisone injection, which he had done, and have him continue on light therapy. Dr. Lehman stated that Petitioner had pre-existing arthritis prior to January 28, 2014, but he appeared fairly well prior to that and had gotten substantially worse

since then. Dr. Lehman advised Petitioner should return in three to four weeks, and if his pain had not resolved at that time he would recommend arthroscopic surgery.

On June 27, 2014, Petitioner presented to Dr. Smith with reports of a knot on his right leg. (PX1) Petitioner reported he had been wearing his knee brace faithfully and he had begun to notice swelling distally to the brace. Petitioner reported his whole leg was tender and he was concerned about a blood clot. Petitioner underwent a Venous Doppler exam on his right lower leg. There was no sonographic evidence for deep venous thrombosis. There were varicose veins identified.

On August 20, 2014, Petitioner presented to Dr. Smith for a release to return to work. (PX1) Petitioner advised his right knee symptoms were poorly controlled, but that he claim was being denied and he needed to return to work. Petitioner requested a return to work light duty and some pain medications to help him sleep. Dr. Smith gave Petitioner a return to work light duty slip.

On July 14, 2014, Petitioner underwent a Section 12 examination with Dr. R. Peter Mirkin at Respondent's request. (RX8) Dr. Mirkin opined that Petitioner had a significantly degenerative right knee. Dr. Mirkin noted that Petitioner advised him that his symptomology increased after January 28, 2014, and if that was true, then Dr. Mirkin opined Petitioner had suffered an aggravation of his degenerative right knee. Dr. Mirkin advised it might have just been a transient aggravation because he did not see any structural damage that was caused by the January 28, 2014 incident. Dr. Mirkin advised Petitioenr would benefit from a total knee replacement, and that it was unlikely an arthrocopic surgery would provide any long lasting relief to his condition. Dr. Mirkin opined that Petitioner's condition was pre-existing and degenerative, but Petitioner claimed he was relatively asymptomatic prior to January 28, 2014 so he may have had an aggravation of his condition.

On September 17, 2014, Petitioner followed up with Dr. Smith and reported severe right knee symptoms that occurred constantly. (PX1) Petitioner reported that he was working, but he was still having pain and swelling in his knee even with restrictions. Petitioner advised he would like to return to work without restrictions, but with an eight hour day restriction. Dr. Smith assessed him with right knee pain, ACL tear, and a ruptured baker's cyst. Dr. Smith advised he would release Petitioner to work full duty with an eight hour work day restriction.

On October 23, 2014, Petitioner presented to Dr. Smith for his right knee. (PX1) Petitioner reported he had been working eight hour days and that seemed to be ok. Petitioner reported that he limped a lot and could not move as quickly as he would like to get to altercations. Petitioner reported that he occasionally got tingling in his toes, and that he felt that the ROM in straightening his leg was getting worse. Dr. Smith advised he could continue working full duty with an eight hour work day restriction.

On November 24, 2014, Petitioner presented to Dr. Smith in follow up of his right knee. (PX1) Petitioner reported that walking was painful but that wearing his knee brace was helpful. Petitioner advised he needed a refill on pain medication and a new work slip.

On January 7, 2015, Petitioner presented to Dr. Smith in follow up of his right knee. (PX1) Petitioner reported that he was still having a lot of knee pain that was worse with cold weather. Petitioner advised he needed a refill on pain medication and a new work slip.

On January 26, 2015, Dr. Mirkin testified via evidence deposition. (RX9) Dr. Mirkin testified that he reviewed records from Petitioner's family physician, Dr. Lehman, Outpatient Rehabilitation Services of Southern Illinois, imaging studies, and injury reports. Dr. Mirkin testified that Petitioner told him his right knee became symptomatic on January 28, 2014, and that it was his understanding that Petitioner was not having symptoms prior to January 28, 2014. Dr. Mirkin opined that he believed Petitioner had an anatomical condition that had been in his knee for a long time, but if he twisted it he might have had a transient aggravation of his knee. Dr. Mirkin described that a transient aggravation generally wouldn't cause any increase in the pathology. That it would "take something that's already abnormal and cause it to be painful for a period of time, generally a day or two".

Dr. Mirkin testified that if Petitioner presented to his primary care physician two days after his alleged work accident and did not report any right knee problems that it would be inconsistent with the history Petitioner had given him, but that it could certainly be consistent with Petitioner's symptoms having already resolved by the time he saw his family doctor. Dr. Mirkin testified that was inconsistent with Petitioner's story because it was his understanding from talking with the Petitioner that after the January 28, 2014, incident he developed symptomology to the point that he couldn't live with it and wanted to have surgery for it. Dr. Mirkin testified that he was also under the impression that Petitioner was relatively asymptomatic prior to January 28, 2014. Dr. Mirkin was asked that if Petitioner had testified thirteen days prior to his accident on January 28, 2014, that his right knee was in constant pain to the point he had difficulty sleeping, that he could not support his weight fully on his right knee, that his knee would give out, that he had difficulty walking down a hill, that he could no longer participate in hobbies, and could not use his right knee to push off with his weight if that was inconsistent with the history Petitioner had given him. Dr. Mirkin testified that it was inconsistent. Dr. Mirkin testified that information would support his overall opinion that Petitioner's condition was anatomically preexisting, but that it would certainly be different than the impression he got from Petitioner and that it was different than what Petitioner had told some of his doctors.

Dr. Mirkin testified that Petitioner was at maximum medical improvement from the transient aggravation that Petitioner had as a result of the January 28, 2014 incident. Dr. Mirkin testified that he recommended Petitioner undergo a total knee replacement, but that it was not related to his alleged accident on January 28, 2014.

On May 4, 2015, Dr. Lehman testified via evidence deposition. (PX3) Dr. Lehman testified that he had treated Petitioner previously and Petitioner had pre-existing degenerative changes in his right knee. Dr. Lehman testified that Petitioner had reported to him that prior to this incident he had occasional soreness but that he was able to function work-wise. Dr. Lehman testified that he believed Petitioner's condition was different than before January 28, 2014, in that it appeared he had some changes in the posterior horn of the medial meniscus and what could potentially be suggestive of a progressive degenerative tear of the meniscus. Dr. Lehman testified that Petitioner was also noted to have a Baker's cyst and what appeared to be some breakdown of the patellar tendon and quadriceps tendon, but Dr. Lehman felt primarily that it appeared Petitioner had exacerbated or reinjured his medial meniscus. Dr. Lehman testified that Petitioner's knee had been in a steady state and started to swell after the incident, so he had more meniscal symptoms and that his arthritis became substantially more problematic. Dr. Lehman agreed that, due to his previous injury, it was recommended that Petitioner undergo a total knee replacement. Dr. Lehman testified that he still felt that Petitioner would need to undergo a total knee replacement at some point.

On cross-examination Dr. Lehman admitted that if had been given the January 30, 2014 note from Murphysboro Health Center indicating that Petitioner presented to his family physician two days after the alleged accident and did not describe any problems to his right knee that it might impact Dr. Lehman's causation opinion of the knee. Dr. Lehman agreed that it was possible that what happened to Petitioner's joint could simply be from his leg giving out. Dr. Lehman admitted that he thought the only thing that would resolve his knee pain would be to perform a total knee replacement. Dr. Lehman testified that the arthroscopy would be palliative and potentially allow Petitioner to return to baseline, but it would be to just try to put off a total knee replacement. Dr. Lehman testified that Petitioner's osteoarthritis had progressed on the imaging studies from 2009 when compared to 2014, but he further testified that it's the natural history of osteoarthritis to generally progress.

On cross-examination Dr. Lehman testified that he believed that the progression of Petitioner's degenerative meniscal tear and some progression of his arthritis is different from than it was in 2009. Dr. Lehman testified that he felt there was an acute component to Petitioner's meniscal tear, but that it would be impossible to say how much of the progression of Petitioner's degenerative arthritis was acute versus the natural history of the disease process. Dr. Lehman testified that he could not say whether or not Petitioner's Baker's cyst was degenerative or acute. Dr. Lehman testified that the tendinosis of Petitioner's quadriceps and patellar tendon was likely just a progression of his degenerative changes.

Petitioner testified at arbitration on June 12, 2015. Petitioner testified that on January 28, 2014, he was involved in a patient altercation that resulted in him placing a patient in a physical hold. Petitioner testified that during the hold Petitioner struggled and he fell to the floor landing on his knees and elbows. Petitioner testified that he told the nurses his knee felt different. Petitioner

testified that his knee really didn't seem to bother him too much, but then the pain wouldn't go away and it continued to progress so he turned it in.

Petitioner testified that he had injured his right knee before January 28, 2014 and received treatment from Dr. Lehman for it. Petitioner testified that he had a workers' compensation hearing for that matter one month prior to January 28, 2014, and there was a recommendation from Dr. Lehman to possibly have a total knee replacement. Petitioner testified that following that hearing in December 2013 he was able to function, work, and get back in to hunting mode. Petitioner testified that he still had a little pain, but he was able to function. Petitioner testified that prior to January 28, 2014, he had a lot of soreness, stiffness, and it was hard to climb stairs.

Petitioner testified that his knee is different after January 28, 2014, in that he is in much greater pain, he has to be careful going up stairs because his knee will give out on him, he can't sit or drive for very long because his knee will stiffen up and hurt very bad, and that he will get a tingling in his toes every once and a while.

Petitioner testified that he would like to proceed with the arthroscopic procedure recommended by Dr. Lehman. Petitioner was asked on direct examination if he recalled seeing his family physician two days after his alleged accident on January 28, 2014, and Petitioner testified that he did not. On cross-examination Petitioner was asked why he did not seek treatment for his right knee right away if he was in fact experiencing much greater pain than he did prior to January 28, 2014. Petitioner advised he thought it was just a strain and would go away.

On cross-examination Petitioner was asked about his testimony on January 15, 2014, where he testified that he had constant pain in his knee to the point he had difficulty sleeping, that he could not support his weight fully on his right knee, that his knee would give out, that he no longer participated in hobbies, and he had difficulty walking down a hill, and that he could not use his right knee to push off with his weight. Petitioner was asked how those complaints differed from his complaints after January 28, 2014. Petitioner testified that he believed they were a little bit more now than then because he did try to get back in to hunting mode and at least able to climb in to his tree stand.

On cross-examination Petitioner was asked if he recalled telling Dr. Mirkin he was asymptomatic in his right knee prior to January 28, 2014. Petitioner testified that he did not.

Therefore, the Arbitrator concludes the following:

1. Petitioner has failed to prove that the current condition of ill-being in his right knee was as a result of an alleged work accident on January 28, 2014.

   "To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of evidence, that he has suffered a disabling injury which arose out of and in the course of his employment." *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill.2d 193, 203,

797 N.E.2d 665, 671 (2003). Preponderance of the evidence is "evidence which is of greater weight or more convincing than the evidence offered in opposition of it; it is evidence which as a whole shows that the fact to be proved is more probable than not." *Gonzales v. United Airlines, Inc.*, 03 IL.W.C. 30483, 09 I.W.C.C. 0458 (2009), citing *Jones v. J. Rubin Co,* 98 IL.W.C. 7779, 02 I.I.C. 0142 (2002). "Among the factors to be considered in determining whether a claimant has sufficiently carried his burden is his credibility." *Id.* At trial, a "witness' credibility is always in question." *Bish v.Guiseppe's Pizza*, 07 IL.W.C. 27341, 09 I.W.C.C. 0382 (2009). Credibility is the quality of a witness which renders his evidence worthy of belief. *Gonzales*. It is the Arbitrator's duty to evaluate a witness' credibility, as well as, "the witness's demeanor and internal and external inconsistencies in his testimony." *Id.*

A claimant's testimony, "standing alone, may support an award where all of the facts and circumstances do not preponderate in favor of the opposite conclusion." *Sieber v. Indus. Comm'n*, 82 Ill.2d 87, 97, 411 N.E.2d 249 (1980). However, "when the claimant's testimony is virtually the only evidence favoring an award, and that testimony is repeatedly contradicted by the record, then it is this court's duty to disallow the claim." *Caterpillar Tractor Co. v. Indus. Comm'n*, 73 Ill.2d 311, 315, 383 N.E.2d 220, 222 (1978).

The Petitioner's previous testimony at his arbitration hearing on January 15, 2014, for 09 WC 35546 is at best inconsistent with the history given to his treating physician Dr. Lehman and Respondent's Section 12 examiner Dr. Mirkin. At worst his testimony is directly contradictory to the history he gave to various physicians. Dr. Lehman believed Petitioner was relatively asymptomatic prior to January 28, 2014, however on January 15, 2014, a mere thirteen days prior to his alleged accident Petitioner testified to a plethora of continued complaints with regard to his right knee. Specifically that Petitioner experienced constant pain and difficulty sleeping at times. Petitioner testified that the condition of his right knee affected his hobby of hunting because he could not do a lot of pushing off with his right leg, and that when climbing down from a tree stand his right leg tends to give out and not hold his weight up. Petitioner testified that he had to sleep with his knee bent hanging off the bed or he would be up pacing the house continually. Petitioner testified that when he was at work, after he would sit for an hour when he got up to walk the first three to five steps were "stumble steps" because he didn't have much support on the right knee. Petitioner testified that if he had to drive long distances he had to continue moving his leg to different positions or the pain would shoot down to his foot and then up to his hip while driving and/or sitting in a car. Petitioner testified that he had difficulty getting out of a low riding vehicle because it was difficult to push off with his right leg. Petitioner testified that it was very difficult for him to walk up and down hills in the woods like he used to. Petitioner testified going up a hill was sometimes not that hard but going down a hill was very difficult because of the pressure.

This testimony paints a very different picture than one of Petitioner having a relatively asymptomatic right knee prior to his alleged accident on January 28, 2014. Additionally, Petitioner testified to experiencing an immediate onset of pain in his right knee on January 28, 2014, that was worse than he had experienced before. Yet, on January 30, 2014, when Petitioner presented to his family physician he never mentioned any pain or problems with his right knee. In fact, Petitioner did not present for treatment of his right knee condition until March 13, 2014.

Therefore, the Arbitrator finds the testimony of Dr. Mirkin to be more credible than Dr. Lehman. Dr. Mirkin credibly testified that Petitioner might have sustained a transient aggravation of his underlying condition, but that it would have likely resolved within a day or two. This opinion is supported by the medical records given that Petitioner presented to his family physician two days after his alleged accident yet reported no pain or complaints with regard to his right knee. Dr. Lehman admitted that Petitioner's meniscal injury could have occurred due to Petitioner's knee "giving out", and based upon his testimony on January 15, 2014, Petitioner's knee gave out during regular every day activities. Dr. Mirkin credibly testified that the anatomical condition of Petitioner's knee was long standing. Dr. Lehman admitted that he couldn't say how much of the progression of Petitioner's underlying arthritic condition was due to the natural history of the disease or due to an acute injury.

The Arbitrator finds that in light of the many inconsistencies at issue in this case the Petitioner's testimony is less than credible. Therefore, the Petitioner has not met his burden of proving by a preponderance of the evidence that his injury is causally connected to his alleged accident on January 28, 2014.

The claim 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 causal connection	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Christopher Riley,

Petitioner,

17IWCC0083

vs.

NO: 13 WC 39135

Cook County Sheriff's Office,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, and permanent partial disability and being advised of the facts and law, reverses the Decision of the Arbitrator on the issue of causal connection. The Commission further modifies the Arbitrator's award of medical expenses, temporary total disability, and permanent partial disability consistent with our findings and conclusions set forth below.

Petitioner, a 48-year-old correctional officer, sustained injuries arising out of and in the course of his employment by Respondent on November 1, 2013. As set forth in the Arbitrator's statement of facts, at approximately 7:00 p.m. Petitioner was performing a search for contraband hidden in the ceiling of a shower room. Standing on milk crates, Petitioner reached with his left arm into the hole where a light fixture had been removed. Petitioner accidentally grasped an exposed electrical wire and was electrocuted. Petitioner testified that he felt shocks all over his body and fell backward against the shower wall, striking his upper back, neck, and head. Petitioner complained of intractable neck and left arm pain resulting from the accidental injury. He sought an award of workers' compensation benefits for lost time, medical treatment including a cervical fusion on March 6, 2014, and permanent partial disability for the loss of use of the person as a whole under §8d(2) of the Act. Petitioner was released to return to his regular job activities without restrictions on June 11, 2014.

In a Decision dated March 1, 2016, the Arbitrator found that Petitioner failed to prove causal connection between the cervical fusion and the accidental electrocution injury he sustained on November 1, 2013. The Arbitrator found that Petitioner's testimony that he hit his head, neck, and shoulder area against the wall was inconsistent with other evidence offered at arbitration. The Arbitrator denied medical expenses and temporary total disability related to the cervical fusion. We find that the Decision of the Arbitrator is not supported by a preponderance of the evidence and we reverse to award benefits under the Act.

The evidence shows that immediately after Petitioner was electrocuted, he fell back against the shower wall. We rely on the testimony of Petitioner, whose description of the accident is overall corroborated and confirmed by the testimonies of Officer Green and Sergeant Rodriguez. Officer Green and Sergeant Rodriquez were both present when the accident occurred. Neither Officer Green nor Sergeant Rodriguez contradicted the material facts of Petitioner's description of the accident.

Officer Green testified that he was facing Petitioner at the time of the accident on November 1, 2013. He recalled that Petitioner was standing on a milk crate in order to reach the ceiling of the shower stall. He estimated that there was an 18 inch to 2 foot gap between Petitioner and the wall behind him. Officer Green testified, "Riley reached his hand up there and all of a sudden there was a pow and a big shock with sparks and we all ducked." (T. 54) When he looked back up he saw Petitioner "up against the wall." He testified that he asked Petitioner if he was alright and then after a moment he helped Petitioner step down off of the milk crate. He testified that Petitioner appeared dizzy and reddened. He believed that Sergeant Rodriguez assisted in helping him carry Petitioner from the shower room to the break room. Officer Green agreed that he did not actually see Petitioner's body make initial contact with the wall, but when he looked up Petitioner's head and shoulders were leaning against the wall.

Sergeant Rodriguez testified that he was present standing just outside the shower room when Petitioner's accident occurred on November 1, 2013. Sergeant Rodriguez recalled seeing Petitioner standing on a milk crate and pulling items out of the ceiling. He testified that he saw the exposed wire protruding from the hole in the ceiling. Suddenly, "*there was like a pop and a giant spark flew, so I got out of the way.*" (T. 67) Sergeant Rodriguez testified that he ducked to the side of the door for a few seconds and when he looked back in he saw Petitioner "slumped" against the wall. On further questioning, he agreed that he actually saw Petitioner's neck and shoulder area against the wall. He testified that he asked Petitioner if he was alright and then he and Officer Green helped Petitioner out of the shower area to the break room. Sergeant Rodriguez recalled that Petitioner "didn't seem normal" after the accident.

Officer Green and Sergeant Rodriquez completed accident reports on November 1, 2013. The reports do not contradict the testimony at hearing. Sergeant Rodriquez's reports do not specifically mention that Petitioner fell back and struck the wall. (PX12, PX13) Officer Green's report states that "Officer Riley fell back and didn't look good." (PX14) Petitioner completed his accident report one day later on November 2, 2013. He reported that he was "zapped" by an electrical cable in the presence of Officer Green and Sergeant Rodriquez and that he injured his neck and his left shoulder, arm, and leg, and had tingling in the left hand. The report does not mention striking the wall or falling. The Arbitrator found it unbelievable that Petitioner would fail to mention that he struck the wall when he made his own report the day after the accident. We acknowledge the absence of a report of a fall in Petitioner's accident report. However, we also note that Petitioner's report is not the earliest subjective history of the mechanism of injury. Petitioner spent approximately 16 hours in Mt. Sinai Hospital before completing his accident report for Respondent, and we note Petitioner's history as recorded by several examining physicians over the course of his hospital stay.

Petitioner arrived via ambulance at Mt. Sinai Hospital before 8:00 p.m. The ER nurse took Petitioner's history of performing a search in the jail, standing on milk crates, and reaching his hand into the ceiling where he was electrocuted by loose wires. The ER nurse noted that Petitioner felt the shock from his head to his toes. The attending ER physician took Petitioner's history of having been electrocuted about one hour earlier, with current complaints of pain in the left arm, chest, and neck. The doctor noted "no fall." A cervical spine CT scan showed no acute abnormalities. Petitioner was admitted into the hospital for overnight testing and observation. The nursing notes show that Petitioner complained of pain and difficulty moving his left shoulder. He was treated with pain medication and muscle relaxers and placed in a left arm sling. Petitioner was reexamined by the resident physician at approximately 10:30 p.m. The resident physician noted that Petitioner was being kept

under observation after he presented with numbness in the body after electrical wires fell on him at work in Cook County Jail. The resident noted no obvious injury other than redness around the neck. An EKG, CT scan of the brain, and blood testing were all normal and Petitioner was not found to have any neurological deficits. The resident physician noted neck spasms and left shoulder pain.

Early in the morning of November 2, 2013, Petitioner was examined by an internal medicine physician. The doctor took Petitioner's history of a brief episode of jerking movements after shock from electric cables. Petitioner complained of left shoulder pain and the doctor recommended an orthopedic consultation to rule out dislocation. A left shoulder x-ray was performed and the report indicated no acute abnormalities. Petitioner was examined by an orthopedic surgeon prior to being discharged from the hospital. The orthopedic surgeon took Petitioner's history of sustaining electric shocks when an exposed wire came in contact with his head. The doctor further noted that Petitioner felt electricity through his left arm and fell backward against the wall but did not fall down. The doctor noted Petitioner did not remember the exact details. Petitioner complained of neck and left shoulder pain and numbness and tingling. On exam, the doctor noted limited abduction of the left shoulder and guarding due to pain. The doctor confirmed there was no facture or dislocation. He recommended Petitioner remain in a left arm sling and return to the orthopedic clinic in two weeks. Petitioner was discharged from the hospital just after 12:30 p.m. on November 2, 2013.

Petitioner followed up with his primary care physician, Dr. Pethkar, two days later on November 4, 2013. Dr. Pethkar took Petitioner's history of striking his head against the floor and the wall and having complaints of severe soreness and stiffness in his neck, difficulty walking, and numbness in his left arm. Dr. Pethkar concluded that Petitioner's symptoms were caused by the extensive electrical shocks he received during the accident and he took Petitioner off of work. We note that Dr. Pethkar's history mentioning Petitioner striking his head against the floor is not consistent with the rest of the evidence, including Petitioner's own testimony. However we do not find this inconsistency to be fatal to Petitioner's claim in light of all of the evidence.

We do not find that striking the wall alone caused Petitioner's injuries. Rather, we find that the entirety of the accident - the electrocution, jerking, the loss of balance and falling backward, striking the wall, is causally related to Petitioner's current condition of ill-being. The preponderance of the evidence shows that the accident caused the acute onset of Petitioner's neck and left arm symptoms. Consistent with the witnesses' testimony, the contemporaneous medical records provide a history that the Petitioner was shocked while reaching overhead and that he fell backward after being shocked. We find that this mechanism of injury is supported by the preponderance of the evidence.

We further address causal connection in light of our findings above. We find that the timing of and type of symptomatology that Petitioner developed immediately after the accident is consistent with the cervical condition treated by Dr. Mataragas with a fusion surgery on March 6, 2014. Petitioner was diagnosed with herniated discs at C4-5 and C5-6 and radiculopathy. After failing to obtain relief from a course of physical therapy and three epidural steroid injections Petitioner had surgery consisting of a C5-6 and C6-7 anterior cervical fusion with C6-7 hemi-corpectomy and anterior cervical osteotomy with the excision of herniated cervical discs. Dr. Mataragas testified that Petitioner gave him a history of being electrocuted and thrown against a wall on November 1, 2013. Dr. Mataragas testified that assuming Petitioner's history was truthful and also assuming that Petitioner had no prior neck and left shoulder pain, Dr. Mataragas would agree that the need for surgery was causally related to the accident. Dr. Mataragas was questioned regarding the November 1, 2013 ER records which are absent any mention of hitting the wall and the November 2, 2013 hospital records noting a fall against the wall. Dr. Mataragas testified that the two records were not necessarily inconsistent, however one was more detailed. Dr. Mataragas testified that either being jerked or striking the wall could disrupt cervical discs. (PX9, P. 32)

Dr. Troy, Respondent's §12 examiner and an orthopedic surgeon, opined that Petitioner's condition was degenerative rather than the result of trauma. He testified that he did not review any ER records indicating that there had been a fall. However, Dr. Troy admitted during his deposition testimony that causal connection was possible assuming that Petitioner had no prior treatment or symptoms and sustained the injury as described. Dr. Troy agreed that the surgery appeared to have vastly improved Petitioner's symptoms. He agreed that surgery was reasonable and necessary treatment in light of Petitioner's condition and presentation. (RX2, P. 57) Dr. Moisan, Respondent's other §12 examiner and an internal medicine physician, opined that Petitioner's underlying cervical spondylosis was transiently aggravated to the point where it became symptomatic as a result of the accident. Although Dr. Moisan believed that the aggravation was temporary, he agreed that the records did not show that Petitioner reported any relief of his symptoms. Dr. Moisan agreed that Petitioner's underlying cervical spondylosis would have made him more susceptible to injury. (RX3, P. 72) Dr. Moisan also agreed that the surgery was reasonable; however it was his opinion that the surgery addressed Petitioner's pre-existing multi-level cervical spondylosis (RX3, P. 74)

During the surgery on March 3, 2014, Dr. Mataragas confirmed the presence of herniated discs at C4-5 and C5-6, and that the herniations at these levels were producing mass effect upon the nerve roots especially on the left side. Even if Petitioner had some preexisting cervical degenerative disc disease, there is no evidence that he had any complaints of neck and left shoulder pain prior to November 1, 2013. We find that Petitioner's medical treatment was reasonable and necessary to treat or cure the effects of his work-related injury.

The evidence shows that Petitioner was not medically cleared by his physicians to return to work until he completed his treatment in June of 2014. Petitioner returned to his regular job duties on June 11. 2014. We find that Petitioner is entitled to temporary total disability benefits from November 2, 2013 through June 10, 2014.

We find that Petitioner sustained the 20% loss of use of the person as a whole under §8(d)2. Our findings on the issue of the nature and extent of the injury take into account the §8.1b factors for determination of permanent partial disability. With respect to the first factor, as the Arbitrator noted, neither party submitted medical evidence documenting an impairment rating and this factor is given no weight. Secondly, Petitioner is currently employed as a correctional officer for Respondent. The evidence shows that Petitioner was able to return to his regular job duties without restrictions. Third, Petitioner was 48-years-old at the time of the injury. No evidence was presented as to how the Petitioner's age might affect his disability. Fourth, no evidence suggests a diminishment in Petitioner's future earning capacity as a result of his injury. Petitioner testified that six months after he returned to work he applied for and subsequently obtained a transfer into inmate processing. Petitioner testified that as a correctional officer in inmate processing he is no longer required to do any lifting or perform any searches. He offered no evidence that his job transfer was related to his medical condition. Finally, we consider the evidence of disability corroborated by the treating medical records. On June 4, 2014, Dr. Mataragas's physician's assistant noted that Petitioner was feeling much better and was happy with the results of surgery although he was still working on regaining strength in his arm. After Petitioner's last physical therapy visit on June 18, 2014, the therapist noted that Petitioner had continued neck discomfort and fatigue, although he reported that he was stronger. Petitioner reported that he continued to wear his neck brace occasionally. We additionally note Dr. Troy's examination of Petitioner at the request of Respondent on October 23, 2014. Dr. Troy performed a physical examination and found Petitioner's strength to be 5/5 in all areas other than grip strength which was 4/5. Petitioner complained of pain radiating down both shoulders, his back, and down his left arm. Petitioner complained of weakness in his left arm and numbness in his fingers. It was Dr. Troy's opinion that Petitioner displayed some self-limiting behaviors. At arbitration on October 7, 2015, Petitioner testified that he still had residual pain in his neck and weakness in his left arm. He testified that he occasionally wears his cervical collar at night and he takes Advil or Aleve twice a day for pain. Based upon consideration of the above factors, the evidence supports and award of permanent partial disability equal to 20% loss of use of the person as a whole as provided in §8(d)2 of the Act.

17IWCC0083

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $705.55 per week for a period of 31 4/7 weeks, from November 2, 2013 through June 10, 2014, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $705.55 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 20% of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is ordered to pay medical expenses of $192,907.35 set forth in Petitioner's Exhibit 10 and pursuant to §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.

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: FEB 10 2017
RWW/plv
o-1/18/17
46

Ruth W. White

Joshua D. Luskin

Charles J. DeVriendt

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

Justen Kempfer,
Petitioner,

vs.

SOI/Menard Correctional Center,
Respondent.

17IWCC0084

NO: 15 WC 14406

DECISION AND OPINION ON REVIEW

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

DATED: FEB 10 2017
o2/1/17
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0084

KEMPFER, JUSTEN
Employee/Petitioner

Case# **15WC014406**

MENARD C C
Employer/Respondent

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:

0969 THOMAS C RICH PC
6 EXECUTIVE DR
SUITE 3
FAIRVIEW HTS, IL 62208

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

0558 ASSISTANT ATTORNEY GENERAL
KENTON OWENS
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

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

17IWCC0084

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

Justen Kempfer
Employee/Petitioner

v.

Menard C.C.
Employer/Respondent

Case # **15** WC **14406**

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 **7/15/15**. 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 **10/21/13**, 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 **$49,608.04**; the average weekly wage was **$954.00**.

On the date of accident, Petitioner was **27** 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 **$Any paid** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$Any paid**.

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

ORDER

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, Respondent shall pay Petitioner permanent partial disability benefits of $572.40/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

6/25/16
Date

ICArbDec p. 2

JUL 28 2016

FINDINGS OF FACT

Petitioner was a 27 year old employee of the State of Illinois at working Menard Correctional Center as a correctional officer. On October 21, 2013, Petitioner was involved in an altercation with an inmate. During the altercation Petitioner fell to the ground. Following the incident, Petitioner completed a Notice of Injury form. (Rx. 1) Petitioner described injuries to his right knee, left shoulder and low back. (Rx. 1, p1) On the day of accident Petitioner was examined at the by his family physician, Dr. Walls. (Px. 3) At that time Petitioner had complaints of lumbar pain, right knee pain and left shoulder pain. Petitioner was given ibuprofen and x-rays were ordered. On October 28, 2013, Petitioner returned to Dr. Walls. At that time the only noted complaint was left shoulder pain. Dr. Walls performed a physical examination on the shoulder only and his diagnosis was shoulder injury. There is no mention of the low back or knee on this date and no diagnosis was made regarding these body parts. Petitioner was told to follow up as needed.

Following his release, Petitioner returned to his regular job duties. On January 15, 2014 Petitioner was involved in another inmate altercation however there is no indication of any injury as a result of this altercation.

At the hearing Petitioner testified that his shoulder and knee conditions have resolved, but he continues to feel pain in his low back. He continues to experience symptoms of soreness, pain shooting from his back down to his knees, and loss of range of motion. Sitting for prolonged periods of time at work and any activities performed below the waist aggravate his symptoms. He takes over-the-counter pain medication 2-4 times a day to cope with his symptoms, and stretches every morning before work. He has not sought or received medical care for his work-related injuries since his October 28, 2013 visit with Dr. Walls. Petitioner stated at trial that he just chose to deal with it on his own. Petitioner testified that he has not had any intervening accidents between October 21, 2013, and the date of hearing.

CONCLUSIONS

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

As a result of this accident, Petitioner suffered injuries to his low back, right knee and left shoulder. Petitioner's last was on October 28, 2013. At that time the only noted complaint was left shoulder pain. Dr. Walls performed a physical exam on the shoulder only and his diagnosis was shoulder injury. There is no mention of the low back or knee on this date and no diagnosis was made regarding these body parts. Petitioner was told to follow up as needed. He has not done so.

Petitioner testified at trial that his shoulder and knee symptoms have resolved, but he has had constant low back pain since the accident. There are, however no medical records supporting any relationship between his current low back complaints and this incident.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that although Petitioner did sustain injuries to his low back, right knee, and left shoulder at the time of the accident, any continued low back symptoms from which Petitioner may suffer are not causally related to the accident.

17IWCC0084

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

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party submitted an AMA rating. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner is now employed as a Carpenter. Petitioner's new employment requires extensive use of his upper and lower extremities as well as his low back.The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 27 years old at the time of his injury. Based on Petitioner's young age and the fact that Petitioner has many working years left during which he must cope with his injury, the Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes there is no direct evidence of reduced earning capacity contained in the record. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the relevant evidence to establish disability in this matter is contained in the treatment records of Dr. Walls and through Petitioner's testimony. Petitioner testified that as of the date of hearing his shoulder and knee conditions had resolved, but he continues to feel pain in his low back. The medical records however show that Petitioner initially had complaints of right knee, left shoulder and low back pain. He was treated with ibuprofen. When he returned to Dr. Walls on October 28, 2013, he only had complaints of left shoulder pain. He was released and told to follow up as needed. Petitioner has not seen any medical providers since October 28, 2013 for the injuries sustained in this accident. The Arbitrator therefore gives *some* weight to this factor

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

Respondent shall pay Petitioner permanent partial disability benefits of $572.40/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.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Beverly Joiner,

Petitioner,

vs. NO: 13WC 33869

Cook County,

Respondent,

17IWCC0085

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner, herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary total disability, pemanent 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 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.

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.

17IWCC0085

DATED: FEB 14 2017
MJB/bm
o-12/13/16
052

Michael J. Brennan

Kevin W. Lamborn

DISSENT

I respectfully dissent from the majority decision. For the reasons that follow, I would reverse the Decision of the Arbitrator and find that the Petitioner sustained an accident on July 22, 2013, which arose out of and in the course of her employment. Accordingly, I would award the Petitioner workers' compensation benefits for her work related injuries.

A claimant has the burden of proving all of the elements of her case in order to recover benefits under the Workers' Compensation Act. This burden of proof must be met by a preponderance of the evidence. *Illinois Bell Tel. Co. v. Industrial Comm'n*, 265 Ill. App. 3d 681, 685 (Ill. App. Ct. 1st Dist. 1994). Given the evidence and the relevant case law, the Petitioner has met her burden of proof by a preponderance of the evidence.

The relevant facts of this case are as follows: The Petitioner was asked to run an errand for her supervisor. She returned to work following the errand and parked her car in the employee-only parking lot. When she returned to her work area, she could not find her eye glasses and believed that they were in her car. She informed her supervisor of this and returned to the parking lot to look for her glasses. However, they were not in her car. As the Petitioner was returning to the office from the employee-only parking lot, she tripped on a defect in the curb that was owned by the City of Chicago and subsequently fell. The Petitioner sustained several injuries from the fall.

There is no evidence that the Petitioner's condition is not causally related to her accident. Dr. Paul T. Prinz, one of the Petitioner's treating physicians, noted that her shoulder injury may have been pre-existing, but then he stated that her work-related fall likely aggravated her condition. The Respondent offered no evidence in rebuttable of Dr. Prinz's opinion. Further, there was no evidence that the Petitioner's thumb or wrist condition was pre-existing. Thus, a finding of causal connection would be appropriate.

The Arbitrator should have applied *Brias v. Illinois Workers' Compensation Comm'n*, 2014 Ill. App. (3d) 120820 WC (2014). In *Brias,* the petitioner's heel caught a defect on a public pathway sidewalk causing her to fall. The court found the injury compensable as she was

returning from a work-related meeting at the time of the occurrence. In the case at bar, the Petitioner had already started her day, ran an errand for her supervisor, returned to work and forgot her glasses that she needed for work. She returned to her car and was en route to her office when the injury occurred. The injury occurred because of a special hazard that was on her sole and direct route from the employee parking lot to the entrance.

The case of *Bommarito v. Industrial Comm'n*, 82 Ill. 2d 191, 412 NE.2d (1980) is also relevant to the case at bar. Applying the analysis in *Bommarito*, it could be determined that the Petitioner's injury occurred because of a special hazard that was on her route to her office. She had to park in an employee-only parking lot and then cross over several lanes of traffic to arrive at her office. Seemingly, this was the sole and direct route to her office. Thus, the Petitioner's injury would be compensable applying the analysis set forth in *Bommarito.*

Moreover, and perhaps the most compelling support for a finding of compensability, is that the Petitioner was a travelling employee at the time of her accident. She was directed by her supervisor to leave work to pick up cake and flowers for a celebration at work. Again, when the Petitioner returned, she thought that she forgot her reading glasses. She informed her supervisor and returned to her car to look for the glasses, which were not there. She was then injured. Then, the Petitioner was cloaked under the travelling employee theory from the time that she left to run the work-related errand until she returned to work. The travelling employee status would not have ended until after she returned from her car to look for her glasses. It was reasonable for the Petitioner to return to her car to look for her glasses as she had just been at her car to perform a task for the Respondent at their direction. Thus, she was still a travelling employee at the time of the accident.

An award of medical expenses and permanent partial disability would be appropriate in this case. The Petitioner sustained a full thickness tear in her right shoulder from the fall. She testified that she still experiences some symptoms that have had a negative impact on her daily activities. She also sustained a possible fracture of the wrist that improved without surgery, and she was diagnosed with flexor tenosynovitis of the right thumb which has led to some loss of range of motion.

For the aforementioned reasons, I would reverse the Arbitrator's decision and find that the Petitioner proved that she sustained an accident arising out of and in the course of her employment while working for the Respondent on July 22, 2013. Accordingly, I would award the applicable benefits.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

.R, BEVERLY
yee/Petitioner

Case# **13WC033869**

COOK COUNTY
Employer/Respondent

17IWCC0085

On 2/5/2016, 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 0.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0412 RIDGE & DOWNES
MEGHAN O'BRIEN
101 N WACKER DR SUITE 200
CHICAGO, IL 60606

132 COOK COUNTY STATE'S ATTORNEY
TEPHEN L GARCIA
0 RICHARD J DALEY CENTER
IICAGO, 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

Beverly Joiner
Employee/Petitioner
v.
Cook County
Employer/Respondent

Case # 13 WC 33869

17IWCC0085

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **January 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. ☐ 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 22, 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 **$59,930.00**; the average weekly wage was **$1152.50**.

On the date of accident, Petitioner was **63** years of age, ***single*** 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 $ for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

Respondent is entitled to a credit of **$329.20** under Section 8(j) of the Act.

ORDER

Because the incident of July 22, 2013, did not arise out of Petitioner's employment, benefits are denied.

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

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

David A. Kane
Signature of Arbitrator

February 4, 2016
Date

FEB 5 - 2016

FINDINGS OF FACT

Petitioner is an Administrative Assistant who works as a time-keeper in the Office of the Clerk of the Circuit Court. Petitioner works in the Criminal Court Building at 2650 S. California Avenue, in Chicago ("Court Building"). On July 22, 2013, she allegedly suffered injuries while stepping off of the curb while crossing California Avenue, across from the Court Building.

Petitioner testified that she works from 8:00 a.m. to 4:00 p.m. and that on July 22 she had reported to work at her normal time and had clocked in. Petitioner parked in a parking garage which is across both California Avenue and California Boulevard, east from the Court Building. Petitioner testified that from the parking garage, she walks west out of the garage toward the Court Building and first crosses California Boulevard. Petitioner demonstrated her route on a diagram she drew, which was marked as Petitioner's Exhibit 8. There is a park-like parkway between California Boulevard and California Avenue, which Petitioner crossed to get to California Avenue. At California Avenue, there is a cross-walk going across the street, where Petitioner crossed to get to the Court Building. At the Court Building, there is one main entrance, up some steps, where both employees and the general public enter.

Petitioner testified that only employees may park in the parking garage. Petitioner stipulated that California Avenue and the curb along it are owned and maintained by the City of Chicago. (See Respondent's Exhibit 3.) Petitioner acknowledged that she is allowed to park elsewhere, including on the street or in another parking lot down the street by Popeye's Chicken, but testified that those spots would not be free.

Petitioner testified that sometime during the morning on July 22, the Assistant Chief asked her asked her to pick up cake and flowers for another employee's birthday. Petitioner went to her car and drove to a strip mall to pick up the cake and flowers and drove back to the Court Building, where she dropped off the items in front to another employee who was waiting. She then parked her car uneventfully and returned to the office. Petitioner testified that she thought she had left her glasses in her car and therefore went back down to her car. The glasses were not there and she started back to the office, using the same route she did before. This was sometime around 11:00 a.m.

After exiting the parking garage and crossing California Boulevard, she crossed the parkway and came to California Avenue. Petitioner testified she stopped with others on the east side of California Avenue to wait for passing cars and then began to walk across California Avenue. Petitioner testified that both employees and the public cross at that area and that there were both employees and the public waiting to cross at that time. Petitioner testified that when she went to step off the curb, her foot got caught in a hole in the curb and she fell onto California Avenue. Petitioner took pictures of the location of her fall, which were introduced into evidence.

Petitioner testified that she reported to Mt. Sinai Hospital, where she reported pain in her right shoulder, her right wrist, and her right fifth finger. She subsequently had her right hand casted at Gottlieb and continued to be seen by her primary care physician, Dr. Prinz. Petitioner was diagnosed with a trapezoid fracture and she was told an MRI showed a full thickness rotator cuff tear. She continued to treat with Dr. Prinz, who gave her an injection for her hand. Petitioner testified that she sought a second opinion regarding her hand with Dr. Wysoki, who gave her another injection. Petitioner testified that Dr.

Wysoki told her to come back, but she never did because she had already had two injections and they didn't help.

Petitioner testified on cross-examination that she had previously been involved in a motor vehicle accident in May of 2012. In his notes, Dr. Prinz noted on August 16, 2013, that Petitioner stated she had been having some shoulder pain for several months. (PX3) This would have predated the accident date in this matter. Petition acknowledged that Dr. Prinz had told her that he could not definitively state that the fall on July 22 caused her rotator cuff tear. In his notes, Dr. Prinz states his opinion that Petitioner had some shoulder pathology prior to the fall, which may have been aggravated after the fall. Petitioner testified that she never sought a second opinion regarding her shoulder. Petitioner testified that her group health plan paid for all of her medical bills.

Petitioner testified that she went to work while she was receiving treatment for her injuries from the July 22 accident. She further testified that, after changing her health plan, she is no longer with Dr. Prinz and has not sought any further treatment for her injuries. As to her current condition, Petitioner testified that she cannot bend her thumb on her right hand all the way down and that sometime she feels a tingling in her hand. She also testified that because of her shoulder, she cannot sleep on her right side and cannot reach stuff on a high shelf. She takes Tylenol and sometimes uses a topical spray. If it bothers her at work, she takes a little break and walks around.

The Arbitrator finds in relationship to (C):

It is Petitioner's burden of proof to establish that she sustained accidental injuries arising out of and in the course of her employment. However, injuries are not arising out of employment where Petitioner is not exposed to a greater risk than the general public. The Arbitrator finds, based on Petitioner's own description of the accident, that Petitioner was not exposed to a greater risk than the general public when walking across California Avenue, which is owned and maintained by the City of Chicago. "Curbs, and the risks inherent in traversing them, confront all members of the public." *Caterpillar Tractor Company v. Industrial Commission*, 129 Ill. 2d 52, 62 (Ill. 1989).

Petitioner was crossing a public street and walking in an area where, according to her own testimony, the general public also walks. In fact, according to Petitioner, members of the general public were crossing California Avenue with her at the time of the accident in order to get to the courthouse. Although Petitioner parked in an employee only parking garage, she was not required to park there and could park elsewhere. The accident did not take place in the parking garage, but at California Avenue, which was across California Boulevard and a small park-like parkway from the garage. Consequently, the Arbitrator finds that Petitioner did not sustain an accident arising out of and in the course of her employment on July 22, 2013. Therefore, compensation is denied.

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

WAYNE TROY POTOCKI,

Petitioner,

vs.

NO: 14WC014507

STATE OF IL/VIENNA CC,

17IWCC0086

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, 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 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.

17IWCC0086

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: FEB 14 2017
MJB/bm
o-2/6/17
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

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

POTOCKI, TROY WAYNE
Employee/Petitioner

Case# **14WC014507**

17IWCC0086

STATE OF IL/VIENNA CC
Employer/Respondent

On 4/27/2016, 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 0.40% 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:

0969 THOMAS C RICH PC
6 EXECUTIVE DR
SUITE 3
FAIRVIEW HTS, IL 62208

0558 ASSISTANT ATTORNEY GENERAL
AARON WRIGHT
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT SYSTEMS
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

APR 27 2016

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

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Troy Wayne Potocki
Employee/Petitioner

v.

State of IL/Vienna C.C.
Employer/Respondent

Case # 14 WC 14507

Consolidated cases: N/A

17IWCC0086

An *Application for Adjustment 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 **September 2, 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. ☒ 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, **08/31/2013**, 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 **$59,259.00**; the average weekly wage was **$1,139.59**.

On the date of accident, Petitioner was **42** years of age, ***married*** with **1** dependent children.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $8,457.25, 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 care including, but not limited to, the ECU surgical release recommended by Dr. Wood, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Michael k. Nowak, Arbitrator

3/29/16
Date

ICArbDec19(b)

APR 27 2016

17IWCC0086

FINDINGS OF FACT

Petitioner claims that on August 31, 2013, while working as a Correctional Officer for Respondent, that he sustained a work-related injury to his left hand. On that date, Petitioner was assisting an inmate who was having a problem getting the door to his cell open. The lock to the door was stuck and Petitioner initially attempted to turn the key with his right hand, but began to use his left hand as well. After approximately 5 to 7 minutes, Petitioner was able to turn the key and unlock the door.

Petitioner testified that he felt discomfort in his left wrist but did not believe it to be serious. When the condition did not improve, Petitioner completed an Incident Report on September 3, 2013, which was received into evidence at trial. In that report, Petitioner stated that he had pain and discomfort in the left outer wrist and left outer arm areas (PX9).

Petitioner stated that he had not sustained any prior workers' compensation injuries to his left wrist. However, Petitioner did testify that he sustained a non work-related injury to the top part of his wrist in either 2009 or 2010.

Petitioner sought treatment with Dr. Elizabeth Eversmann, his family physician, on December 9, 2013. Petitioner informed Dr. Eversmann and that he hurt his left wrist while turning a key at work on August 31, 2013, and that he still had symptoms. She recommended conservative treatment, but when she saw Petitioner on February 17, 2014, his symptoms had not improved. She referred Petitioner to an orthopedic surgeon (PX3).

Petitioner was seen by Dr. John Wood, an orthopedic surgeon, on March 12, 2014. Dr. Wood examined Petitioner and noted tenderness over the extensor carpi ulnaris (ECU) tendon. Dr. Wood diagnosed ECU tendinitis, performed an injection and ordered physical therapy (PX6).

Dr. Wood saw Petitioner on April 7, 2014, and Petitioner had swelling over the ECU of the left wrist. Dr. Wood ordered an MRI scan which was performed on April 18, 2014. The MRI scan revealed ECU tendinitis and some arthritic changes. Dr. Wood saw Petitioner on May 1, 2014, and reviewed the MRI. Dr. Wood agreed that the MRI revealed ECU tendinitis. In regard to the arthritic changes, Dr. Wood noted that these arthritic changes were not on the ulnar side of the wrist where most of Petitioner's symptoms were. He recommended Petitioner undergo a surgical release of the ECU tendon (PX6; PX7).

Respondent had Petitioner examined by Dr. Anthony Sudekum on July 17, 2014. When examined by Dr. Sudekum, Petitioner complained of pain in the ulnar aspect of the left wrist. Dr. Sudekum's examination revealed swelling in the dorsal aspect of the distal ulnar head in the area of the ECU insertion. Dr. Sudekum opined that Petitioner's left wrist symptoms were not work-related because while Petitioner may have experienced some symptoms while turning a key on August 31, 2013, this did not constitute an "accident." (RX3).

Dr. Wood was deposed on April 1, 2015. Dr. Wood testified that Petitioner had ECU tendinitis and that the accident of August 31, 2013, was the cause of that condition. He recommended Petitioner have a surgical release of the ECU tendon (PX8; pp 9–10, 12–13).

Dr. Sudekum was deposed on April 28, 2015. On direct examination, Dr. Sudekum restated his opinion that Petitioner's left hand condition was not related to the key turning incident of August 31, 2013. He opined that Petitioner had a chronic arthritic condition and the accident described by Petitioner was not significant enough to cause any pathology (RX4; pp 24–25).

On cross-examination, Dr. Sudekum was asked whether the accident could have aggravated and exacerbated Petitioner's left wrist condition. In response, Dr. Sudekum stated, in part "... turning a key can aggravate a chronic condition of the wrist or hand." (RX4; p 54).

CONCLUSIONS

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

The Arbitrator finds that Petitioner was a credible witness and that his testimony was unrebutted. In this case, the evidence shows that Petitioner injured his left wrist when he used his hands to forcefully open a lock that was stuck during the performance of his job duties for Respondent.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that he sustained an accidental injury which arose out of and in the course of his employment with Respondent.

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

Dr. Wood testified that the accident of August 31, 2013, was the cause of the ECU tendinitis that he diagnosed.

Dr. Sudekum opined that the incident of August 31, 2013 was not an "accident." The Arbitrator initially notes that this is a legal conclusion. Further, while Dr. Sudekum stated it was not an "accident," when cross-examined, Dr. Sudekum, in fact, conceded this issue when he stated that Petitioner's turning of the key could "...aggravate a chronic condition of the hand or wrist."

The Arbitrator finds the opinions and testimony of Dr. Wood to be more persuasive than those of Dr. Sudekum in this case.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner's current condition of ill-being is causally related his employment.

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

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

The Arbitrator finds that all of the medical care rendered to Petitioner for his left hand injury was reasonably sought in the quest to relieve and or cure the effects of the work-related injury.

Respondent is therefore ordered to pay medical expenses of $8,457.25, as set forth in PX 1, pursuant to § 8(a) and § 8.2 of the Act. Respondent shall be given credit for medical benefits that have been paid through its

group carrier, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in § 8(j) of the Act.

Petitioner has had conservative treatment but his left hand symptoms have continued. Given the failure of conservative treatment to provide lasting relief, Dr. Wood recommended that Petitioner undergo a surgical release of the ECU tendon.

The Arbitrator therefore finds that Petitioner is entitled to prospective medical care including, but not limited to, the ECU surgical release recommended by Dr. Wood.

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TAMMY MORRIS-VELAZQUEZ,
Petitioner,

vs.

NO: 12 WC 25909

BRIGHTSTAR HEALTHCARE,
Respondent.

17IWCC0087

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical, prospective medical, average weekly wage (AWW), temporary total disability (TTD), choice of two physicians, balance billing, and temporary partial disability (TPD), and being advised of the facts and applicable law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all of the testimony, exhibits, pleadings and arguments submitted by the parties.

The Commission finds that Petitioner reached maximum medical improvement (MMI) as of August 12, 2013. Thus, she failed to prove that her current condition of ill-being is causally related to her May 19, 2012 work-related accident. Accordingly, her request for prospective medical treatment is denied. The Commission awards Petitioner all reasonable and necessary medical expenses through August 12. 2013. Petitioner is entitled to TTD and TPD benefits through October 9, 2012. All else is affirmed and adopted.

Petitioner began working as a CNA for Respondent on March 21, 2012. She worked from 7:00 a.m. until 7:00 p.m. on Mondays, Wednesdays, Saturdays, and Sundays. T.23. She also began working for Health Source/Abundant Life Chiropractic on May 7, 2012 performing marketing massages. She was paid $500.00 per week. T.24. She testified that she informed Sonia Delcampo, who was in charge of scheduling for Bright Star, of her second job. She stated that Delcampo took her off work the week of May 7, 2012 so she could perform massages at Butterfield Elementary for teachers' appreciation week. T.25.

On May 19, 2012, Petitioner was in the process of moving a patient when the patient began to fall. She used her right arm to break his fall causing her right arm to twist in front of her. T.34. She testified that she felt immediate pain all the way up her right arm. She described her patient as 6' 1" tall and weighed 190 pounds.

She contacted Phoebe Johnson, the head CNA to report the incident. T.35. Ms. Johnson came to the location about 30 minutes later and Petitioner went home. T.36.

Petitioner completed a report of injury on May 22, 2012. She reported that she felt a burning sensation then a sharp pain in her right arm. She also reported that she injured her right arm, bicep, and sustained a tricep tear. RX.1.

Petitioner was seen by Dr. Daniel O'Malley at Alexian Brothers on May 22, 2012 for knee pain, hand pain and arm pain. She reported her work injury. She noted weakness but no numbness and joint pain and swelling in the extremities of her right hand. The assessment was sprains and strains of the shoulder and upper arm, and a contusion of the upper limb. PX.7.

Petitioner was next seen by Dr. O'Malley on May 29, 2012 with continued arthralgias/joint pain and swelling in the extremities (dorsum of the right hand). She reported weakness and numbness that she described as moderate but worsening. She also reported more pain, numbness and tingling. She had limited range of motion of the right elbow. The assessment was contusion of the upper limb and "other disorder of the cervical region." An EMG and physical therapy was recommended. She was given restriction of no use of the right arm. PX.7.

Petitioner testified that she attempted to perform two massages for her second employer after her injury. The massages, however, caused more pain towards her neck, shoulder and trapezius area. It irritated her arms and caused more pain. T.27. She continued to perform marketing for her second employer through June 27, 2012. T.39.

Per the report from Healthsource of Lombard dated June 30, 2015, Petitioner worked the following dates and hours: May 30, 2012 for 2 hours; June 1, 2012 for 4 hours; June 4, 2012 for 30 minutes; June 6, 2012 for 2 hours 30 minutes; June 8, 2012 for 2 hours; June 11, 2012 for 3 hours; June 13, 2012 for 2 hours; June 18, 2012 for 1 hour; June 20, 2012 for 2 hours and 30 minutes; June 22, 2012 for 3 hours 15 minutes; June 25, 2012 for 3 hours; and June 27, 2012 for 1 hour.

In a letter dated August 26, 2015, HealthSource indicated that they do not have many records for Petitioner given how long ago she worked for HealthSource. They confirmed that she mentioned her injury and advised that performing massages aggravated her injury. She resigned July 11, 2012. They acknowledged Petitioner was paid $500.00 on May 15, 2012. PX.2.

Petitioner testified that she did not perform massages on the above dates. T.116.

Petitioner underwent an EMG on June 22, 2012 at Midwest Neurology. She had been complaining of neck, right shoulder, right arm, and right hand pain radiating proximally to the right arm, forearm, hand, and 4th, and 5th fingers since May 19, 2012. She also had numbness in the right arm, forearm, hand, and 4th and 5th fingers. The EMG of the right upper limb was within normal limits without signs supporting a diagnosis of radiculopathy, plexopathy or peripheral neuropathy. PX.7.

Respondent provided Petitioner with a light duty work agreement on June 26, 2012. Her work schedule was Saturday, and Tuesday through Friday from 8:30 to 5:00 and her rate of pay was $8.25 per hour. She was to perform general office duties that would not require the use of her injured arm. She was to notify her supervisor as soon as possible of any situation involving absences or tardiness. She was to advise of her doctor appointments and therapy. PX.28.

Petitioner testified that she was provided with the light duty work agreement on July 10, 2012. She refused to sign the agreement as she felt she was being picked on. She stated that the light duty schedule did not meet her restrictions as it did not allow for her to go to therapy. T.53.

Petitioner began physical therapy on July 2, 2012 at Atheltico. The diagnosis was "other disorders of cervical region." Per the history, Petitioner reported that she currently had no neck pain; however, she had increasing shock and burning pain in the medial aspect of her right elbow. She reported that any type of hand or elbow flexion movement severely increased her pain, which was 2 out of 10 at best and 10 out of 10 at worse. She was unable to perform her job duties secondary to pain and inability to use her right arm. Her shoulder internal rotation lacked 40 degrees. She was unable to move her arm behind her back. Her cervical range of motion was within normal limits. The physician noted that her subjective and objective findings were consistent with the diagnosis. She displayed decreased strength in the right shoulder, elbow, and wrist musculature as well as significant pain with any right upper extremity movement which contributed to her altered biomechanics and limited activity participation. PX.7.

Petitioner had a conversation with Jonathan Gray, a manager at Bright Star, on July 6, 2012. She began working light duty on July 7, 2012 shredding paper. She was provided a box and chair with no arms. She had to lift the paper out of the box, which required her to bend over at the waist to lift the paper. She then had to place it in the shedder. T.46. She had restrictions of no use of the right arm at that time, but had to use her right arm to move the box. *Id.* She last worked for Respondent on July 10, 2012. *Id.*

Dr. O'Malley authored a letter "To Whom It May Concern" on July 11, 2012 stating that Petitioner should be allowed to work 12 hour days to accommodate her physical therapy and she was not allowed to work more than 40 hour per week. PX.7.

Petitioner was seen by Dr. Gregory Drake of Core Orthopedics & Sports Medicine on referral from Dr. O'Malley on July 14, 2012. She reported right elbow pain that radiated up to the shoulder as well as down to the hand including the pinky and ring finger. Her pain went into her neck and head. She had headaches, and neck and back pain. She had mild pain in the right trapezius. Dr. Drake noted the x-ray of the elbow was negative and the x-ray of the cervical spine revealed good disc heights without instability or fracture. He diagnosed Petitioner with epicondylitis lateral – elbow, tendinitis/bursitis-shoulder lateral epicondylitis right elbow right upper extremity ulnar neuritis versus neuropraxia. He recommended a right elbow MRI to further delineate pathology. PX.8.

Petitioner testified that she had a telephone conversation with John Gray on July 25, 2012 and was advised that they were not going to accommodate her restrictions as they had already given her a light duty job that she needed to accept. Petitioner then followed-up with Mr. Gray via e-mail. Per the e-mail dated July 25, 2012, Petitioner indicated that Mr. Gray advised her that they could not accommodate her work-restrictions. Bright Star responded on July 27, 2012 indicating they would accommodate her restrictions. RX.16.

Jonathan Gray is the Director of Operations for Respondent and testified on behalf of the Respondent. He recalled offering Petitioner light duty. He noted that nothing in the light duty agreement indicated she would be fired if she was late. T.129. He noted that she did not accept the light duty offer in June 2012 as she was working for another company. T.130. On cross-examination, Mr. Gray stated that Petitioner would not have had to use her right arm for the light duty. She only had to shred a few pieces of paper at a time.

Petitioner testified that she moved from West Chicago to Elgin in July 2012 but did not injure herself as she did not move anything.

Petitioner underwent an MRI of the right elbow without contrast at Alexian Brothers Medical Center on August 11, 2012. The MRI revealed no significant internal derangement. There was mild redundancy of the triceps tendon at its insertion and minimal joint effusion laterally. The collateral ligaments were intact and there was no stress fracture. PX.16.

Petitioner was seen by Dr. Drake on August 20, 2012. He reviewed the MRI with her and noted that her right elbow was work-related and she needed continued therapy. She was to remain off work. PX.8.

Petitioner underwent a Section 12 examination with Dr. Leon Benson of Illinois Bone and Joint on September 24, 2012. Petitioner reported she has had paresthesias, pain, and sharp

burning in her arm from her shoulder down into her finger tips, mostly in the ulnar distribution in her hand, which was quite debilitating. She had almost full passive range of motion in the right shoulder, but was tender at the extremes of motion. She had some rotator cuff weakness, but no focal neurologic deficit. She had normal elbow motion in all planes, but was tender about the medial epicondyle less so laterally. She had normal passive motion of the right wrist and forearm. Dr. Benson opined Petitioner probably had a brachial plexus injury as a result of her injury. He recommended a repeat EMG and noted that the first EMG may have been performed too soon after the accident to pick up her findings. He opined that her current condition was related to the injury and she was not at MMI. It could take many months for her to obtain MMI. He also recommended an MRI of the shoulder and/or the neck. She could work with no use of the right arm. He noted that her injury may not require any invasive treatment. PX.6.

Petitioner began working for CMK Investments/All Lenders on October 1, 2012 and worked for them through January 8, 2013 as an office manager. T.55. She testified they accommodated her physical therapy. *Id.*

On October 9, 2012, Bright Star sent Petitioner an e-mail and a letter indicating that they had work available to her within her restriction. PX.42. She was to work Monday through Friday from 8:30 a.m. to 5:00 p.m. They would accommodate her physical therapy and time missed would be made up Saturday mornings. The rate of pay was $8.25 per hour. They reiterated that the job would in no way interfere with her right arm. RX.16.

Petitioner testified that she did not accept the position as she had a light duty position with CMK/All Credit Lenders paying $10.00 per hour. T.57.

Petitioner responded on October 17, 2012 indicating that she could not accept the position as they could not accommodate her earlier restriction. Her TTD benefits were stopped so she accepted a position as a loan manager earning $10.00 per hour. The new company was aware of and accommodating her restriction. PX.43.

Petitioner underwent an EMG of the right and left upper extremities at Midwest Neurology on October 31, 2012. The study was within normal limits without signs supporting a diagnosis of radiculopathy, plexopathy, or peripheral neuropathy. The Brachial Plexus study was normal bilaterally. PX.8.

Petitioner followed-up with Dr. Drake on November 8, 2012 following her EMG/NCV. Dr. Drake noted the EMG revealed no evidence of brachial plexopathy, cervical radiculopathy, or peripheral neuropathy. She continued, however, to complain of pain along the medial and lateral aspect of the right elbow, and she now had muscular pain in the right side of the upper thoracic region. He did not see anything structurally on the MRI or neurologically wrong on the EMG. She continued to complain of paresthesias in the ulnar nerve distribution in the right upper extremity. He noted that her cervical and shoulder exam was normal. He referred her to Dr.

Kelly Holtcamp for a second opinion. He did not believe she required a cervical or shoulder MRI. PX.8.

Petitioner testified that she saw Dr. Joshua Alpert of Midwest Bone & Joint instead of Dr. Holtcamp as she had previously treated with Dr. Alpert.

Petitioner was seen by Dr. Alpert on November 28, 2012 for right arm pain. She had full range of motion of the shoulders without pain. X-ray of the cervical spine was normal. He noted that her neck work up had been limited. He recommended an MRI of the neck. She was to continue with physical therapy. PX.9.

Petitioner underwent a cervical MRI on December 12, 2012 that revealed moderate central and right upper sided spurs at C6-C7 with encroachment on the anterior right paracentral thecal sac and right neural foramen. In a handwritten note on the report, it was noted that he disagreed as he did not see any significant cervical nerve root compression on the MRI. The person's name is illegible. PX.9.

Petitioner followed-up with Dr. Alpert on December 19, 2012 and was referred to Dr. James Fister of Midwest Bone & Joint.

Petitioner was seen by Dr. Fister on January 16, 2013 for her cervical pain. She developed right posterior neck pain with flexion and extension and had pain radiating to the right shoulder and right scapula. He noted that the MRI of the cervical spine revealed a very small disc herniation at C6-C7, that was mild and diffused and not causing any significant nerve compression. He did not see any large disc herniation or any indication for surgery. She was not tender over the lateral epicondyle and not tender over the medial epicondyle, and active flexion and extension motion of the right wrist against resistance did not produce elbow pain. He referred her to a neurologist. In his letter to Dr. Wilkerson, he noted that her condition was consistent with chronic neck pain, chronic numbness and pain travelling down the arm. He was not recommending surgery as the EMG and MRI did not reveal any significant disc herniation and no cervical nerve root compression. PX.8.

Petitioner was seen by Dr. Barry Bikshorn, a neurologist, of Northwest Neurology on January 30, 2013. She had pain in the right neck and shoulder including scapula and upper arm. Lifting aggravated her pain. He noted that she underwent a cervical MRI on December 12, 2012 that revealed a moderate right sided spurring at C6-C7 with encroachment upon the right neural foramina. Physical therapy was recommended but surgery was not. The therapy was delayed due to workers' compensation. Examination revealed some tenderness to the right paraspinal muscles and slight decreased range of motion. The assessment was a headache and facial pain, cervicalgia, neck pain, and limb pain. He noted that it was unclear whether or not all of her right upper extremity symptoms could be explained on a radicular process at C6-C7 raising the possibility of possible brachial plexus stretch injury. He recommended physical therapy of the neck. PX.8.

Petitioner testified that her nurse case manager, Kathy Pearson, advised her that Dr. Bikshorn would not accept workers' compensation patients. She therefore went to Dr. Nicholas Schlageter of Tri-City Neurology. T.62.

Petitioner was seen by Dr. Schlageter on referral from Dr. Wilkerson on February 13, 2013 for right arm pain, neck pain and headaches. She reported a sharp burning pain in the thumb and index finger up the medial side of the forearm to the elbow. She had sharp pain in the upper arm, and neck pain especially when she looked up, and some burning pain going down the back. He recommended continued therapy and an MRI of the cervical spine. PX.11.

On February 26, 2013, Dr. Schlageter sent a letter to Ms. Pearson indicating that Petitioner could work with restrictions of no use of the right arm. T.64.

Petitioner underwent an MRI of the cervical spine on February 28, 2013. The MRI revealed mild disc degeneration and mild stranding in the cervical spine. There were mild disc bulges and protrusions for canal or foraminal stenosis especially at C5-C6 and C6-C7. PX.10.

Petitioner testified that she contacted Jim Flickinger, owner of Bright Star, on February 28, 2013 asking if light duty was available as she had been laid off at All Credit Lenders. Mr. Flickinger advised her that they did not. T.65.

On March 1, 2013, Petitioner sent an e-mail to Jonathan Gray of Bright Star asking if light duty was available. PX.51.

Petitioner was seen by Dr. Schlageter on March 6, 2013 for right arm pain. Examination of the cervical spine revealed that she lacked full range of motion with elevation of the head and she had mild tenderness to palpation in the cervical area. The assessment was a cervical strain. PX.11.

On March 8, 2013, Petitioner sent an e-mail to Bright Star again asking for light duty work. PX.54.

On March 11, 2013, Jim Flickinger sent a letter to Petitioner indicating that since she declined their October 17, 2012 light duty offer as she was working for another company, they accepted her voluntary resignation. She was not to contact any employees and could only communicate with him. PX.55.

Petitioner responded to the letter on March 12, 2013 and indicated that it was her intention to continue to work for Bright Star as a CNA. She never resigned. She accepted another position as Bright Star could not accommodate her restrictions and she was not being paid TTD. PX.56.

17IWCC0087

Dr. Schlageter referred Petitioner to Illinois Spine Institute for pain management on April 3, 2013.

Petitioner was seen by Dr. Lami on April 17, 2013. He noted the MRI revealed a slight disc protrusion at C6-C7 with some foraminal stenosis and a disk bulge at C5-C6. The impression was cervicalgia with a component of radiculitis. He recommended a trial cervical epidural injection. He did not see any surgical pathology on the MRI. PX.10.

Per the wage statement from Dovenmuehle Mortgage, Petitioner earned wages between May 24, 2013 and August 30, 2013. Her rate of pay was $10.00 per hour. She voluntarily resigned August 16, 2013. PX.4. Petitioner testified this was light duty work and she wore a headset to make calls. T.82.

Petitioner underwent one injection and on July 15, 2013 and noted that her pain returned. She reported pain in her neck, scapula that radiated down to her right arm all the way to the distal elbow. Dr. Lami recommended another epidural injection and noted that if she did not improve, he would then want to review the actual MRI to determine the next step. PX.10.

On August 12, 2013, Petitioner saw Dr. Lami and noted that the second injection helped but she still had some pain in her arm. He reviewed the MRI and did not see a surgical target. She reported she was moving to Missouri so Dr. Lami provided her with a referral to a Missouri doctor. PX.10.

Petitioner moved to Nevada, Missouri in August 2013. She did not injure her neck, right shoulder, right arm, or right elbow during the move. T.75. She stated that she has been treating since August 12, 2013 just under her regular insurance as her Missouri doctors did not take workers' compensation claims. T.76.

Petitioner worked at Casey's General Store as a manager in Missouri from April 13, 2014 through April 17, 2014. She had to stand the entire time which aggravated her pain.

Petitioner next worked at Conway Freight through Manpower from June 13, 2014 through June 24, 2014. She would input their bill of ladings into the computer. She stopped working because she tested positive for Hydrocodone. T.85.

Respondent offered the following Facebook photos and posts of the Petitioner into evidence:

- Petitioner posted that she stood at the car rental for one hour and never moved. She took a shuttle back to the airport and then to the motel. She was hungry and very tired. RX17.

- On March 14, 2014, Petitioner posted that she had her workout going on at the YMCA, "I love it when u call me big poppa." RX.17.

- On March 31, 2014, she posted getting our work out on. Petitioner is seen in a photo taking a selfi at the gym. RX.17.

- On April 25, 2014, she posted a photo of her performing a leg press. RX.17.

- On October 31, 2014, she posted a photo of herself looking up.

- On November 29, 2014, Petitioner posted that she slept in her husband's truck last night. She also posted that she was visiting her hubby in Kansas City. RX.17.

- On December 24, 2014, Petitioner posted a photo of her and said "just call me super mom." She is posing with her right arm up on her head. RX.17.

- On January 5, 2015, Petitioner posted a photo stating that she had to work off bomb bay food...@gym. RX.17.

Petitioner testified on cross-examination in regards to the above Facebook photos. She stated that the photo of her turning her head and lifting both arms up was posted on March 31, 2014 but it was an old photo from around 2006. T.118. There was also a photo of her doing leg presses on April 25, 2014, which she stated was another old picture. *Id.* She also testified that she does stretching at the gym, which her therapist recommended. T.123.

Petitioner worked at US Bank from November 10, 2014 through January 21, 2015 as a "Difi" Administrator. T.86. She assisted with inbound and outbound calls. She woke up one morning and could not move her neck. She was terminated as she needed another day off. T.87. She earned $8.75 per hour. T.88.

Respondent obtained a Section 12 examination from Dr. Mitchell Rotman of the Orthopedic Center of St. Louis on January 26, 2015. Dr. Rotman stated that Petitioner had a prolonged course of treatment for a minor elbow strain. Her complaints significantly progressed with little objective correlation. He saw no evidence of injury and she was in no need of work restrictions. He noted that Petitioner was seeing his partner Dr. Gornet later that day. While he had not seen the x-rays or MRI of her neck, based on the clinical exam, he saw no reason for any further neck treatment that was related to the work accident. She was at MMI relative to her elbow. She sustained 0% impairment relative to the accident. RX.13.

Respondent also obtained a Section 12 examination with Dr. Matthew Gornet of The Orthopedic Center of St. Louis on January 26, 2015. Dr. Gornet performed an MRI and noted there was a lobulated massive C6-C7 disc herniation, the largest in the right lateral recess and central neural foramen up to 7.5 mm in thickness. There was marked right greater than left

ventral cord flattening, moderate central canal stenosis, and severe bilateral recess and foraminal stenosis. A small cord syrinx was observed just below the herniated disc, likely secondary to cord compression at the disc herniation level. RX.2.

Dr. Gornet noted that his examination revealed pain in her right shoulder that branched up toward her neck, scapula, right arm, right elbow, forearm and hand. She had mild decreased range of motion in her cervical spine. She had decreased wrist volar flexion and triceps on the right at 4 to -4/5. He noted that the December 12, 2012 MRI was of moderate to poor quality, but clearly showed an annular tear and disc herniation, at a minimum, centrally and more to the right at C6-C7. The subsequent MRI of January 26, 2015 revealed an obvious increase in size of the herniation/annular tear at C6-C7. Foraminal views revealed no significant foraminal stenosis on the left at C5-C6 or on the right at C5-C6. He opined that Petitioner suffered a work-related C6-C7 disc injury. Her symptoms of arm, shoulder and elbow pain with intermittent numbness and tingling were fairly classic of this injury. He noted that the early MRI revealed disc pathology at C6-C7. He stated that EMGs can be negative in spite of a person having significant radicular pain and symptoms. The disc pathology on the original MRI had progressed into a larger disc herniation. She suffered from significant radiculopathy at C6-C7. Her objective findings on the physical exam correlated with the objective findings on her previous MRI as well as her current MRI. She was not at MMI, but could continue to work. She required a cervical disc replacement and he noted that he would expect her to rapidly return to full-duty work without restrictions thereafter. RX.2.

Dr. Gornet was deposed on September 18, 2015. He is a board certified orthopedic surgeon. He stated that Petitioner had complaints of very early neck pain, pain in the shoulder, and pain in the arm with tingling. Just because the doctors had not arrived at a diagnosis did not mean that the diagnosis was not present. PX.23. pg.21. He stated that the EMGs were false negatives. PX.23. pg.22. He noted that the MRI scans fit identically with her distribution. *Id.* Based on his examination, he diagnosed Petitioner with a disc injury at C6-C7 as part of her work related injury. Her symptoms of arm, shoulder, elbow pain, and intermittent numbness and tingling were classic of this injury. The MRI revealed pathology at C6-C7. Her herniation had progressed because of the effects of her work related injury. She has had persistent symptoms since the time of her injury and her persistent symptoms have been remarkably consistent over a period of time. PX.23. pg.43. She would benefit from surgery. He considered the December 12, 2012 MRI very early objective pathology that substantiated her complaints. PX.23. pg.45. He stated that if the information provided to him was not factually correct, then he could change his opinion. PX.23. pg.48.

On cross-examination, he stated that the annular tear at C6-C7 was caused by the work accident. PX.23. pg.67.

On re-direct examination, he stated that her symptoms in the beginning were consistent with cervical spine pathology. PX.23. pg.73. As of June 22, 2012, she had pain and weakness in her shoulder and arm. Thus, the diagnosis of epicondylitis was not consistent with her history.

PX.23. pg.74. Rather, it was fairly consistent a cervical spine issue. *Id.* He stated that the annular tear is present on both MRIs. PX.23. pg.83.

Petitioner worked at Butler & Davidson as an office manager from August 24, 2015 through August 25, 2015 earning $8.00 per hour. T.90. She was let go because her daughter skipped school and a parent came into her place of employment to let her know. She stated that the company does not like drama in the office, so she was let go. *Id.*

Petitioner began working at Joe Clark, a residential care home as a certified medication administrator on October 6, 2015. She earns $8.75 per hour and is paid per month.

Petitioner stated that she has pain down her right arm with numbness in her pinkie and ring finger. She has pain in her right arm, in the tricep and bicep, and elbow and forearm down to her fingertips. Every morning she has to stretch as her right arm is numb. T.97. She has 50% weakness in her right arm with limited range of motion. She cannot brush her hair with her right arm. She is very painful and has a lot of aching and throbbing. T.98. Her condition is the same, if not worse, from when she last saw Dr. Lami in August 2013. T.100. She cannot perform the duties of a CNA or massage therapist.

In resolving disputed issues of fact, including issues related to causation, it is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999).

The Commission finds that the record does not support any significant ongoing cervical issues after August 12, 2013. In support of its position, the Commission notes that the two EMGs were both within normal limits and demonstrated no evidence of radiculopathy. While Dr. Benson noted that the first EMG performed June 22, 2012 may have been performed too soon after the accident, the second EMG was performed October 31, 2012 and again demonstrated no evidence of radiculopathy. The Commission notes that the two EMGs are in conformance with one another and both demonstrate no evidence of radiculopathy.

Further, the Commission notes that the physical therapy record from July 2, 2012 revealed that Petitioner did not have any neck pain and her cervical range of motion was within normal limits. Dr. Schlageter noted Petitioner sustained a strain only. When the Petitioner saw Dr. Drake on July 14, 2012, the x-ray of her cervical spine revealed good disc height without any instability, and Dr. Drake noted on November 8, 2012 that her cervical and shoulder exam were both normal. Furthermore, Dr. Fister noted on January 16, 2013 that the MRI revealed only a very small disc herniation at C6-C7 that was mild and diffused, and not causing any significant nerve compression. When she last saw Dr. Lami on August 12, 2013, she indicated her second injection helped. The record establishes that Petitioner then had a 17 month gap in treatment.

During the gap in medical treatment from August 2013 and January 2015, Petitioner moved to another state, worked several different jobs, and made several Facebook posts that are contrary to her claimed level of disability. The Commission is not persuaded by Petitioner's testimony that the Facebook posts were several years old and that she just reposted the photos. The Commission notes that the evidence contradicts Petitioner's claim of pain as she is seen at a gym performing leg presses, and she is seen posing with her right arm on her head. Yet she testified that she cannot brush her hair. The evidence does not demonstrate a person suffering from any ongoing cervical issues.

While the Petitioner testified that she received some medical treatment in 2014 while in Missouri, no records were offered to substantiate her testimony. The Commission will not speculate as to whether she received care relative to her work injury during those visits.

The Commission is also not persuaded by Dr. Gornet's Section 12 opinion. His opinion was not rendered until several years after the accident and he is the only physician who is recommending surgery. Dr. Gornet noted that his opinion is partially premised upon Petitioner's complaints of pain and his opinion could change if the information provided to him was not factually correct. The Commission notes that Petitioner's complaints of pain are not borne out by the evidence. The Commission finds that overall the evidence does not support Dr. Gornet's opinions.

Accordingly, the Commission finds Petitioner reached MMI as of August 12, 2013, which is the last day she received medical treatment before her nearly 17 month gap in medical treatment. Her actions thereafter are not indicative of a person with any ongoing issues and are not consistent with her subjective complaints. Petitioner is entitled to all reasonable and necessary medical expenses through August 12, 2013.

The Commission also finds that Petitioner is not entitled to prospective medical treatment as recommended by Dr. Gornet. As stated above, the Commission does not find Dr. Gornet's opinion persuasive. Rather, the Commission notes that Dr. Bikshorn, Dr. Fister, and Dr. Lami have all indicated that Petitioner is not a surgical candidate. The Commission finds their opinions more persuasive than Dr. Gornet's opinion.

The Commission also modifies the award of TTD and TPD, and finds Petitioner is entitled to TTD and TPD benefits through October 9, 2012 only. The Commission notes that Respondent offered Petitioner a position within her restrictions on October 9, 2012. However, she accepted another position and refused their offer. Accordingly, the Respondent is not liable for TTD or TPD benefits after October 9, 2012.

IT IS THEREFORE ORDERED BY THE COMMISSION, that the Decision of the Arbitrator filed February 29, 2016, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $564.88 per week for a period of 13 weeks, June 28, 2012 through July 6, 2012 and July 11, 2012 through September 30, 2012, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary partial disability benefits as provided in Section 8(a) of the Act for 7-3/7 weeks, May 20, 2012 through June 27, 2012, July 7, 2012 through July 10, 2012 and October 1, 2012 through October 9, 2012.

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 $7,800.00. 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: FEB 14 2017

Michael J. Brennan

MJB/tdm
O: 1/10/17
052

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MORRIS, TAMMY A/K/A VELAZQUEZ, TAMMY Case# **12WC025909**
Employee/Petitioner

BRIGHT STAR HEALTHCARE
Employer/Respondent

17IWCC0087

On 2/29/2016, 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 0.45% 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:

5541 FRED J BEER LAW OFFICES
2295 VALLEY CREEK DR
SUITE K
ELGIN, IL 60123

2965 KEEFE CAMPBELL BIERY & ASSOC
PANKHURI K PARTI
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

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

Tammy Morris a/k/a Tammy Velazquez
Employee/Petitioner

v.

Bright Star Healthcare
Employer/Respondent

Case # 12 WC 25909

Consolidated cases: _____

17IWCC0837

An *Application for Adjustment 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 **Geneva**, on **12/8/15**. 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 **Did petitioner exhaust her choice of two doctors?**

FINDINGS

On **5/19/12**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$2,976.50 = 8 4/7 weeks and $500.00 = 1 week concurrent income**; the average weekly wage was **$847.32.**

On the date of accident, Petitioner was **36** years of age, ***married*** with **6** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services. **Petitioner did not violate the "two doctor rule".**

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

Respondent shall be given a credit of **$3,095.71** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

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

ORDER

Respondent shall approve and pay reasonable and necessary medical services, pursuant to the medical fee schedule for the treatment recommended by Dr. Gornet and also pay medical bills to:

• Petitioner for Alexian Brothers Medical Group unpaid medical bill and co-pay (PX7)	$ 25.00
• CORE Orthopaedic and Sports Medicine (PX8)	$ 274.87
• Midwest Bone & Joint Institute MRI (PX9)	$2,010.00
• Illinois Spine Institute (PX10)	$ 632.57
• Dr. Nicholas Schlageter, M.D. of Tri Cities Neurology (PX11)	$ 690.00
• Dr. Barry H. Bikshorn, M.D. of Northwest Neurology (PX15)	$ 40.00
• Orthopedic Center of St. Louis cervical x-rays (PX24)	$ 274.00
• MRI Partners 1/26/15 cervical MRI (PX22)	$2,150.00
Total Unpaid Medical Bills	**$6,096.44**

as provided in Sections 8(a) and 8.2 of the Act and respondent shall receive a credit for any prior payments made and balance billing will not be allowed.

Respondent shall pay Petitioner temporary partial disability benefits as provided in Section 8(a) of the Act for 54 5/7 weeks for the following weeks: 5/20/12-06/27/12, 7/07/12-07/10/12, 10/1/12-01/08/13, 04/29/13-08/12/13, 04/13/14-04/17/14, 06/13/14-06/24/14, 11/10/14-01/21/15, 08/24/15-08/25/15, and 10/6/15-12/08/15.

Respondent shall pay Petitioner temporary total disability benefits of $564.88 per week for 127 4/7 weeks, as provided in Section 8(b) of the Act for the following weeks: 06/28/12-07/06/12, 07/11/12-09/30/12, 01/09/13-04/28/13, 8/13/13-04/12/14, 04/18/14-06/12/14, 06/25/14-11/09/14, 01/22/15-08/23/15, and 08/26/15-10/05/15.

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TAMMY MORRIS VELASQUEZ, Petitioner, v. BRIGHT STAR HEALTHCARE, Respondent,	)	Case No: 12 WC 25909 Geneva

17IWCC0087

ADDENDUM TO THE DECISION OF THE ARBITRATOR

This case tried before Arbitrator Jessica A. Hegarty in Geneva, Illinois pursuant to Sections 19(b) and 8(a) of the Illinois Workers' Compensation Act on December 8, 2015. (Arbitrator's Ex. 1)

Petitioner testified that she is 39 years old, married, and has six children. She lived her first 28 years in California.

Prior to May 19, 2012, she did not have any problems with her neck, right shoulder, right arm, or right elbow. She is right hand dominant.

From 1994 to 1995, Petitioner attended Pacific Travel Trade college/school in Long Beach, CA. She studied medical billing, business computer operations, and office skills.

From 1996 to 2003, she worked in various secretarial jobs through a temporary worker agency.

In 2004, she underwent training and education to become a Certified Nursing Assistant ("CNA"). She obtained her certification and was trained at her employer, Medical Lodge, in Nevada, Missouri. She underwent a three month, hands on, program where she learned skills such as proper patient lifting, bed pan service, and feeding. She worked for Medical Lodge for about one year.

From 2005 to April 2007, she worked for Prairie Crest Assisted Living in Beaver Dam, WI and obtained her certification as a Certified Medication Administrator ("CMA") after completing the three month CMA program. While working as a CMA, she also worked for Alliance Building Plumbing as an office manager and secretary.

Prior to working for Respondent Bright Star Health Care, she worked for about 15 years as a Certified Nursing Assistant ("CNA") and or a massage therapist.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 5/19/12 through 12/8/15, and shall pay the remainder of the award, if any, in weekly payments. Respondent shall be given a credit of $3,095.71 for temporary total disability benefits that have been paid.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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. Myatt

Signature of Arbitrator

2/25/16
Date

FEB 29 2016

From May 2007 through July 2010, she worked as a CNA for Provena St. Joseph Hospital in Elgin, IL. She worked in the ER/triage, charted and transported patients and took blood pressure. In 2010, she attended the European Massage Therapy School in Skokie, IL. She studied and learned how to do acupressure, deep tissue, and Swedish massage techniques.

From August 2010 through December 2011, she worked as a massage therapist for Bodies in Balance in Bartlett, IL. She managed the office, set appointments, answered phones, conducted marketing, provided massages, assisted the doctors/chiropractors with patient therapy, administered hearing pads, and other activities.

On September 30, 2011, she underwent a physical exam at with Dr. Clifford Kearns, D.C. of the Center for Physical Health. (PX5). The records indicate her major concern was tension. She reported sometimes when waking up she had numbness in her hands due to giving messages, but had no pain in her hands. She had a dull ache in her upper back. No pain, numbness or other problems with her neck, right shoulder, right arm, or right elbow. Dr. Kearns issued a note indicating, "I have given this patient a physical exam today and find her able bodied and physically capable of performing the work of a CNA."

Petitioner started working on March 21, 2012 as a CNA for Respondent who assigned her to work at a retirement community known as Windsor's Park Residence in Carol Stream, IL. She generally worked 12 hours a day on Monday, Wednesday, Saturday, and or Sunday.

In late April or early May of 2012, Petitioner informed Respondent's nurse scheduler, Sonia Del Campo, that she was going to start working as a massage therapist for Abundant Life Chiropractic a/k/a Healthsource in Lombard, Illinois. (PX2) Petitioner informed Ms. Del Campo that she could not work for Bright Star the week of May 7, 2012 through May 13, 2012 because she had to work at an elementary school in Lombard doing chair massages for teachers during teacher appreciation week. She did the massages that week and was paid $500.00 for her first week of work from May 7 through May 13, 2012. Her job at Abundant Life/Healthsource involved doing marketing by doing free massages for potential clients like the teachers. She also handed out flyers at a golf event, did other marketing activities and assisted the doctors in the office with instruction on corrective exercises, and other activities.

In the first week of May 2012 at Windsor's Park Residence, Petitioner suffered a work injury to her right hand when she was assisting a male patient/resident (Dr. Cole) whom she described as about six foot tall, 190 pounds. She assisted him down a hallway with a gait belt wrapped around him and her hands on the right and left side of his body when he rocked to the right causing the top of

her right hand to strike a hallway railing. Her hand swelled and bruised. She did not injure her neck, right shoulder, or right elbow. She told Respondent about the incident but did not want to report it as a work injury claim and did not hire a lawyer to file a workers' compensation claim because it was not a major injury and she thought it would heal with time.

On May 19, 2012, Petitioner was working at Windsor's Park Residence, assisting Dr. Cole get from a sitting to a standing position. Petitioner testified that Dr. Cole was about to fall, but she grabbed him with her right arm and tried to pull him back. She felt an immediate burning and pain sensation in her right forearm and elbow. She reported the injury to Respondent. About an hour and a half later Respondent replaced her with another CNA. She worked for approximately one to two hours on May 19, 2012.

After her May 19, 2012 work injury, she continued working at Abundant Life/Healthsource. (PX2). She did marketing in the office and assisted the doctors in the office with instruction on corrective exercises. She tried to do two massages while sitting, but her pain and discomfort in her right arm and neck prevented her from doing massage therapy. She normally would do full body massages while standing. The last day that she worked at Abundant Life/Healthsource was on June 27, 2012. (RX2).

On May 22, 2012, Petitioner completed an employee's incident report (RX1) and her manager, Jonathan Gray, prepared a First Report of Injury or Illness. (RX16).

On May 22, 2012, Petitioner presented to her primary physician, Dr. Daniel O'Malley at Alexian Brothers Medical Group who noted a history of a right arm injury at work on May 19, 2012 and an injury to her right hand when she struck it on a rail at work. (PX7). The doctor diagnosed "sprains and strains of the shoulder and upper arm" and a "contusion of [the] upper limb". He issued a note indicating that Petitioner may return to work with the restrictions of no use of right arm until re-evaluated on May 29, 2012. Petitioner provided this note to Respondent. (PX7, 26).

On May 29, 2012, Dr. O'Malley re-examined Petitioner and noted complaints of joint pain and swelling in right hand with weakness and numbness. Upon exam, she had tenderness of the dorsum of the right hand and limited range of motion of the right elbow. He diagnosed a "contusion of the upper limb" and "other disorders of cervical region". He recommended an EMG for her right arm and ordered physical therapy. He also issued a letter indicating she was on restricted light duty and may not use her right arm. Petitioner faxed/provided this note to Respondent. (PX7, 27).

On June 20, 2012, the claims adjuster sent a check to Petitioner in the amount of $220.00 for her time off representing 1 week of temporary total disability (TTD) for the period of May 22-28, 2012. (RX15).

On June 22, 2012, Dr. Andrew D. Ta, D.O. of Midwest Neurology conducted an EMG of Petitioner's right upper extremity. (PX14). Dr. Ta noted a history of complaints since May 19, 2012 of neck, right shoulder, right arm and right hand pain, radiating proximally to the right arm, forearm, hand, and fourth, and fifth fingers, with numbness in the right arm, forearm, hand, and fourth, and fifth fingers. The doctor further noted complaints of weakness of the right arm, forearm, and hand and that the symptoms occurred after a work related injury. The EMG impression was within normal limits without supporting a diagnosis of radiculopathy, plexopathy, or peripheral neuropathy. (Id.)

On June 26, 2012, Dr. O'Malley re-examined Petitioner and ordered that she proceed with physical therapy. On June 28, 2012, Dr. O'Malley prepared and electronically signed a letter indicating that Petitioner should be allowed to work but with limited use of her right arm and that she may need to see an orthopedic physician if her symptoms persisted. Petitioner provided this letter to the Respondent. (PX7, 29).

Petitioner underwent physical therapy at Athletico from July 2, 2012 through November 7, 2012. (PX12).

On July 2, 2012, Petitioner proceeded with her physical therapy initial evaluation at Athletico. (PX12). She provided her May 19, 2012 work injury history. The records indicate: "She states she felt an immediate burning pain and 'shock' sensation in the medial aspect of her right elbow, as well as numbness in the right side of her neck and tingling in digits 4 and 5. She states that currently she has no neck pain, however has increasing 'shock and burning pain' in the medial aspect of her right elbow. ... She states she had an EMG done and states there were no significant findings. She states she does not think this is related to her neck." Petitioner could not do all the physical therapy exercises. She was in extreme pain and had neck spasms. (Id.)

A case manager named Kathy Pearson was assigned to Petitioner's case.

On or about July 6, 2012, Jonathan Gray, Petitioner's manager, called Petitioner and asked if she could work 8 hours every Saturday doing light duty work such as shredding papers.

On July 7, 2012, Petitioner worked 3.5 hours on light duty for Respondent. At times, she had to use her right arm because she had to sit in a chair with no arms with a box full of documents next to her. She had to bend down to pick

of the paper documents and put them in the shredder. From July 9, 2012 through July 15, 2012, Petitioner worked an additional 7 hours. (PX57).

On July 7, 2012, the adjuster sent a TTD check to Petitioner in the amount of $1,650.00 for the period of May 29, 2012 to July 2, 2012. (RX15).
On July 10, 2012, Mr. Gray asked Petitioner to sign a Light Duty Work Agreement dated June 26, 2012. (PX28). The agreement stated she would work 8:30 a.m. to 5 p.m. on Saturday, Tuesday through Friday. She would work a 40 hour work week at $8.25 per hour. She would be doing general office duties including various projects that would not require the use of her injured arm. She was to report to Respondent at its Wheaton location on July 10, 2012 at 8:30 AM. Petitioner refused to sign the agreement and told Respondent that her attorney needed to review the agreement. She worked 3.5 hours that day which was the last day she worked for Respondent. (PX57).

On July 11, 2012, the adjuster sent a TTD check to Petitioner in the amount of $330.00 for the period of July 3-9, 2012.

On July 11, 2012, Dr. O'Malley re-examined Petitioner. She had problems with medial epicondylitis, sprain of the shoulder and upper arm, and disorder of her neck. He prescribed tramadol and again requested the EMG of the upper extremity since she had pain, numbness, heaviness to the right arm and hand. He also issued a letter advising that she was undergoing evaluation and treatment for severe arm pain. It was his recommendation that she be allowed to work 12 hour days to accommodate her physical therapy schedule, which was vital for her improvement and ability to return to normal capacity. She should not work over 40 hours per week. Dr. O'Malley referred Petitioner to Core Orthopedics & Sports Medicine. That day, Petitioner faxed the letter to her employer. (PX7, 30).

From July 14, 2012 through November 8, 2012, Petitioner treated with Dr. Gregory Drake, D.O. of Core Orthopedics & Sports Medicine examined Petitioner. (PX8).

On July 14, 2012, Dr. Drake examined Petitioner. (PX8). She reported her work injury, the negative EMG, and complaints of right elbow pain that radiated up to the shoulder as well as down to the hand including the pinky and ring finger. She described her arm as "heavy." She also had a tingling sensation into her right hand particularly in the small and ring fingers. Her symptoms were constant, burning, sharp, stabbing, throbbing, aching, stiffness, tingling, weakness, fatigue, range of motion limitation, radiation of pain on the involved side with sleep disturbances. Her pain went into her neck and head. Symptoms had been worsening. He took x-rays of her elbow showing no abnormality. He diagnosed lateral epicondylitis of the right elbow

and right upper extremity ulnar neuritis versus neuropraxia. He prescribed Naproxen and an unloader brace for the right elbow. Petitioner testified that Dr. Drake recommended an MRI of her right elbow and issued a work status report indicating that effective July 16, 2012 she could return to work with the restrictions of left-handed duties only up to 35 hours a week, and 12 hour shifts to allow for physical therapy appointments. Petitioner faxed/provided this note to Respondent. (PX8, 31)

On July 18, 2012, Mr. Gray called Petitioner and indicated that Respondent could not accommodate her doctor restrictions. She asked Gray to call her if Respondent could accommodate her.

On July 25, 2012, Petitioner wrote a memo (PX32) regarding her July 18, 2012 phone conversation with Respondent and provided Respondent with copies of the July 11, 2012 Dr. O'Malley restriction (PX30) and the July 14, 2012 Dr. Drake restriction. (PX31).

On July 26, 2012, Petitioner's attorney faxed and sent a letter to Adjuster Aldridge notifying her that his law firm was representing Petitioner. (PX33) He provided the limited medical records that he had and the pay stubs from her secondary employer Abundant Life/Healthsource for work done after her work injury. He requested the payment of TTD/TPD taking into account her secondary employment income and a wages she earned after the work injury because Respondent could not accommodate the recent work restriction orders. (Id.)

On July 27, 2012, Respondent sent a letter to Petitioner stating they reviewed her recent doctor restrictions and offered light duty work which required only the use of her right hand until her arm healed according to the work offer as stated on June 26, 2012. (PX34). Her work schedule would be Tuesdays through Fridays from 8:30 a.m. until 5 p.m. and Saturdays from 8:30 a.m. to 5 p.m.

According to Petitioner, this work did not allow her to work using only her left hand as Dr. Drake ordered and did not allow her to work 12 hours at a time so she could work less days and attend her physical therapy as recommended by Drs. O'Malley and Drake.

On August 6, 2012, Dr. Drake re-examined Petitioner. (PX8). She was unable to get the MRI of her right elbow because workers' compensation denied it. She continued to have significant medial right elbow pain that traveled down to her hand with complaints at the right bicep and shoulder. She had difficulty working. She also had compensatory right shoulder and neck pain. X-rays of the elbow were negative. X-rays of the cervical spine showed good disk height

without instability or fracture. She reported that she failed physical therapy and that the physical therapy made her worse. He ordered an MRI of the right elbow. He ordered that she should be off work until the next appointment. He issued a work status note indicating that she should remain off work until the next appointment. Petitioner faxed Dr. Drake's work status report to the Respondent on August 6, 2012. (PX8,35).

On August 10, 2012, Petitioner's attorney faxed a letter to Adjuster Aldridge requesting an AWW calculation and payment of TTD/TPD, summarizing recent TTD payments, and explaining her physical therapy schedule. Her attorney re-faxed the letter on August 22, 2012. (PX36, 38).

On August 11, 2012, Petitioner underwent an MRI of her right elbow at Alexian Brothers Medical Center. (PX16). On August 20, 2012, Dr. Drake re-examined Petitioner and reviewed an MRI of her left elbow which revealed no significant internal derangement. There was mild redundancy of the triceps tendon at its insertion and minimal joint effusion present laterally. The collateral ligaments were intact and there was no stress fracture. Her pain improved with physical therapy, but she still had residual pain with active use of the elbow. Paresthesias from the elbow down the arm resolved. He opined that her right elbow condition was related to the work accident. He ordered that she continue physical therapy. She was to remain off work until the next appointment. Petitioner provided this work status note to Respondent. (PX8, 37).

On September 4, 2012, Dr. Drake re-examined Petitioner. She was off work and in physical therapy. She continued to have elbow pain and swelling. The numbness returned to her right hand pinky and ring fingers intermittently. When she worked with the therapist, the numbness and pain improved. He ordered that she continue with physical therapy and issued a work status note indicating that effective September 4, 2012 she had restrictions of left-hand duties only and she needed to be accommodated for physical therapy. On that day, Petitioner faxed the note to Respondent. (PX8, 39).

On September 5, 2012, Petitioner's attorney faxed to Adjuster Aldridge the Dr. Drake September 4, 2012 work restriction note and notified her that Petitioner had not received TTD since July 9, 2012. Respondent had not been able to accommodate her restrictions. The adjuster had not responded to his prior letters and faxes and voicemail messages for TTD and AWW calculation. Her attorney advised that he may need to file a petition for TTD and penalties. (PX40).

On September 24, 2012, Dr. Leon S. Benson, M.D. of the Illinois Bone and Joint Institute, LLC examined Petitioner at the request of Respondent. (PX6). She reported she had paresthesias, pain, and sharp burning in her arm from

her shoulder down into her fingertips, and mostly in the ulnar distribution in her hand. She had been unable to use her arm to work and hold her arm. He opined that she probably had a brachial plexus injury, ordered a repeat nerve conduction study and a trial of oral steroids for a short period of time. Her condition was due to her work injury. It may take many months for her to reach maximum medical improvement. He also recommended that she get an evaluation by a neurologist. He also recommended an MRI of her shoulder and/or neck if the nerve conduction studies were negative. He would allow her to do work that required no use of the right arm. Said restrictions were related to her work injury. (Id.)

On September 28, 2012, Dr. Drake re-examined Petitioner and noted continued complaints of medial right elbow pain with numbness and tingling that traveled down her arm to her ring and index fingers. During and just after her physical therapy she did not have numbness or pain. He referred her for an EMG/NCV of the left in upper extremities. He issued a work status report indicating that she could return to work with the restriction of left-hand duties only. (PX8, 41).

From October 1, 2012 to January 8, 2013, Petitioner obtained a light duty manager/loan officer job at CMK Investments a/k/a All Credit Lenders. (PX3). She obtained this job because no TTD was paid since July 2012.

On October 9, 2012, Mr. Gray emailed a letter to Petitioner which offered a light duty work assignment based on the latest IME report beginning on October 15, 2012 from Monday through Friday 8:30 a.m. to 5 p.m. and she would be allowed to leave early to go to physical therapy and the missed time would be made up on Saturday mornings. (PX42, RX16 p. 8).

On October 17, 2012, Petitioner sent an email to Mr. Gray informing him she was working for two weeks for $10 an hour as a loan officer because Respondent stopped payments in July 2012. She worked 10 am to 6 pm and her physical therapy facility was just down the street and she goes there either mornings or after work. She could not take Respondent's light-duty position because she worked Monday to Friday 10 a.m. to 6 p.m. and then therapy either mornings or after work. (PX43, 16 p. 9).

On October 31, 2012, Petitioner underwent an EMG/NCV of the left and right upper extremities at Midwest Neurology (PX14) which were within normal limits without signs supporting a diagnosis of radiculopathy, plexopathy, or peripheral neuropathy. The brachial plexus study was normal bilaterally.

On November 7, 2012, Petitioner was discharged from physical therapy. (PX12). She made slow progress in slightly reducing her symptoms, but she

still had pain with her right shoulder flexion and abduction. She also had strength deficits due to her pain. The therapist advised her on a home exercise program. She would continue treatment elsewhere based on a physician's second opinion.
On November 8, 2012, Dr. Drake re-examined Petitioner. They reviewed the EMG/NCV results. She continued to complain of pain along the medial and lateral aspect of the right elbow and now she had muscular pain in the right side of the upper thoracic region. He referred her to Dr. Kelly Holtcamp, an orthopedic surgeon specializing of the elbow/hand/wrist, for a second opinion. Her restrictions were to continue. Petitioner did not treat with Dr. Holtcamp because she wanted to treat with orthopedic surgeon Dr. Joshua M. Alpert, M.D. of the Midwest Bone & Joint Institute since she treated with him in the past for a left ankle injury.

On November 28, 2012, Dr. Joshua Alpert examined Petitioner. (PX9) She provided her work injury and treatment history to date. She was having stiffness and numbness in her pinky and ring finger. She could not lift anything with her right arm more than 2 pounds without pain. The pain was in the medial elbow and into the neck. She had numbness into the small fingers. Her pain was 10/10. The cervical palpation examination revealed paraspinal muscle spasms. The right elbow exam revealed diffuse pain around the elbow. X-ray of the cervical spine was normal. He reviewed the prior MRI of the right elbow which revealed mild inflammation but no obvious pathology. His assessment was neck pain with ulnar neuropathy after a work related injury in May of 2012. He recommended an MRI of the cervical spine assess for any kind of disc pathology. She was to continue physical therapy. He provided her a Medrol Dosepak, a steroid pack, to take for the next five days due to her significant nerve complaints. (Id.)

From November 28, 2012 through June 8, 2013, Petitioner underwent physical therapy at Accelerated Rehabilitation Therapy. (PX13).

On December 12, 2012, Petitioner underwent a cervical MRI at Royal Open MRI. (PX17). The radiologist's findings were C5–C6 mild unconvertebral joint hypertrophy bilaterally. C6– C7 central disc bulge. Osteophytes were demonstrated which extended greater on the right side. There was mild to moderate encroachment along the anterior right paracentral thecal sac and moderate narrowing of the right neural foramen and nerve roots due to lateral osteophytes. There was no cord compression or intrinsic cord lesion. No paraspinal mass. (Id.)

On December 19, 2012, Dr. Alpert and one of his partners, Dr. James Fister, M.D., examined the cervical MRI. Dr. Fister initially opined that it appeared that Petitioner had a disc herniation at C6-C7. Petitioenr informed Dr. Fister

that since her work injury she had right-sided neck pain and right arm pain and arm weakness. She was right hand dominant. She had numbness in the right fourth and fifth fingers. He opined that this could all be due to her disc herniation at C6–C7, but he wanted to spend more time to go through her EMG and do a full exam both of her neck and right arm because she previously saw Dr. Drake 4 to 5 times keying on a medial epicondylitis condition. He needed more time to differentiate whether this was cervical radiculopathy versus some type of soft tissue injury to the right arm or elbow. Thereafter, Dr. Fister examined the MRI and determined that there was a C6–C7 mild and diffuse disc protrusion, but it was not large. He did not see any large disc herniation at any level of the cervical spine. Dr. Fister issued a work status note indicating that Petitioner may return to her job on December 19, 2012 with restrictions of no use of right arm. Petitioner provided this note to Respondent. (PX9, 44).

On January 3, 2013, Dr. Allen Deutsch, M.D. conducted a review of Petitioner's medical records and prepared a case report at the request of Respondent. (PX21). He opined that in May 2012 while helping a patient in bed, Petitioner sustained a "yanking" injury while pulling a belt and there was a mechanism of injury consistent with a strain injury to the upper extremity, neck, and right elbow. Her cervical MRI showed a disc herniation. He recommended 10 visits of cervical physical therapy. (Id.)

On January 16, 2013, Dr. Fister re-examined Petitioner and her cervical MRI. She again reported that ever since her work injury, she had pain in the right side of her neck traveling to the right shoulder and traveling to the right scapula and traveling down the right arm. She was complaining of posterior neck pain more on the right than the left. The pain traveled to the right scapula and traveled to the right shoulder. She had pain traveling down the right arm. She had numbness and tingling traveling down the right arm and she had numbness and tingling down the left arm, but no pain in the left arm. Occasionally, she had some tingling down the left leg. Symptoms seemed to travel to the fourth and fifth fingers on the right hand. She also experienced a burning type sensation that traveled towards the right scapula. She had never formally seen a neurologist. She had an EMG but not a formal neurology evaluation. Upon Dr. Fister's neurological exam of the upper extremities, she had light touch sensation diffusely decreased in the entire right upper extremity. Her left extremity light touch sensation was normal. He tested her neck motion and flexion and extension right and left rotation. With flexion she developed right posterior neck pain and with extension she developed pain radiating to the right shoulder and radiating to the right scapula. He reviewed the cervical MRI and opined that there was a very small disc herniation at C6–C7 and osteophyte complex. It was mild and diffuse and not causing any significant nerve compression. The cervical spine MRI was not finding a definite cause for her symptoms and the EMG testing did not find a definite cause for

her symptoms so he did not recommend cervical surgery because he thought a discectomy and fusion at C6–C7 would probably not relieve her complaints. He referred her back to her primary care physicians group, Dr. John Wilkerson, M.D. and a neurologist for further evaluation and treatment. She possibly just had a stretch injury to the nerves, but the EMG should pick that up, but he did not see any indication for neck surgery. He checked for right elbow epicondylitis but she was not tender in the elbow. He issued a work status note indicating she was unable to work and wrote a letter to Dr. Wilkerson. (PX9, 45).

On January 16, 2013, Dr. Wilkerson (Dr. O'Malley's fellow doctor) of Alexian Brothers Medical Group examined Petitioner and discussed her symptoms, treatment and treatment recommendations relating to her work injury. He prescribed tramadol and made referrals for neurology-Northwest Neurology, Barrington Orthopedic Specialists, and physical medicine and rehabilitation. (PX7).

On January 23, 2013, Dr. Fister completed a work status note at the request of Case Manager Kathleen Pearson indicating that Petitioner could work and lift sedentary 10 to 20 pounds and light 10 to 20 pounds. (PX9). Ms. Pearson contacted Dr. Fister's office without the consent or knowledge of Petitioner or Petitioner's attorney. Pearson also did not provide Petitioner or her attorney with this work status report.

On January 30, 2013, Dr. Barry H. Bickshorn of Northwest Neurology examined Petitioner pursuant to the referral of Dr. Wilkerson. (PX15). She reported her work injury and the sharp shooting electric-like pain felt in the right neck radiating into the right arm all the way to the fingers since the work injury. The pain was worse with any lifting or movement of the right arm. Her right arm felt heavy and possibly weak. There was numbness and tingling from the right elbow to the hand and especially the fourth and fifth digits greater than the thumb. She also had issues with headaches, shooting pain, and blurry vision. She went to Sherman Hospital where a CT scan of the brain was performed which was normal. She also underwent an MRI of her brain which was normal. His assessments were: 1. Headache–facial pain. 2. Cervicalgia neck pain. 3. Pain in limb–soft tissues of limb. He reviewed the cervical MRI and opined that it did show evidence of spurring at C6-C7 raising the possibility of brachial plexus stretch injury. She had a separate complaint of headaches that started in early December 2012 that were persistent. The CT and MRI of the brain were normal. His treatment recommendations were: 1. Gabapentin for the headache-facial pain. 2. Physical therapy aimed at the neck for the pain in limb, soft tissues of limb. The Gabapentin may also help her neck and upper extremity pain symptoms. He also wanted to review the two prior EMG studies and the consultation report of Dr. Fister or the IME that

was done. He sent his report to Dr. Wilkerson. Petitioner testified that she could not treat with Dr. Bickshorn because Ms. Pearson informed her that he generally did not treat workers' compensation patients. Pearson contacted Dr. Wilkerson and she scheduled a visit with a different neurologist, Dr. Nicholas Schlageter, M.D. of Tri Cities Neurology. Petitioner did not follow-up with Dr. Bickshorn.

On February 4, 2013, Petitioner's attorney faxed Dr. Fister's January 16, 2013 work status note to Adjuster Aldridge indicating that Petitioner was unable to work and requested TTD and case management reports. (PX46)

On February 13, 2013, neurologist Dr. Schlageter examined Petitioner pursuant to the referrals of Drs. Fister and Wilkerson. (PX11). Upon a neurological exam, her cervical spine showed full range of motion, but she reported a Lhermitte's sign going down the spine, sometimes down her right leg. He reviewed the cervical MRI and opined it may show cord lesions. His assessment was headaches syndromes migraines, right brachial plexus injury (stretch), positive Lhermitte's sign [which is sudden transient electric-like shocks extending down the spine triggered by flexing the head forward]. He prescribed Gabapentin and an MRI of the cervical spine with no contrast. He issued a note indicating that Petitioner may not work until her next appointment in one month. (PX11, 47).

On February 13, 2013, Petitioner's attorney faxed Dr. Schlageter's February 13, 2013 note to Adjuster Aldridge and requested TTD and case management reports. (PX48). On February 23, 2013, Respondent paid TTD in the amount of $660.00 for February 13, 2013 through February 26, 2013. (RX 15).

On February 26, 2013, Case Manager Pearson contacted Dr. Schageter and obtained a work status note from him indicating that Petitioner may work with restrictions of no use of her right arm for lifting or carrying. (PX49). Ms. Pearson contacted Dr. Schlageter's office without the consent or knowledge of Petitioner or Petitioner's attorney.

On February 28, 2013, Petitioner called Gray and spoke to him regarding any light duty available. He said there was none and that he would check. She asked him to notify her if there was any light duty available.

On February 28, 2013, Adjuster Aldridge sent a fax to Petitioner's attorney indicating that the adjuster received the February 26, 2013 Dr. Schlageter work status note releasing Petitioner to work light duty. TTD through the previous Sunday would be released. (PX50). On March 3, 2013, Respondent paid TTD and the amount of $231.71 for February 27, 2013 to March 3, 2013. (RX15).

On February 28, 2013, Petitioner underwent an MRI of her cervical spine at CDI (PX18) which revealed mild disc degeneration and mild stranding in the cervical spine. Slight cervical lordosis does remain which is an improvement from the prior lateral x-ray image. There was mild disc degeneration. There was mild disc bulges and protrusions for canal or foraminal stenosis, and especially at C5-C6 and C6-C7. (Id.)

On March 1, 2013, Petitioner sent an email to Respondent confirming her conversation with her manager on February 28, 2013. (PX51).

On March 4, 2013, Petitioner's counsel sent a fax to Adjuster Aldridge and Case Manager Pearson confirming he received Aldridge's February 28, 2013 fax and Dr. Schalageter's February 26, 2013 work status note faxed to Pearson. Petitioner's attorney objected to Pearson having conversations with Dr. Schlageter without Petitioner being present in person or on the phone in violation of her attorney's previous agreement for case management. He also requested copies of all case management reports. If he did not receive all case management reports by March 9, 2013, authorization for his case management would be terminated effective 5 p.m. on March 9, 2013. The case manager was not to have any conversations with any of Petitioner's doctors regarding opinions and return to work issues without Petitioner being on the phone to discuss the same. Petitioner's attorney confirmed the recent TTD check that Petitioner received and requested that TTD should continue after February 26, 2013. TTD also needed to be paid at the correct rate including her secondary employment income or he would file a petition for TTD, penalties, and attorney's fees. (PX52).

On March 6, 2013, Dr. Schlageter re-examined Petitioner. She still had neck pain and pain down the spine and right arm. Gabapentin did not help the pain. He reviewed the February 28, 2013 MRI of the cervical spine and opined that it showed degenerative changes. He assessed a cervical strain and issued a note indicating that Petitioner may work, but she was not to use her right arm for lifting or carrying. (PX11, 53).

On March 8, 2013, Petitioner sent another email to Respondent checking to see if there was any light duty work. (PX54).

On March 11, 2013, Respondent sent a letter to Petitioner indicating that Respondent alleged that her October 17, 2012 email declining light duty due to her loan officer job was her voluntary resignation and that Respondent accepted her voluntary resignation so that she was "Terminated– by means of Voluntary Resignation" and directing her not to contact Respondent. (PX55, RX16 p. 10).

On March 11, 2013, a Rehabilitation and Injunction Order in the Court of Chancery of the State of Delaware was entered concerning Ulico Casualty Company which covered Patriot Insurance stayed all workers' compensation proceedings. Respondent's attorney notified Petitioners attorney on March 15, 2013. On July 17, 2013, Respondent's attorney notified Petitioner's attorney that the court entered a second stay for 120 days to give the Illinois Insurance Guaranty Fund time to prepare proper defense on all claims including Petitioner's claim.

On March 12, 2013, Petitioner sent emails to Respondent clarifying that her intentions were to continue working for Respondent as a CNA. Respondent offered her light duty for an office position and she never sent an email stating she resigned as a CNA from Respondent. At the time of the offer of the light duty office job, she was already employed due to the fact that she was not being paid TTD since July 2012 and Gray sent her a certified letter stating he could not accommodate her doctors' advice for hours she needed for physical therapy in order to heal so she could get back to work as a CNA. So she never voluntarily resigned as a CNA. She requested confirmation that Respondent was terminating her as a CNA. Respondent sent a response email stating her employment status was as stated in the March 11, 2013 letter. (PX56).

On April 3, 2013, Dr. Schlageter re-examined Petitioner. She reported that she developed more severe pain in her neck, right shoulder and down the spine. His assessment was cervicalgia and muscle spasm. He ordered that she continue her current medication, Baclofen, Gabapentin, recommended physical therapy. She was to follow-up in one month. He issued a work status note indicating she could work with a restriction of no lifting or carrying with her right arm. He also referred Petitioner to Dr. Lami of the Illinois Spine Institute for pain management.

From April 17, 2013 through August 12, 2013, Petitioner treated at the Illinois Spine Institute. (PX 10). Adjuster Aldrige approved said treatment.

On April 17, 2013, spinal surgeon Dr. Babak Lami, M.D. of the Illinois Pain Institute examined Petitioner. (PX10). She reported her work injury, treatment and that she was complaining of pain in her neck radiating down to her right shoulder. She had physical therapy which helped. Her initial pain was 10/10. Her pain as of April 17, 2013 was 5/10. She denied any myelopahthic symptoms. Upon exam her cervical spine had good motion with tightness of paraspinal muscles. Scapulothoracic muscle was intact. He reviewed her February 28, 2013 cervical MRI which he opined showed some slight disc protrusion at C6–C7 with some foraminal stenosis. There also was a disc bulge at C5–C6. His impression was cervicalgia with a component of radiculitis. He

recommended a trial of cervical epidural injections. He did not see any surgical pathology on her MRI. He ordered that she could work restricted light duty of occasional lifting of 20 pounds, frequent lifting of 10 pounds and or walk and/or stand with operational controls, and constant negligible and/or operation of controls well seated. He also recommended physical therapy for her neck pain. Adjuster Aldridge approved the treatment recommendations. On May 7, 2013, interventional pain management physician Dr. Neema Bayran, M.D. of the Illinois Spine Institute examined Petitioner and found that she had tenderness over the right paraspinal muscles in the cervical spine. She had a slightly positive Spurling's test on the right side. She had some tenderness over the right paraspinal muscles and the thoracic spine area. She had weak handgrip on the right side. She also had tenderness over the midline and the cervical spine area. Sensation to light touch was decreased over the lateral aspect of her right thigh. He reviewed the February 28, 2013 cervical MRI and opined that it showed a disc protrusion at C6 -C7 and disc bulge at C5–C6. There was some neroforaminal narrowing at C6–C7. His assessment was that she had neck pain and right sided cervical radiculopathy secondary to: 1. Cervical disc bulge at C5–C6 and cervical disc protrusion at C6- C7. 2. Bilateral epicondylitis, right side. The doctor recommended and administered a cervical epidural steroid injection on the right side without complications and recommended that she continue to work with the restrictions as recommended by Dr. Lami. She was to continue with her Flexeril and Tylenol 3 was prescribed.

Petitioner continued with her physical therapy at Accelerated Rehabilitation Therapy through June 8, 2013. (PX13).

On July 15, 2013, Dr. Lami re-examined Petitioner. The first epidural injection helped her for a week or so before her pain returned. She complained of pain in her neck, scapula, and radiating down to the right arm, distally to the elbow. The doctor's impression was still cervical radiculopathy. Another epidural injection was recommended and work restrictions were continued.
On July 25, 2013, Dr. Bayran administered the second cervical epidural steroid injection at C6-C7 without complication. Petitioner was to continue with the same work restrictions.

On August 12, 2013, Dr. Lami re-examined Petitioner. The second injection helped Petitioner but she still had pain going on in her arm. The doctor reviewed the cervical MRI again and told Petitioner he did not really see any surgical targets. She engaged in her activities as tolerated; however if there was heavy work, it aggravated her symptoms. Dr. Lami recommended that she do lighter work and continued her restrictions. She was moving to Missouri. He gave her a referral to see a doctor in Missouri for continuation of care.

In August 2013, Petitioner moved to Nevada, Missouri. Her husband and his friends helped load the moving truck in Illinois. In Missouri, her husband, Petitioner's brother, and her son unloaded the truck. She did not injure her neck, right shoulder, right arm, or right elbow during the move. According to Petitioner she did not injure her neck, right shoulder, right arm, or right elbow since May 19, 2012.

According to Petitioner she did not obtain any treatment for her neck since August 12, 2013 because Respondent would not approve any additional treatment, she did not have health insurance, and doctors in Missouri generally did not accept Illinois Workers' Compensation patients. She was on Missouri public aid, but when her husband obtained a job she was no longer on public aid. She took hydrocodone and gabapentin until she received a positive drug test result when working at Conway Freight through ManPower employment agency.

On January 26, 2015, orthopedic surgeon Dr. Mitchell B. Rotman, M.D. of the Orthopedic Center of St. Louis conducted an independent medical evaluation and examination of Petitioner at the request of the Respondent. Dr. Rotman focuses his practice on reconstructive surgery of the hand, elbow and shoulder. (PX25). At the end of the exam, he told her that she had neck arthritis and could return to work. (PX25, RX13). Dr. Rotman opined that Petitioner sustained a minor elbow strain and was at MMI. Her current symptoms are not related to her work injury. He did not review her x-rays or MRIs of her neck. On January 26, 2015, orthopedic surgeon Dr. Matthew F. Gornet, M.D. of the Orthopedic Center of St. Louis conducted an independent medical evaluation and examination of the Petitioner and testified in his evidence deposition at the request of the Respondent. (PX19-20, 23 Dep. 7-88). Dr. Gornet focuses his practice on about 120 patents a week and performs surgery of the neck and low back and extensive research and clinical trials regarding the same as well as independent medical examinations but not many IMEs. (PX19-20, 23 Dep. 5-7, 30-31, 50-51, 55-57, 60). According to the doctor, many patients travel from outside Missouri to treat with him. (PX23 Dep. 49). Dr. Gornet's office took x-rays of her cervical spine (PX 24) and referred Petitioner for a cervical MRI which she underwent on January 26, 2015 at MRI Partners. (PX22). Dr. Gornet reviewed the x-rays and MRI digital files of her cervical spine, head, and right arm. He opined that the January 26, 2015 MRI of her cervical spine revealed a massive C6-C7 disc herniation. He opined that she sustained a disc injury at C6–C7 as part of her work injury. Her symptoms of arm, shoulder and elbow pain with intermittent numbness and tingling are fairly classic of this injury. The MRI disc pathology observed on the original December 12, 2012 MRI progressed into a larger disc herniation causing significant cervical radiculopathy at C6–C7. She was definitely not at MMI. She would require surgery at C6–C7 to be a cervical disc replacement with anticipated recovery

and return to work full duty assuming her two year delay in treatment did not produce nerve damage. He requested a CT myelogram prior to surgery. In his report and deposition, he considered petition's negative EMGs and nerve function studies and noted that often EMGs and nerve function studies are negative about 40% of the time in spite of patients having significant radicular pain and symptoms and they also do not detect pain or discomfort. (PX19, 23 Dep. 17-22). Unfortunately, because her EMG and nerve function studies have been negative, her doctors focused on other potential injuries and no further treatment has been performed regarding her neck work injuries. (PX19, 23 Dep. 12-36, 73-81). Dr. Gornet also testified that he reviewed the medical records and they confirmed that Petitioner started reporting numbness and tingling and pain into her right arm during her Dr. O'Malley May 29, 2012 visit when he assessed contusion, upper limb, and other disorders of the cervical spine and recommended an EMG and physical therapy. (PX7, 23 Dep. 12-13, 61, 79-80). She also reported symptoms consistent with cervical spine pathology during her June 22, 2012 EMG (PX 7, 14, 23 Dep. 45-47, 62-63, 73-79). At her first physical therapy visit on July 2, 2012, she mentioned numbness and tingling on the right side of her neck. (PX12, 23 Dep. 79-80). He opined that the work injury also caused the annular tear at C6-C7 as revealed in the December 12, 2012 cervical MRI. (PX23 Dep. 25-28, 66-67, 81-83). She suffered injuries at the C6-C7 level even though the MRIs did not reveal any nerve root compression at C6-C7 because the work injury to the disc caused an inflammatory response or inflammation in her cervical spine. (PX23 Dep. 29-35, 68-69). He opined that her disc herniation at C6-C7 increased about 50% in size as revealed in the December 12, 2012 and January 26, 2016 MRI's which created a structural problem at C6-C7 which was causally connected to her work injury as a progression of that injury. (PX23 Dep. 36-38, 41-44, 70-71). Petitioner could continue working in the same capacity that she was working when he saw her. (PX23 Dep. 70) and he had no problem with her previous attempts to work if she could work in those various jobs. (PX 23 Dep. 48-49). She could undergo an epidural injection before surgery, but it would be better to fix her to get her to work full duty. With surgery in his hands, he opined that she would be released to full duty probably within three months post surgery. His re-operation rate is less than one percent and there usually is not a very significant sequela. They do not need to worry about a failed fusion because the disc replacement prosthesis is designed to move so the complication rate is very low. (PX23 Dep. 41-42, 83-84). Dr. Gornet honestly discussed his findings and recommendations with Petitioner but he did not recall discussing the possibility of continuing treatment with him since he was the IME. (PX23 Dep. 51-53). He did not talk to Petitioner after January 26, 2015 or her counsel prior to his deposition. (PX 23 Dep. 54-55).

After the pay period ending July 15, 2012, Petitioner did not work for a Respondent.

Since July 15, 2012, Petitioner has not worked as a CNA or a massage therapist because her neck condition related symptoms did not allow her to do those jobs and continue to prevent her from doing those jobs.
Petitioner's subpoenaed records from the Respondent show that Petitioner worked for the Respondent for 8-4/7 weeks from March 21, 2012 through May 19, 2012 and earned $2,976.50. This calculates to Bright Star AWW of $347.32. Petitioner worked as a massage therapist for Abundant Life/Healthsource (PX2) and earned $500.00 for one week from May 7 through May 13, 2012

In 2012, 2013, 2014, and 2015, Petitioner conducted self-directed job searches including but not limited to the potential employers listed on PX1.
Petitioner testified and her trial exhibits indicate that from May 20, 2012 to December 8, 2015, she worked at the following employers and earned the following wages:

Periods	Weeks		Employers	Wages
5/20/12- 6/27/12	5-4/7	PX2	Abundant Life	$ 915.25
7/7/12 - 7/10/12	4/7	PX57	Bright Star	$ 169.96
10/1/12 - 1/8/13	14-2/7	PX3	CMK Invest./ACL	$ 5,000.00
4/29/13 - 8/12/13	15-1/7	PX4	Dovenmuehle Mtg.	$ 3,450.30
4/13/14 - 4/17/14	4/7	PX58	Casey's Gen. Stores	$ 181.84
6/13/14 - 6/24/14	1-5/7	PX59	ManPower-Conway	$ 621.50
11/10/14 - 1/21/15	7-3/7	PX60	US Bank	$ 2,861.26
8/24/15 - 8/25/15	2/7		Butler & Davidson	$ 96.00
10/6/15 - 12/8/15	9-1/7	PX61	Joe Clark Res. Care	$ 2,305.63
Total	54-5/7 weeks			$15,601.74

Petitioner testified that the specific jobs she obtained are as follows:
From October 1, 2012 through January 8, 2013, Petitioner worked for CMK Investments a/k/a All Credit Lenders as a collection manager/loan officer in customer service regarding debt collection of mortgages. Customers would call her and make payments. She would call to remind them of payments. She also moved payments and set up payment plans. (PX3). This was a light duty job that she obtained because Respondent did not pay any TTD to her since July 2012. She earned regular non-overtime wages of $5,000.00.
From April 29, 2013 through August 12, 2013, Petitioner worked for Dovenmuehle as a collection agent in customer service. She earned regular non-overtime and non-bonus wages of $3,450.30. (PX4) From April 13, 2014 through April 17, 2014, Petitioner worked for Casey's General Store as a manager which was supposed to be a light duty position within her work restrictions. She earned $8 per hour, but she was assigned to make pizzas while standing on her feet the entire shift with no breaks. She resigned and did

not work on April 18, 2014 because her employer could not meet her work restrictions. She earned wages of $181.84. (PX58). From June 13, 2014 through June 24, 2014, Petitioner work for ManPower temp agency which assigned her to her to work at Conway Freight. She worked in an office scanning bills of lading so drivers could get paid. She earned $12.72 an hour. She took a drug test which came up positive for Hydrocodone. ManPower and Conway Freight let her go on June 25, 2014 because of the positive drug test even though she did not drive a truck. She earned wages of $621.50. (PX59). From November 10, 2014 through January 21, 2015, Petitioner worked for US Bank in a data entry job. She earned $8.75 an hour. She administered thousands of incoming and outgoing emails regarding loan payments and payment reminders. She would send incoming emails to the correct department at US Bank. She had neck spasm and could not move her head. She went to the emergency room and the ER administered injections in her neck. She could not work the next day. US Bank laid her off after second day off. She and her counsel calculated and estimated her gross wages on her wage payments schedule since her wage payment schedule showed net wages. The gross wages is $2,861.26. (PX60). From August 24, 2015 through August 25, 2015, Petitioner worked for Butler & Davidson Counseling firm for marriage and other counseling as an office manager. She earned $8 per hour. She worked 2 days. 4 hours on her first day plus 8 hours on her second day for a total of 12 hours and earned $96.00. She was laid off because she had to go to Fort Scott, KS because her daughter ran away. From October 6, 2015 through the hearing date on December 8, 2015, Petitioner worked for Joe Clark Residential Care Home as a certified medication administrator. She earned $8.75 per hour. From October 15, 2016 through October 31, 2015, she earned $695.63 as stated on her paystub. (PX61). From November 1, 2015 through November 30, 2015, she worked 4 weeks at 40 hours per week for a total of 160 hours which calculates to $1,400.00. From December 1, 2015 through December 8, 2015, she worked 8 hours on December 1, 2015 and 8 hours on December 2, 2015, and 8 hours on December 4, 2015 for a total of 24 hours which calculates to $210.00. Her total wages while working at Joe Clark is $2,305.63.

Petitioner's unpaid medical bills are as follows (ARBX1):

Provider	Amount
Alexian Brothers Medical Group unpaid medical bill and co-pay	$ 25.00
CORE Orthopaedic and Sports Medicine (PX8)	$ 274.87
Midwest Bone & Joint Institute MRI (PX9)	$2,010.00
Illinois Spine Institute (PX10)	$ 632.57
Dr. Nicholas Schlageter, M.D. of Tri Cities Neurology (PX11)	$ 690.00
Dr. Barry H. Bikshorn, M.D. of Northwest Neurology (PX15)	$ 40.00
Sub-Total Unpaid Medical Bills	$3,672.44

Orthopedic Center of St. Louis cervical x-rays (PX24)	$ 274.00
MRI Partners 1/26/15 cervical MRI (PX22)	$2,150.00
Total Unpaid Medical Bills	$6,096.44

As of the December 8, 2015 hearing date, Petitioner testified her symptoms are extreme pain in the neck with radiating pain and numbness down her right arm to her fingers in her right hand. The pain increases with movement or lifting of her right arm. She has headaches. When she wakes up in the morning her right arm is numb. She moves her arm around for 10 to 15 minutes to get feeling. She also has numbness in her right triceps area. She has burning around the right elbow. She has neck spasms and tension in her right trapezius. She massages and squeezes her right hand, arm and shoulder with her left hand to get feeling to make it more comfortable. Her husband also does acupressure massages on her. Her symptoms are made worse with cold weather. She uses a pain patch and soaks her body in Epsom salt. She takes over-the-counter medications such as Tylenol and ibuprofen. She has decreased right arm strength of approximately 50% of her strength before her work injury. She has slight limited range of motion in her neck.

On cross examination, Petitioner testified that she worked as a CNA for about 15 years before her work injuries at Respondent. She did not contest any reported symptoms to her doctors as stated in medical records. Dr. O'Malley referred her to Dr. Drake. Dr. Wilkerson and Case Manager Pearson referred her to Dr. Schlageter. Dr. Lami referred her to an orthopedic doctor in Missouri to assist with her medication management and other treatment. Petitioner admitted that the August 10, 2015 letter from Susan Sutherland of Abundant Life/Healthsource (RX14) was also included in PX2 and stated that it has records showing specific hours she worked doing massage appointments from May 30, 2012 until June 27, 2012 but that prior to this period of time was paid a flat fee of $500 during one week that was payment for a one-time event which Petitioner previously testified was the one week of doing free massages for teachers at an elementary school in Lombard, IL from May 7, 2012 through May 13, 2012.

Petitioner admitted that on March 31, 2014 she posted to her Facebook page pictures of her and her husband at a jam with her twisting at the waist, but those pictures were old pictures and found from when she and her husband first got together and 2006 or 2007. On April 25, 2015, she posted a similar old picture from about 2007 to her Facebook page showing her doing leg presses. On November 29, 2014, she posted a message to her Facebook page indicating that she slept in her husband's truck last night and that it was so cozy. Her husband's truck cab has essentially a full-size regular bed in it. On January 5, 2015, she posted a message to her Facebook page indicating, "Had

to work off that bomb bay food ... @ the gym". She regularly did her home exercise program as recommended by physical therapy stretching and lifting lighter weights of 30 to 45 pounds to help with her cope with her neck and right arm symptoms.
Petitioner admitted that on October 17, 2012, she sent an email to Mr. Gray thanking him for the light duty job offer but that she could not take the job because Respondent could not accommodate her doctor orders so she had to find a desk job because workers' comp stopped payments in July. She was working as a loan officer for $10 an hour for the past two weeks and her employer was very accommodating about her physical therapy schedule and the facility, which was just down the street. She could not take the position because she was working Monday through Friday from 10 am to 6 pm. (PX43).

Jonathan Gray testified that he worked for Respondent as the Central DuPage/Wheaton Director of Operations for four years as of January 1, 2016. He was responsible for the day-to-day operations regarding nonclinical matters. He was responsible for scheduling employees, recruiting, accounts receivable, accounts payable, and billing. He was familiar with Petitioner. He got involved if their scheduler had a problem. He could not recall whether Petitioner informed him about her second job as a massage therapist. He could not recall whether she asked him about scheduling to accommodate her second job as a massage therapist. Petitioner worked for one main client. She worked three 12 hour shifts per week. Respondent offered her a light duty job and she denied the light duty job as stated in the emails and correspondence between Respondent and Petitioner as stated in RX16. The last page of RX16 is the Workers Compensation – First Report of Injury or Illness that Gray prepared indicating that her May 19, 2012 injury report identified a muscle tear in her upper arm as her work injury.

On cross-examination, Gray testified that he did not observe Petitioner perform the light duty job at Respondent, but that shredding papers would involve her sitting in a chair and taking documents and putting them into the shredder. Mr. Gray admitted that he received the July 25, 2012 memo from Petitioner to him confirming their conversation on July 18, 2012 that they discussed that her primary care doctor and orthopedic physician both ordered that she not use her right arm and that she needed to work 12 hour shifts three days a week not more than 35 hours a week so that she could attend physical therapy and recover from her work injury as soon as possible. Respondent could not accommodate her doctors' orders. She previously provided Dr. O'Malley's orders and provided him with Dr. Drake's orders on July 25, 2012. She asked Mr. Gray to call her if Respondent could accommodate her doctors' orders. (PX32, RX16 p.4).

Mr. Gray admitted that on October 9, 2012, he emailed a letter to Petitioner indicating Respondent had light duty work available starting on October 15, 2012 so that she could attend physical therapy. She would work 40 hours a week at $8.25 per hour. (PX42, RX16 p. 8). Mr. Gray admitted that on October 17, 2012, he received an email from Petitioner thanking him for the light duty offer and notifying him that when he informed her that Respondent could not accommodate her doctors' orders, she had to find a desk job because workman's comp stopped TTD payments in July of 2012. She obtained a job as a loan manager and her employer was able to accommodate her doctors' orders.

Mr. Gray admitted that on March 12, 2013, he and Petitioner exchanged emails (PX56) regarding the March 11, 2013 letter from Respondent's president, Jim Flinkinger, to Petitioner regarding Respondent's contention that Petitioner voluntarily resigned her position as a CNA when she sent the email on October 17, 2012 declining the Respondent's offer of a light duty job. Plaintiff stated that she never resigned and her intentions were to continue to work for the Respondent as a CNA. Gray admitted that Petitioner never used the words, "I resign" when she declined the light duty job offer.

CONCLUSIONS OF LAW

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

Petitioner testified that prior to May 19, 2012, she did not have any significant problems with her neck, right shoulder, or right elbow. She underwent a pre-employment physical exam on September 30, 2011 indicating she was "able bodied and physically capable of performing the work of a CNA." (PX5). During the first week of May 2012, she suffered a right hand bruise injury while working for Respondent, but she did not injure her neck, right shoulder, or right elbow. On May 19, 2012, she was assisting a patient to get him to a standing position. He was about to fall, but she grabbed him with her right arm and tried to pull him back. She felt an immediate burning and pain sensation in her right forearm and elbow. She reported the injury to Respondent. A few days later she also began to experience pain in the neck, right shoulder, right arm and right hand pain, radiating proximately to the right arm, forearm, hand, and fourth, and fifth fingers, and also experience numbness in the right arm, forearm, hand, and fourth, and fifth fingers, and weakness of the right arm, forearm, and hand. These symptoms were confirmed by her early treatment records with Dr. O'Malley (PX7) and her first EMG visit on June 22, 2012. (PX14). Based on the above un-rebutted facts, the Arbitrator finds that

Petitioner sustained accidental injuries which arose out of and in the course of her employment by Respondent.

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

The Arbitrator adopts all the opinions of Dr. Gornet and that some of the opinions of Drs O'Malley, Drake, Benson, Alpert, Fister, Deutsch, Wilkerson, Bickshorn, Schlageter, Lami, and Bayran.

Dr. Gornet had the benefit of reviewing all of the medical records, MRIs, and was the last doctor to examine Petitioner. He focuses his practice on neck and low back patients, performs neck and low back surgeries, conducts extensive research and clinical trials regarding the neck and low back, and was the IME selected by Respondent. (PX19-20, 23 Dep. 5-7, 30-31, 49-51, 55-57, 60). He opined that the January 26, 2015 MRI of her cervical spine revealed a massive C6-C7 disc herniation. He opined that she sustained a disc injury at C6–C7 as part of her work injury. Prior to the work injury, she had no significant problems with her right arm or right shoulder. Her symptoms starting shortly after the work injury of arm, shoulder and elbow pain with intermittent numbness and tingling are fairly classic of this injury. The MRI disc pathology observed on the original December 12, 2012 MRI progressed into a larger disc herniation causing significant cervical radiculopathy at C6–C7. She was not at MMI and would require surgery at C6–C7 , a cervical disc replacement with anticipated recovery and return to work full duty assuming her two year delay in treatment did not produce nerve damage. He requested a CT myelogram prior to surgery. In his report and deposition, he considered Petitioner's negative EMGs and nerve function studies and noted that often EMGs and nerve function studies are negative about 40% of the time in spite of patients having significant radicular pain and symptoms and they also do not detect pain or discomfort. (PX19, 23 Dep. 17-22). Unfortunately, because her EMG and nerve function studies have been negative, her doctors focused on other potential injuries and no further treatment has been performed regarding her neck work injuries. (PX19, 23 Dep. 12-36, 73-81).

Dr. Gornet also testified that he reviewed the medical records and they confirmed that Petitioner started reporting numbness and tingling and pain into her right arm during her Dr. O'Malley May 29, 2012 visit when he assessed contusion, upper limb, and other disorders of the cervical spine and recommended an EMG and physical therapy. (PX7, 23 Dep. 12-13, 61, 79-80). She also reported symptoms consistent with cervical spine pathology during her June 22, 2012 EMG (PX 7, 14, 23 Dep. 45-47, 62-63, 73-79). Specifically, on June 22, 2012, Dr. Ta of Midwest Neurology took a detailed history stating,

"She has been complaining since May 19, 2012 of neck, right shoulder, right arm and right hand pain, radiating proximally to the right arm, forearm, hand, and fourth, and fifth fingers, and has also experienced numbness in the right arm, forearm, hand, and fourth, and fifth fingers. The patient also complains of weakness of the right arm, forearm, and hand. Symptoms occurred after a work related injury." (PX14). These symptoms were the identical symptoms she reported to Dr. Gornet. Also, at her first physical therapy visit on July 2, 2012, she mentioned numbness and tingling on the right side of her neck. (PX12, 23 Dep. 79-80). He opined that the work injury also caused the annular tear at C6-C7 as revealed in the December 12, 2012 cervical MRI. (PX23 Dep. 25-28, 66-67, 81-83). She suffered injuries at the C6-C7 level even though the MRIs did not reveal any nerve root compression at C6-C7 because the work injury to the disc caused an inflammatory response or inflammation in her cervical spine. (PX23 Dep. 29-35, 68-69). He opined that her disc herniation at C6-C7 increased about 50% in size as revealed in the December 12, 2012 and January 26, 2016 MRIs which created a structural problem at C6-C7 which was causally connected to her work injury as a progression of that injury. (PX23 Dep. 36-38, 41-44, 70-71). Petitioner could continue working in the same capacity that she was working when he saw her (PX23 Dep. 70) and he had no problem with her previous attempts to work if she could work in those various jobs. (PX 23 Dep. 48-49). She could undergo an epidural injection before surgery, but it would be better to fix her to get her to work full duty. With surgery in his hands, he opined that she would be released to full duty probably within three months post surgery. His re-operation rate is less than one percent and there usually is not a very significant sequela. They do not need to worry about a failed fusion because the disc replacement prosthesis is designed to move so the complication rate is very low. (PX23 Dep. 41-42, 83-84). Dr. Gornet discussed his findings and recommendations with Petitioner but he did not recall discussing the possibility of continuing treatment with him since he was the IME. (PX23 Dep. 51-53). He did not talk to Petitioner after January 26, 2015 or her counsel prior to his deposition. (PX 23 Dep. 54-55).

The Arbitrator also adopts the May 29, 2012 Dr. O'Malley assessment opinion of other disorders of cervical region and various work restrictions (PX7); Dr. Drake's opinions regarding various work restrictions (PX8); Dr. Benson's opinion that the work injury probably caused a brachial plexus injury (PX6); Dr. Alpert's assessment opinion of neck pain with ulnar neuropathy after the May 2012 work injury (PX9); Dr. Fister's opinions regarding various work restrictions (PX9); Dr. Deutsch's opinions that in May 2012 while helping a patient in bed, Petitioner sustained a yanking injury while pulling a belt and there was a mechanism of injury consistent with a strain injury to the upper extremity, neck, and right elbow and that her cervical MRI showed a disc herniation (PX21); Dr. Wilkerson's opinions regarding treatment and referral of

Petitioner to neurologist and orthopedic physicians (PX7); Dr Bickshorn's assessment opinions of cervicalgia neck pain and cervical MRI showed evidence of spurring at C6–C7 raising the possibility of brachial plexus stretch injury (PX15); Dr. Schlageter's assessment opinions of right brachial plexus injury (stretch), positive Lhermitte's sign, various work restrictions, and referral to Drs. Lami and Bayran at the Illinois Pain Institute (PX11); Dr. Lami's assessment opinions of C6-C7 disc protrusion and C5-C6 disc bulge, cervicalgia with a component of radiculitis/cervical radiculopathy and various work restrictions (PX10); and Dr. Bayran's assessment opinions of C6-C7 disc protrusion and C5-C6 disc bulge, cervical radiculopathy and various work restrictions. (PX10).

The Arbitrator places less weight on the opinions of Dr. Rotman since his practice focuses on the reconstructive surgery of the hand, elbow and shoulder. He did not review Petitioner's x-rays or MRIs of her neck. Therefore, his opinions are less credible than Dr. Gornet's opinions.

What were Petitioner's earnings and AWW?

The Arbitrator finds Petitioner's Average Weekly Wage is $847.32 based on the credible evidence contained in the record.

Section 10 of the Act provides the basis for computing AWW and states in part: "When the employee is working concurrently with two or more employers and the Respondent employer has knowledge of such employment prior to the injury, his wages from all such employers shall be considered as if earned from the employer liable for compensation." The AWW of each job is determined separately and then added together even if the concurrent job wage period is only for 1 week. This method more fairly represents the claimant's earning power at the time of the injury. *Village of Winnetka v. Ind. Com.* 250 Ill.App.3d 240 (1st Dist. 1993); *Mason Manufacturing v. Ind. Com.* 331 Ill.App.3d 575 (4th Dist. 2002).

Petitioner's subpoenaed records from the Respondent show that Petitioner worked for the Respondent for 8-4/7 weeks from March 21, 2012 through May 19, 2012 and earned $2,976.50. This calculates to Bright Star AWW of $347.32. Respondent agreed with this calculation. Petitioner also worked as a massage therapist for Abundant Life/Healthsource (PX2, RX14) and earned $500.00 for one week from May 7 through May 13, 2012. Therefore, the total AWW is $847.32. The subpoenaed records from Abundant Life/Healthsource (PX2, RX14) including Petitioner's Payroll History Report and letters and email correspondence confirm the Petitioner's wages. Susan Sutherland of Abundant Life/Healthsource confirmed that Abundant Life is also known as Healthsource

and Petitioner's position was a combination of working as a message therapist in the office and doing marketing/promotion inside and outside the office. The hours listed in Sutherland's June 30, 2015 and August 10, 2015 letters only included hours that Petitioner worked in the office providing massage therapy services. The first payment to her in the amount of $500.00 for the pay period of May 7 to 13, 2012 was paid to Petitioner on May 15, 2012 for work outside the office. Petitioner testified that in or about late April or early May of 2012, Petitioner informed Respondent's nurse scheduler, Sonia Del Campo, that Petitioner was going to start working as a massage therapist for Abundant Life Chiropractic a/k/a Healthsource in Lombard, Illinois. (PX2) She informed her that she could not work for Bright Star the week of May 7, 2012 through May 13, 2012 because she had to work at an elementary school in Lombard doing chair massages for teachers during teacher appreciation week. She did the messages that week and was paid $500.00 for her first week of work from May 7 through May 13, 2012. Her job at Abundant Life/Healthsource involved doing marketing by doing free massages for potential clients like the teachers. She also handed out flyers at a golf event and did other marketing activities. She also assisted the doctors in the office with instruction on corrective exercises, messages, and other activities. Petitioner's testimony was un-rebutted.

Were the medical services provided to Petitioner reasonable and necessary?

Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

Did Petitioner exhaust her choices of doctors pursuant to Section 8(a) of the Act?

Under Section 8(a) of the Act, an employer is liable for all necessary first aid, medical, surgical, and hospital services incurred that are reasonably required to cure or relieve the injuries related to the work accident. This is limited to the first and second choices of physicians by Petitioner and any chains of referrals resulting from these choices. Emergency room hospital services and expenses do not constitute a choice of medical service provider when the Petitioner seeks services at an emergency room when the current physician is unavailable. See *Wolfe v. Indust. Com.*, 138 Ill.App.3d 680 (4th Dist. 1985). When a doctor suggests to an employee that a specialist be seen, such a suggestion constitutes a referral, which would then place treatment by such a specialist chosen by the employee within the chain of referral. See *Davis v. Baskin Clothing Co.*, 95 IIC 796.

The medical services that were provided to Petitioner were reasonable and necessary as stated in the medical records. Case Manager Pearson scheduled and Respondent approved all prior medical services.

Petitioner did not exhaust her choices of doctors. Petitioner's first doctor/clinic choice was her primary care doctors, Drs. O'Malley and Wilkerson at Alexian Brothers Medical Group. (PX7). Dr. O'Malley referred Petitioner to Midwest Neurology for an EMG (PX14), to Athletico for physical therapy (PX12), and to Dr. Drake (PX8). Dr. Drake referred Petitioner to Alexian Brothers Medical Center for an MRI of her right elbow (PX16), continued physical therapy, and to an orthopedic surgeon. Petitioner selected Dr. Alpert as her orthopedic surgeon (PX9). Dr. Alpert her referred her to his fellow spine orthopedic surgeon, Dr. Fister and for a cervical MRI at Royal Open MRI. (PX17). Dr. Fister referred her back to Dr. Wilkerson and to a neurologist. Dr. Wilkerson referred her to a neurologist, another orthopedic surgeon, and for physical medicine and rehabilitation. Case Manager Pearson assisted Petitioner is selecting neurologist Dr. Bickshorn, He recommended additional physical therapy which she underwent at Accelerated Rehabilitation (PX13). Pearson informed Petitioner that Dr. Bickshorn generally did not treat workers' compensation patients. Pearson contacted Dr. Wilkerson for a referral and scheduled a visit with a different neurologist, Dr. Schlageter. (PX11). Dr. Schlageter referred Petitioner for an MRI of her cervical spine with no contrast at CDI Lake in the Hills (PX18). Dr. Schlageter referred Petitioner to Drs. Lami and Bayran of the Illinois Spine Institute for treatment and pain management. (PX10). Dr. Lami referred Petitioner see a doctor in Missouri for continuation of care.

Based on the above, Petitioner did not violate the "two doctor rule".

The Arbitrator further finds that Respondent has not paid all appropriate charges for all reasonable and necessary medical services as follows:

Provider	Amount
Alexian Brothers Medical Group (PX7)	$ 25.00
CORE Orthopaedic and Sports Medicine (PX8)	$ 274.87
Midwest Bone & Joint Institute MRI (PX9)	$2,010.00
Illinois Spine Institute (PX10)	$ 632.57
Dr. Nicholas Schlageter, M.D. of Tri Cities Neurology (PX11)	$ 690.00
Dr. Barry H. Bikshorn, M.D. of Northwest Neurology (PX15)	$ 40.00
Sub-Total Unpaid Medical Bills	$3,672.44
Orthopedic Center of St. Louis cervical x-rays (PX24)	$ 274.00
MRI Partners 1/26/15 cervical MRI (PX22)	$2,150.00
Total Unpaid Medical Bills	$6,096.44

The parties stipulated that if the Arbitrator awarded unpaid medical bills, Respondent would pay said bills pursuant to the medical fee schedule under the Act and Respondent would receive credit for any prior payments made and balance billing would not be allowed. The Arbitrator finds that all of the above treatment bills in the sub-total amount of $3,672.44 were necessary and reasonable to diagnose and treat Petitioner's condition. In regard to the Dr. Gornett Orthopedic Center of St. Louis January 26, 2015 cervical x-rays bill in the amount of $274.00 (PX24), the records indicate that Respondent agreed to pay for the cervical x-rays in addition to Dr. Gornet's IME fee. Dr. Gornet also ordered the MRI Partners January 26, 2015 cervical MRI which was necessary to diagnose and make treatment recommendations regarding the cervical spine including but not limited to the massive herniated disc at C6–C7. (PX22).

The Arbitrator hereby orders that Respondent pay for all of the above medical expenses in the total amount of $6,096.44 pursuant the medical fee schedule of the Act and Respondent shall receive a credit for any prior payments made and balance billing will not be allowed.

Is Petitioner entitled to any prospective medical care?

As stated above, the Arbitrator hereby adopts the opinions of Dr. Gornet. The MRI disc pathology observed on the original December 12, 2012 MRI progressed into a larger disc herniation causing significant cervical radiculopathy at C6–C7. She was not at MMI and would require surgery at C6–C7 to be a cervical disc replacement with anticipated recovery and return to work full duty assuming her two year delay in treatment did not produce nerve damage. He requested a CT myelogram prior to surgery. She could undergo an epidural injection before surgery, but it would be better to fix her to get her to work full duty. With surgery in his hands, he opined that she would be released to full duty probably within three months post surgery. His re-operation rate is less than one percent and there usually is not a very significant sequela. They do not need to worry about a failed fusion because the disc replacement prosthesis is designed to move so the complication rate is very low. (PX23 Dep. 41-42, 83-84).

Based on the above, the Arbitrator hereby orders that Respondent approve and pay for the treatment recommended by Dr. Gornet.

What amounts of compensation are due for temporary partial disability and temporary total disability?

Compensation amounts are due for TPD and TTD. Petitioner's doctors issued numerous work restriction orders and reports indicating either Petitioner could not work or had restrictions beginning on May 22, 2012. Petitioner testified that after her May 19, 2012 work injury, she continued working at Abundant Life/Healthsource. (PX2). She did marketing in the office and assisted the doctors in the office with instruction on corrective exercises. She tried to do two massages while sitting, but her pain and discomfort in her right arm and neck prevented her from doing massage therapy. She normally would do full body massages while standing. The last day that she worked at Abundant Life/Healthsource was on June 27, 2012. (RX2). On or about July 6, 2012, Jonathan Gray, Petitioner's manager, called Petitioner and asked if she could work 8 hours every Saturday doing light duty work such as shredding papers On July 7, 2012, Petitioner worked 3.5 hours on light duty for Respondent. At times she had to use her right arm because she had to sit in a chair with no arms with a box full of documents next to her. She had to bend down to pick of the paper documents and put them in the shredder. From July 9, 2012 through July 15, 2012, Petitioner worked an additional 7 hours. Thereafter, she did not work for Respondent. (PX57).

On July 10, 2012, Mr. Gray asked Petitioner to sign a Light Duty Work Agreement dated June 26, 2012. (PX28). The agreement stated she would work 8:30 a.m. to 5 p.m. on Saturday, Tuesday through Friday. She would work a 40 hour work week at $8.25 per hour. She would be doing general office duties including various projects that would not require the use of her injured arm. She was to report to Respondent at its Wheaton location on July 10, 2012 at 8:30 AM. She refused to sign the agreement and told Respondent that her attorney needed to review the agreement. She worked 3.5 hours that day which was the last day she worked for Respondent. (PX57).

On July 11, 2012, Dr. O'Malley issued a letter advising that she was undergoing evaluation and treatment for severe arm pain. It was his recommendation that she be allowed to work 12 hour days to accommodate her physical therapy schedule, which was vital for her improvement and ability to return to normal capacity. She should not work over 40 hours per week. On July 14, 2012, Dr. Drake also issued a work status report indicating that effective July 16, 2012 she could return to work with the restrictions of left-handed duties only and limit the 35 hours a week, and 12 hour shifts to allow for physical therapy appointments. Petitioner faxed/provided this note to Respondent. (PX8, 31)

On July 18, 2012, Mr. Gray called Petitioner and they discussed her work restrictions from Drs. O'Malley and Drake. Gray indicated that Respondent could not accommodate her doctor restrictions. She asked Gray to call her if Respondent could accommodate her. (PX32).

On October 9, 2012, Mr. Gray emailed a letter to Petitioner which offered a light duty work assignment based on the latest IME report beginning on October 15, 2012 from Monday through Friday 8:30 a.m. to 5 p.m. and she would be allowed to leave early to go to physical therapy and the missed time would be made up on Saturday mornings. (PX42, RX16 p. 8).

On October 17, 2012, Petitioner sent an email to Gray informing him she was working for two weeks for $10 an hour as a loan officer because Respondent stopped payments in July 2012. She worked 10 am to 6 pm and her physical therapy facility was just down the street and she goes there either mornings or after work. She could not take Respondent's light-duty position because she worked Monday to Friday 10 a.m. to 6 p.m. and then therapy either mornings or after work. (PX43, 16 p. 9).

On February 28, 2013, Petitioner called Mr. Gray and spoke to him regarding any light duty available. He said there was none and that he would check. She asked him to notify her if there was any light duty available. On March 1, 2013, Petitioner sent an email to Respondent confirming her conversation with her manager on February 28, 2013. (PX51).

On March 8, 2013, Petitioner sent another email to Respondent checking to see if there was any light duty work. (PX54). On March 11, 2013, Respondent sent a letter to Petitioner indicating that Respondent alleged that her October 17, 2012 email declining light duty due to her loan officer job was her voluntary resignation and that Respondent accepted her voluntary resignation so that she was "Terminated– by means of Voluntary Resignation" and directing her not to contact Respondent. (PX55, RX16 p. 10). On March 12, 2013, Petitioner sent emails to Respondent clarifying that her intentions were to continue working for Respondent as a CNA. Respondent offered her light duty for an office position and she never sent an email stating she resigned as a CNA from Respondent. At the time of the offer of the light duty office job, she was already employed due to the fact that she was not being paid TTD since July 2012 and Gray sent her a certified letter stating he could not accommodate her doctors' advice for hours she needed for physical therapy in order to heal so she could get back to work as a CNA. So she never voluntarily resigned as a CNA. She requested confirmation that Respondent was terminating her as a CNA. Respondent sent a response email stating her employment status was as stated in the March 11, 2013 letter. (PX56). On

cross examination, Mr. Gray admitted that Petitioner never used the words, "I resign" when she declined the light duty job offer.

After Petitioner's May 19, 2012 work injury, she worked briefly for Respondent at a lower wage and Abundant Life/Healthsource, performed multiple job searches (PX1), and obtained various light duty jobs. (PX2-4, 58-61). Respondent has only paid $3,095.71 of TTD to date. (RX15). The testimony of Petitioner and Mr. Gray, their correspondence, and work restrictions are uncontested in establishing that Respondent did not have any light duty work within her restrictions after the last day that she worked light duty for Respondent on July 10, 2012 until Respondent offered her a light duty job beginning on October 15, 2012. Therefore, it is clear that Petitioner is entitled to TPD and TTD from May 20, 2012 through October 14, 2012.

Respondent contends that Petitioner is not entitled to TPD or TTD because Petitioner denied the light duty offered by Respondent. If an employee refuses to work at a light duty job offered by the employer within the employee's medical restrictions, the employee's refusal generally disqualifies the employee from TTD benefits. *Sharwarko v. Ill. Work. Comp. Com. (Village of Oak Lawn),* 2015 IL App (1st) 131733WC (claimant's voluntary retirement with no attempt to find work was the equivalent of refusing accommodated light duty and disqualified him from TTD benefits).

Petitioner's case is distinguishable from *Sharwarko.* Respondent stopped paying Petitioner TTD after it made a TTD payment on July 11, 2012 for the TTD for the time period of July 3, 2012 through July 9, 2012. (RX15). Petitioner's attorney sent letters and faxes to Adjuster Aldridge requesting TTD. (PX33, 36, 38, 40, 46, 48, 52). Since Petitioner was not receiving TTD, she searched for another light duty job and obtained a full time job starting October 1, 2012 at CMK Investments a/k/a All Credit Lenders as a collection manager/loan officer earning $10 per hour. (PX3). On October 9, 2012, Respondent offered Petitioner a full time light-duty job to start October 15, 2012 earning $8.25 per hour. (PX42). On October 17, 2012, Petitioner sent an email to Mr. Gray informing him she was working for two weeks for $10 an hour as a loan officer because Respondent stopped payments in July 2012. She worked 10 am to 6 pm and her physical therapy facility was just down the street and she goes there either mornings or after work. She could not take Respondent's light-duty position because she worked Monday to Friday 10 a.m. to 6 p.m. and then therapy either mornings or after work. (PX43, 16 p. 9). Petitioner's case is distinguishable from *Sharwarko* because the claimant in *Sharwarko* did not attempt to find work. Petitioner was already working light duty when Respondent offered her light duty. After Petitioner's collection manager/loan officer job ended, she called Gray on February 28, 2013 and asked if light duty was available and he said there was none but he would

check. Thereafter, on March 8, 2013, Petitioner sent another email to Respondent checking to see if there was any light duty work. (PX54). On March 11, 2013, Respondent sent a letter to Petitioner indicating that Respondent alleged that her October 17, 2012 email declining light duty due to her loan officer job was her voluntary resignation and directed her not to contact Respondent. (PX55, RX16 p. 10). On March 12, 2013, Petitioner sent emails to Respondent clarifying that her intentions were to continue working for Respondent as a CNA. Respondent sent a response email stating her employment status was as stated in the March 11, 2013 letter. (PX56). On cross examination, Gray admitted that Petitioner never used the words, "I resign" when she declined the light duty job offer. Based on the above, the Arbitrator finds and rules that Petitioner is entitled to TPD and TTD from May 20, 2012 through December 8, 2015.

The Arbitrator hereby orders that Respondent pay Petitioner TPD for the periods listed below for periods that plaintiff worked after the May 19, 2012 work injury. Taking into consideration a total AWW of $847.32 and her earnings from May 20, 2012 to December 8, 2015, her TPD is $20,505.85 as stated below.

TPD Periods	Weeks		Employers	Wages
5/20/12 - 6/27/12	5-4/7	PX2	Abundant Life	$ 915.25
7/7/12 - 7/10/12	4/7	PX57	Bright Star	$ 169.96
10/1/12 - 1/8/13	14-2/7	PX3	CMK Invest.	$ 5,000.00
4/29/13 - 8/12/13	15-1/7	PX4	Dovenmuehle	$ 3,450.30
4/13/14 - 4/17/14	4/7	PX58	Casey's Gen.	$ 181.84
6/13/14 - 6/24/14	1-5/7	PX59	ManPower	$ 621.50
11/10/14 - 1/21/15	7-3/7	PX60	US Bank	$ 2,861.26
8/24/15 - 8/25/15	2/7		Butler & Davidson	$ 96.00
10/6/15-12/08/15	9-1/7	PX61	Joe Clark Res.	$ 2,305.63
Total	54-5/7 wks			$15,601.74

54-5/7 wks x $847.32 AWW=$46,360.51-$15,601.74=$30,758.77x 2/3 = $20,505.85 TPD

The Arbitrator hereby orders that Respondent pay Petitioner TTD for the periods listed below for the time periods in which Petitioner did not work for any employer less a $3,095.71 credit for previously paid TTD.

TTD Period	Weeks
06/28/12-07/06/12	1-2/7
07/11/12-09/30/12	11-5/7
01/09/13-04/28/13	15-5/7

8/13/13-04/12/14	34-5/7
04/18/14-06/12/14	8
06/25/14-11/09/14	19-5/7
01/22/15-08/23/15	30-4/7
08/26/15-10/05/15	5-6/7

Total	127-4/7 weeks x $564.88 TTD =	$72,062.54
	Less TTD Paid (RX15)	$ 3,095.71
	Net TTD Due	$68,966.83

STATE OF ILLINOIS)
) SS.
COUNTY OF ST. CLAIR)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LISA KEPPNER,

Petitioner,

vs.

NO: 12WC017113

CHOATE MHC,

Respondent,

17IWCC0088

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 17, 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.

17IWCC0088

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: FEB 14 2017
MJB/bm
o-2/6/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

KEPPNER, LISA
Employee/Petitioner

Case# **12WC017113**

12WC017114

CHOATE MHC
Employer/Respondent

17IWCC0088

On 3/17/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.51% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0686 GARY MATHENY LAW OFFICE
303 N JACKSON
FARMINGTON, MO 63640

0558 ASSISTANT ATTORNEY GENERAL
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SPRINGFIELD, IL 62794-9208

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

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

MAR 17 2016

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

STATE OF ILLINOIS)
)SS.
COUNTY OF ST. CLAIR)

☐ 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)

Lisa Keppner
Employee/Petitioner

v.

Choate, MHC
Employer/Respondent

Case # 12 WC 17113

Consolidated cases: 12 WC 17114

17IWCC0088

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Collinsville**, on **May 21, 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. ☒ 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 **Has Petitioner exhausted her selection of physicians?**

17IWCC0088

FINDINGS

On the date of accident, **06/02/09**, 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 **$31,958.00**; the average weekly wage was **$614.58**.

On the date of accident, Petitioner was **37** years of age, ***single*** with **3** dependent children.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $55,040.77, 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.

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

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

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

Michael k. Nowak, Arbitrator

3/10/16
Date

ICArbDec19(b)

MAR 17 2016

BACKGROUND

Prior to the date of her first accident Petitioner was treating with Dr. Moyers, her primary care physician for a number of conditions unrelated to her neck and low back. Also prior to the accident date Petitioner was suffering from migraine headaches for which she received treatment from Dr. Aaron Koonce. A note of Dr. Koonce dated March 4, 2009, indicates Petitioner had been in a four-wheeler accident in 1990 which resulted in a neck injury. There was no medical treatment at that time and there is, no indication of any ongoing neck problems or treatment in the months prior to June 2, 2009. (PX1 at 1)

Petitioner is employed as a Mental Health Technician III for Choate Mental Health and Development Center. Petitioner sustained an undisputed accident on June 2, 2009, when she was pushed into a wall by a combative patient. She sustained a second undisputed accident on July 28, 2011, when she was pushed by a patient and struck a door. The claims arising from these accidents, 12 WC 17113 and 12 WC 17114, were consolidated at the time of Arbitration.

FINDINGS OF FACT

On June 2, 2009, Petitioner was escorting a patient back to his group room when he grabbed her and slammed her into a wall, scratched her face, bit her forehead, and stepped on her left foot. (RX1). Petitioner testified that immediately after the accident she felt pain in her foot, forehead, neck, and back. Her neck pain went from the top of her neck to the base of the neck and down below the back of her shoulders. The back pain was from her mid back to the tailbone.

Petitioner was initially evaluated by the medical staff at Choate and referred to the outpatient clinic at Union County Hospital where they sutured her head and x-rayed her face. No treatment was given for the neck or back. Petitioner testified that she contacted Dr. Moyers regarding the injuries she suffered on June 2, 2009, but the doctor would not treat her because a Workers' Compensation claim was involved. Petitioner did indicate that she had been on pain medication for her migraines and Dr. Moyer "prescribed a stronger one." (T. 16)

On June 3, 2009, Petitioner filled out an Employee's Notice of Injury form for her alleged June 2, 2009, injury. (RX1). That form indicates, in pertinent part, "...back hurts neck hurts...."*Id.*

On August 20, 2009, Petitioner followed up with Dr. Koonce regarding her migraines. Petitioner complained of headaches occurring once weekly and asked for a refill of Percocet. Petitioner also complained of pain in her back and neck. Petitioner denied tingling in the arms and legs. Petitioner's medications were renewed. (PX1 at 12-14). When Petitioner returned to Dr. Koonce on December 14, 2009, she complained of worsening headaches and neck pain. It was noted that her neck had been a problem since June, 2009, when a Patient threw her into a wall and that her headaches have been worse since that time. *Id.* at 15-17. On January 14, 2010, Petitioner returned to Dr. Koonce complaining of headaches, neck pain, and upper back pain. Dr.

Koonce continued Petitioner's prescriptions and added Imitrex. *Id.* Dr. Koonce referred Petitioner to Dr. Karshner.[1]

On January 26, 2010, Petitioner presented to Dr. Matthew Karshner. Dr. Karshner noted she was referred by Dr. Koonce for neck pain and low back pain. (PX2 at 1) Dr. Karshner noted Petitioner had a history of a four-wheeler wreck in 1990 which resulted in neck pain which resolved within two weeks. She began having migraines in 1993. She had another four-wheeler wreck approximately three years prior, and again experienced neck pain which resolved on its own. Petitioner was slammed into a wall at work in June 2009, but forewent therapy so she could change positions at work. *Id.* On physical examination, Dr. Karshner noted Petitioner had normal sensation and regular joint range of motion. Some tenderness revealed in the neck and shoulder muscle; however, no active trigger points identified. Neck range of motion was nearly normal in extension, decreased in flexion, and decreased somewhat with lateral rotation. *Id.* Dr. Karshner diagnosed Petitioner with neck pain, recurrent and chronic; no evidence of neuropathy or radiculopathy; no distinct evidence of myofascial pain; Axis I/II disorders, figuring significantly; and mental status alteration, possibly secondary to medication versus other. (PX2). Dr. Karshner recommended physical therapy for Petitioner's neck and indicated that he would see Petitioner back in two to three weeks and "we can talk about her back at that point." *Id.* at *3*.

On February 9, 2010, Petitioner presented to Outpatient Rehabilitation Services for physical therapy for chronic neck pain. (PX3). Petitioner filled out a medical History Progress Note and indicated pain in her neck at a two out of 10 on the pain scale. (PX3). Petitioner did a physical therapy evaluation and was recommended to do physical therapy two to three times a week for four weeks. (PX3). She did not attend further.

On March 10, 2010, Petitioner returned to Dr. Karshner. Petitioner complained of neck pain and low back pain. (PX2 at 5). Petitioner went to one physical therapy session for her neck, but indicated it hurt so much that she did not return. Petitioner indicated her low back pain was constant, sharp, dull, and with no radiation. Dr. Karshner's impressions were cervical pain and low back pain. Dr. Karshner recommended physical therapy for Petitioner's thoracic and lumbar spine and an MRI of the cervical spine. *Id.* at 1-2.

On March 25, 2010, Petitioner followed up with Dr. Koonce regarding her migraines. Petitioner also complained of continued neck pain. Dr. Koonce assessed Petitioner with migraines, tension headaches, and neck pain and gave petitioner six additional syringes of Imitrex. (PX1). When Petitioner next saw Dr. Koonce on June 8, 2010, Dr. Koonce assessed Petitioner with headaches and neck pain. On July 13, 2010, Petitioner returned to Dr. Koonce. Petitioner indicated that she had no change in her migraines and neck pain. The notes reflect that Petitioner stated "Dr. Moyers is running a bunch of new tests to make sure that nobody is missing anything. That's all next week, and I asked that all the copies of the results go to you and Dr. Karshner." *Id.* Dr. Koonce assessed Petitioner with migraines, chronic neck pain, and PTSD. *Id.*

[1] The Arbitrator notes that throughout her treatment for the work-related injuries which form the basis for these two claims, Petitioner continued to see Dr. Koonce regarding her preexisting migraine headaches. She also continued to see Dr. Moyer, her primary care physician regarding a number of conditions unrelated to the injuries at issue in this case. Although the records have been reviewed only visits which may have some relevance to the issues herein will be referenced in this decision.

On July 20, 2010, Petitioner underwent an MRI of her cervical spine without contrast, as ordered by Dr. Karshner and Dr. Moyers. (PX2). The impression was disc bulge at C3-4 and facet osteoarthritis particularly at C5-6 and C7-T1, no cervical disc herniation nor central stenosis. (PX2 at 13).

On December 16, 2010, Petitioner followed up with Dr. Koonce. Petitioner indicated that she had been doing well with her migraines until the previous week. Petitioner also complained of continued neck pain and requested a referral to pain management and "some pain medication until I can get in to see the pain physician." Petitioner was given a referral to pain management and given a prescription for Zanaflex. (PX1).

On December 17, 2010, Petitioner returned to Dr. Moyers complaining of pain in her legs and arms for three weeks. (PX4). Petitioner also complained about her balance. (PX4). On January 19, 2011, Petitioner returned to Dr. Moyers to review her lab work. (PX4). Petitioner also complained of congestion and body aches. *Id.*

On February 16, 2011, Petitioner presented to Dr. Terry Cleaver at the Brain and Neurospine Clinic of Missouri on the referral of Dr. Koonce. Petitioner complained of neck pain down to her middle back and lower back. Petitioner indicated that her neck pain is her most significant pain. Petitioner indicated that her pain had been exacerbated by increased household duties since her husband injured his knee. Dr. Cleaver recommended conservative treatment. He prescribed Lidoderm patches. Dr. Cleaver also recommended trigger point injections, but Petitioner declined at that time. Dr. Cleaver noted that he did not have any additional treatment to offer Petitioner, but she was welcome to contact the clinic if she chose to undergo the trigger point injections. (PX5).

On March 16, 2011, Petitioner returned to Dr. Cleaver indicating that she was interested in undergoing the trigger point injections. A trigger point injection was given to Petitioner in her right splenius capitus and right supraspinatus. Petitioner was to return in two weeks for a possible repeat injection. (PX5). On March 30, 2011, Petitioner followed up with Dr. Cleaver and received a trigger point injection in her cervical and thoracic paraspinous muscles. *Id.* On April 18, 2011, Petitioner followed up with Dr. Cleaver and received a trigger point injection in her bilateral trapezius and right splenius cervicus. *Id.*

On May 17, 2011, Petitioner presented to Dr. Annamaria Guidos at the Brain and NeuroSpine Clinic of Missouri. Dr. Guidos noted Petitioner was referred by Dr. Cleaver for muscle spasms. Dr. Guidos' impression was Petitioner had myofascial pain disorder and recommended aquatic physical therapy followed by land physical therapy. Petitioner was to follow up in one month. (PX5).

On June 9, 2011, Petitioner presented to St. Francis Health and Wellness Center for physical therapy as prescribed by Dr. Guidos. (PX7). Petitioner completed an initial physical therapy evaluation. Petitioner indicated that she was thrown against a wall and hit her head in 2009. *Id.* She attended one additional therapy appointment on June 15, 2011.

On July 28, 2011, Petitioner suffered her second undisputed accident when she was pushed backward by a patient and struck her head and low back on the bathroom door of a patient's room.

On August 2, 2011, Petitioner filled out an Employee's Notice of Injury form for her July 28, 2011, injury. (RX5). Petitioner indicated that she was attempting to block a female patient from going after another female when she pushed through Petitioner and jarred her neck. (RX5). She wrote that she injured the "back of neck." *Id.*

On August 15, 2011, Petitioner underwent three view x-rays of her cervical spine at Union County Hospital. (PX8). No fracture or subluxation was found and Petitioner had normal vertebra, interspaces, posterior elements, and dens. (PX8).

On August 23, 2011, Petitioner returned to Dr. Koonce. (PX1 at 54). Petitioner indicated that her migraines have not increased, but that she was injured at work on July 28, 2011. Petitioner stated that she got between two patients and was "thrown against the wall" like she was two years prior. *Id.* Petitioner stated she had increased posterior neck pain and occipital headaches since. Dr. Koonce noted that he would not fill out Petitioner's workers' compensation paperwork, but would continue to treat her migraines. Dr. Koonce assessed Petitioner with migraines and neck pain Petitioner associated with her workers' compensation injury. *Id.*

On August 26, 2011, Petitioner presented to Dr. Mark Austin at SIH Work Care. (PX10). Petitioner indicated that she injured her neck at work on July 28, 2011, when she was splitting up an altercation between two females and she was pushed, jarring her neck. (PX10). Petitioner complained of worse migraines and a stiff neck. (PX10). Petitioner indicated that she had a prior work related injury to her neck in 2009. (PX10). Petitioner was diagnosed with cervical paraspinal strain and spasm and tender upper thoracic paraspinal muscles. (PX10). Dr. Austin recommended work restrictions and gentle stretching. (PX10). Dr. Austin referred Petitioner to Dr. Sawar. (PX10).

On September 23, 2011, Petitioner followed up with Dr. Austin. (PX10). Petitioner indicated she had no improvement of her neck pain and exacerbation of her migraines. (PX10). Petitioner also indicated she now had some numbness and tingling into her right upper extremity. (PX10). Petitioner indicated she was scheduled to see Dr. Sawar on October 3, 2011. (PX10). Dr. Austin recommended Petitioner undergo an MRI of her cervical spine and continued her work restrictions. (PX10).

On October 3, 2011, Petitioner presented to Dr. Amar Sawar at the Neurology and Arthritis Clinic on referral from Dr. Austin. Petitioner indicated on July 28, 2011, while working as a Mental Health Technician, she was trying to separate two females and, as a result, her neck was jarred. Petitioner also complained of lower back pain. Petitioner was assessed with neck pain following physical injury, low back pain following physical injury, possible post traumatic syndrome, and common migraine with increasing frequency after neck injury. Dr. Sawar recommended a cervical spine MRI, lumbar spine MRI, brain MRI, and nerve conduction studies of the upper extremity. (PX11).

On October 11, 2011, Petitioner underwent a cervical spine MRI without contrast. The impression was: mild cervical levoscoliosis; small left C6-C7 paracentral disc protrusion, no cord deformity or central spinal canal stenosis; no overt foraminal stenosis; and small T2 hyperintense lesions within both thyroid lobes, suggest thyroid ultrasound for further evaluation. (PX12).

On October 14, 2011, Petitioner followed up with Dr. Austin. Dr. Austin reviewed Petitioner's cervical spine MRI. Dr. Austin continued Petitioner's work restrictions and indicated he was referring Petitioner to Dr. Sawar for all further care. Dr. Austin also made a referral to Dr. Newell. (PX10).

On October 31, 2011, Petitioner returned to Dr. Sawar to obtain nerve conduction studies. Petitioner indicated she had three migraine episodes since her last appointment and lower back pain and tingling in the left ankle. The nerve conductions studies revealed evidence of mild bilateral carpal tunnel syndrome without active denervation. There was no evidence of ulnar mononeuropathy, cervical radiculopathy, lumbosacral radiculopathy, or large fiber peripheral neuropathy. (PX11).

On November 1, 2011, Petitioner presented to Dr. Brent Newell at the SIH Rehabilitation Institute. (PX13). Dr. Newell noted Petitioner was referred to him by Dr. Austin. Petitioner complained of severe neck pain and back pain. Petitioner indicated that in July, while at work she intervened between two aggressive patients and her neck was jarred. Petitioner also indicated that she suffered an injury in 2009 and had neck and back pain and was off for six months, but returned to work because she was up for a promotion. Petitioner indicated that she already had neck pain at the time of the July injury; but it has increased in severity since the time of the injury. Petitioner also complained of lower back pain, but that it was not aggravated by this incident and was preexisting from the June 2009 incident. *Id.* at 11. Dr. Newell reviewed Petitioner's cervical spine MRI and noted it revealed extremely mild degenerative changes in the cervical spine with no evidence of stenosis. Dr. Newell's impression was neck pain with cervical strain and myofascial pain, which he felt appeared to be an aggravation of her condition following the June, 2009, accident. Dr. Newell recommended trigger point injections followed by physical therapy. Dr. Newell noted that Dr. Sawar referred Petitioner to neurosurgery, but that he, Dr. Newell, did not believe that there were any neurosurgical indications at this time. Dr. Newell gave Petitioner two trigger point injections in the right upper trapezius, one in the low cervical paraspinals, and one in the mid cervical paraspinals. *Id.* at 13-14.

On December 1, 2011, Petitioner returned to Dr. Newell. Dr. Newell noted the trigger point injections seemed to aggravate Petitioner's symptoms, so they would not pursue that any further. Dr. Newell's impression was chronic neck pain, cervical myofascial pain, and cervical spondylosis. (PX13). Dr. Newell again recommended physical therapy indicating he was not sure why it had not yet been approved. (PX13).

On December 27, 2011, Petitioner attended a physical therapy evaluation at the SIH Rehabilitation Institute. (PX15). Petitioner indicated she was breaking up a fight at work and she is not sure what happened but her neck began hurting that night. (PX15). Her diagnoses were listed as neck pain and myofascial pain. (PX15). Petitioner was recommended to attend physical therapy two times a week for four weeks. (PX15).

On January 2, 2012, Petitioner returned to Dr. Sawar. (PX11). Petitioner indicated that her migraine frequency had decreased to one time a week, but her neck pain was unchanged. (PX11). Dr. Sawar assessed Petitioner with common migraine poorly controlled, post traumatic syndrome, bilateral carpal tunnel syndrome, cervical disc bulging, and low back pain. (PX11). Dr. Sawar recommended Petitioner use cock up splints for her wrists and indicated he was still waiting on the lumbar spine MRI. (PX11).

On January 4, 2012, Petitioner returned to Dr. Newell. Petitioner indicated that she went to a therapy evaluation, but it aggravated her symptoms and she did not see any benefit with that visit. Petitioner indicated that she has continued neck pain and numbness in both arms. Dr. Newell's impression was chronic neck pain and cervical spondylosis. Dr. Newell again noted he did not think there was any surgical indication here, but Petitioner would like to get a surgical opinion. Dr. Newell noted that epidural injections may be something the neurosurgeon recommends, but he would prefer the recommendation to come from the surgeon at this point. (PX13).

On January 5, 2012, Petitioner underwent an MRI of her lumbar spine. (PX11). The impression was grade 1 anterolisthesis L5 on S1 due to bilateral L5 pars interarticularis defects, this is associated with a mild disc bulge that is more prominent right posterolaterally and laterally where there is an annular tear; small right paracentral disc protrusion L4-5; and simple cyst left kidney. (PX11).

On January 10, 2012, Petitioner underwent an MRI of her head with and without contrast. (PX11). The impression was no acute intracranial hemorrhage, mass or infarct and an old left lamina papyracea fracture. (PX17).

On February 6, 2012, Petitioner followed up with Dr. Sawar. (PX11). Petitioner indicated that she had one episode of migraine a month on average, but had continued neck pain. (PX11). Dr. Sawar noted they were awaiting consultation with a neurosurgeon. (PX11).

On February 15, 2012, Petitioner presented to Trinity Neuroscience Institute. (PX19). Petitioner was seen by Angela Arnold PAC. Petitioner indicated that on July 28, 2011, she intervened between two patients and her neck was jarred. (PX19). Petitioner complained of neck pain, thoracic pain, shoulder pain, lower back pain, and bilateral hand and feet parasthesias. (PX19). Petitioner's MRIs were reviewed and it was noted Petitioner had minimal cervical spine degenerative changes without stenosis and degenerative disc disease at the L4-5 level with an anterolisthesis of L5 on S1. (PX19). X-rays of Petitioner's cervical and lumbar spine were ordered. (PX19). It was noted Petitioner was referred to Trinity Neuroscience Institute by Dr. Sawar. (PX19).

On February 15, 2012, Petitioner underwent x-rays of her lumbar and cervical spine at Memorial Hospital of Carbondale at the referral of Trinity Neuroscience Institute. (PX18). The impression of Petitioner's lumbar spine was grade one anterolisthesis of L5 on S1 with bilateral pars interarticularis defects and spinal dysraphism posterior elements of L5. (PX18). The impression of Petitioner's cervical spine was no acute abnormality of the cervical spine. (PX18).

On February 16, 2012, Petitioner presented to Dr. Babu Prasad at Advanced Pain Management at the referral of Dr. Austin. (PX20). Petitioner was given a left transforaminal lumbar epidural. (PX20).

On March 22, 2012, Petitioner underwent a Section 12 examination with Dr. Thomas Lee at Tesson Heights Orthopedics for her cervical spine. (RX9, PX21). Petitioner indicated the injury occurred on July 28, 2011, when she tried to break up two female patients who were fighting. (RX9, PX21). Petitioner indicated that she is averaging four Percocet a day. (RX9, PX21). Petitioner provided a history of migraines prior to the July 28, 2011, incident, but they were worse afterwards for a while, and are now under control. (RX9, PX21). Petitioner indicated that she had a previous injury in 2009 where she injured her neck and back, but the case

was closed because she returned to work. (RX9, PX21). Petitioner indicated she has had neck and back pain since. (RX9, PX21). On physical examination, Petitioner had decreased cervical range of motion and some pain with range of motion. (RX9, PX21). Dr. Lee diagnosed Petitioner with C6-7 disc bulge and ruled out left foraminal herniation at C5-6. (RX9, PX21). Dr. Lee opined the July 28, 2011, accident aggravated Petitioner's pre-existing condition, causing her current symptoms in her neck. (RX9, PX21). Dr. Lee recommended a CT myelogram and that Petitioner return to work light duty. (RX9, PX21).

On April 9, 2012, Petitioner returned to Dr. Sawar. (PX11). Petitioner indicated she was having one migraine weekly and that her neck pain, low back pain, and the numbness and tingling in both hands and her right ankle were worse. (PX11). Dr. Sawar recommended a cervical spine MRI, lumbar spine MRI, and nerve conduction studies of the upper and lower extremities. (PX11). Dr. Sawar gave Petitioner a prescription for Vicodin. (PX11).

On April 17, 2012, Petitioner returned to Dr. Newell. (PX13). Petitioner indicated that she underwent an independent medical examination and an epidural injection was recommended, so she was interested in that. (PX13). Petitioner stated she returned to work light duty the day before and that had increased her symptoms some. (PX13). Dr. Newell's impression was cervical spondylosis and chronic neck pain. (PX13). Dr. Newell noted he would perform the epidural injection, but if there was no improvement with the injection, he will likely not have further interventions to offer. (PX13).

On April 19, 2012, Petitioner returned to Dr. Prasad. (PX20). Petitioner was given a left transforaminal lumbar epidural with fluoroscopic guidance. (PX20).

On May 7, 2012, Petitioner returned to Dr. Sawar. (PX11). Petitioner indicated she had one migraine since her last appointment, but her neck pain and numbness and tingling in both hands were worse. (PX11). Dr. Sawar recommended a cervical spine MRI and again referred Petitioner to a spinal neurosurgeon. (PX11). Dr. Sawar gave Petitioner a prescription for Vicodin. (PX11).

On June 5, 2012, Dr. Sawar wrote Petitioner a note indicating that she was unable to work until she was evaluated by a neurosurgeon. (PX22).

On June 6, 2012, Petitioner returned to Dr. Sawar. (PX11). Petitioner indicated she had one migraine a week on average and that her back pain was improved. (PX11). Dr. Sawar increased Petitioner's Lyrica and continued her Imitrex. (PX11).

On July 6, 2012, Petitioner underwent a CT myelogram at Memorial Hospital of Carbondale. (PX23, PX24). The impression was minimal central disc bulge at the C5-C6 level and minimal left paracentral disc bulge at the C6-C7 level, but no spinal canal or neural foraminal narrowing. (PX24).

On August 8, 2012, Petitioner presented to Dr. David Raskas at the Orthopedic Sports medicine & Spine Care Institute. (PX31). Petitioner complained of neck and low back pain. (PX31). Petitioner indicated she had two work injuries: on June 2, 2009, an aggressive male patient at work shoved her into a concrete wall and on July 28, 2011 she was trying to keep two female patients from fighting when she developed pain in her neck. (PX31). On physical examination, Petitioner was noted to have a minimally flat affect and limited range of

motion of the cervical and lumbar spine. (PX31). Dr. Raskas recommended Petitioner undergo discography at L3-4, L4-5, as well as C4-5, C5-6 and C6-7. (PX31). Dr. Raskas noted Petitioner would at minimum need a fusion at L5-S1. (PX31). Dr. Raskas took Petitioner off of work. (PX31).

On September 6, 2012, Petitioner underwent a lumbar and cervical discogram. (PX25). The lumbar discogram impression was classically positive discogram at L4-5 with annular tear and reproduction of pain; negative L3-4 discogram. (PX25). The cervical discogram impression was classically positive C5-6 discogram with reproduction of neck and shoulder pain; negative C4-5 and C6-7 discographies. (PX25).

On September 10, 2012, Petitioner returned to Dr. Raskas. (PX32). Dr. Raskas reviewed the discographies and recommended Petitioner undergo an anterior/posterior fusion at L5-S1 and probably a fusion or disc replacement at C5-6. (PX32). Petitioner continued to follow up with Dr. Sawar regarding her migraines.

On December 13, 2012, Petitioner underwent an independent medical evaluation with Dr. Shawn L. Berkin at the request of Petitioner's counsel. (PX30). Petitioner indicated in June 2009, she injured her head and neck when she was pushed into a wall by a patient. (PX30). Petitioner indicated that in July, 2011, she was breaking up a fight between two patients when she was shoved backwards, striking her back against a bathroom door. (PX30). Petitioner's present complaints included severe pain and tenderness in her neck radiating to her right shoulder and limited range of motion of her neck. (PX30). Petitioner also complained of low back pain down to her buttock and right leg. (PX30). On physical examination, Petitioner had limited range of motion of her cervical and lumbar spine. (PX30). Dr. Berkin's impression of Petitioner was cervical strain, bulging of the C3-4 and C5-6 intervertebral discs, lumbosacral sprain, protrusion of the L4-5 intervertebral disc with annular tear, bulging of the L5-S1 intervertebral disc, and spondylolisthesis of L5 on S1. (PX30). Dr. Berkin opined he believed these conditions were causally related to Petitioner's June 2, 2009, and July 28, 2011, injuries. (PX30). Dr. Berkin recommended Petitioner see a spine surgeon for surgical intervention. (PX30).

On September 16, 2013, Petitioner returned to Dr. Raskas. (PX31). Petitioner continued to complain of significant neck pain. (PX31). Dr. Raskas recommended a cervical disc arthroplasty, but wanted to get a new MRI done first. (PX31). Dr. Raskas recommended putting treatment for the lower back on hold until after petitioner was done treating for her neck. (PX31).

On February 25, 2014, Petitioner returned to Dr. Raskas. (PX31). Petitioner continued to complain of neck pain. (PX31). Dr. Raskas noted that his recommendations were the same as the last time that he saw Petitioner. (PX31).

On May 27, 2014, Dr. Lee authored an addendum to his Section 12 report. (RX10, PX21). Dr. Lee outlined the additional medical records he reviewed and opined that the injury of July 28, 2011 aggravated Petitioner's preexisting condition and caused her current neck symptoms. (RX10, PX21). Dr. Lee agreed with the proposed C5-6 total disc replacement as appropriate treatment and that light duty work restrictions were appropriate. (RX10, PX21).

On June 24, 2014, Petitioner returned to Dr. Raskas for a pre-operative evaluation for her cervical disc replacement. (PX32). Petitioner complained of neck and low back pain. (PX32). Dr. Raskas assessed Petitioner with cervical discogenic pain and recommended an anterior cervical disc arthroplasty. (PX32).

In July 2014 Dr. Raskas performed a cervical disc replacement at C5-6. On July 15, 2014, Petitioner returned to Dr. Raskas for a post-operative follow up. (PX32). Petitioner indicated that she no longer had pain in her neck going to her shoulder and the numbness in her hands was gone. (PX32). Dr. Raskas recommended a myelogram CAT scan to re-evaluate Petitioner's lumbar condition. (PX32).

On August 22, 2014, Petitioner followed up with Dr. Raskas. (PX32). X-rays of Petitioner's cervical spine showed no loosening about the prosthesis and the prosthesis was in good position. (PX32). Dr. Raskas recommended physical therapy for Petitioner. (PX32).

On September 9, 2014, Petitioner underwent a Section 12 examination with Dr. David Robson with regard to her lumbar spine. (RX11). Petitioner indicated she had two work injuries: on June 2, 2009, she stated she was slammed into a concrete wall jarring her neck and hurting her lower back and on July 28, 2011, Petitioner stated she was breaking up a fight between two female patients when she was pushed back into a doorknob and injured her lower back and neck. (RX11). Petitioner indicated that she underwent a disc replacement at C5-6 and has had considerable symptomatic relief of her neck pain, with just some residual achiness and soreness in her neck and shoulders. (RX11). Petitioner indicated that she had low back pain after the 2009 incident that was made worse by the 2011 incident. (RX11). Dr. Robson assessed Petitioner with lumbar spondylolisthesis L5-S1. (RX11). Dr. Robson opined that he did not believe Petitioner's lumbar spine condition was related to her June 2, 2009, or July 28, 2011, incidents. (RX11, RX12).

On October 21, 2014, Petitioner returned to Dr. Raskas. (PX32). Petitioner indicated that her neck was markedly improved, but she still had some right shoulder pain. (PX32). Dr. Raskas again recommended a myelogram CAT scan to re-evaluate Petitioner's lumbar condition. (PX32). Dr. Raskas continued Petitioner off of work. (PX32).

On December 1, 2014, Petitioner returned to Dr. Raskas. (PX32). Dr. Raskas reviewed the results of the myelogram CAT scan noting Petitioner had a protrusion at L4-5 and spondylolisthesis at L5-S1. (PX32). Dr. Raskas recommended Petitioner undergo an anterior fusion at L4-5 and L5-S1 which occurred in late December 2014. (PX32). Dr. Raskas recommended the post-operative use of a lumbar bone growth stimulator. (PX32).

On January 27, 2015, Petitioner returned to Dr. Raskas following her anterior/posterior lumbar fusion. (PX32). X-rays revealed anterior/posterior instrumentation L4 to S1 with anatomic alignment of the spine and marked reduction of Petitioner's spondylolisthesis. (PX32). Petitioner indicated she was having constipation problems. (PX32). Dr. Raskas recommended Petitioner undergo a CAT scan to ensure Petitioner did not have a big fluid collection. (PX32).

On February 6, 2015, Petitioner followed up with Dr. Raskas. (PX32). Dr. Raskas noted Petitioner has done well after her cervical disc arthroplasty. (PX32). Dr. Raskas also noted Petitioner was doing much better with regard to her anterior lumbar fusion. (PX32). X-rays of Petitioner's cervical spine revealed the artificial disc to be in good position with no loosening of the prosthesis. (PX32). Dr. Raskas released Petitioner to return to work with no restrictions and at maximum medical improvement with regard to her cervical spine. (PX32). Dr. Raskas outlined work restrictions for Petitioner for her lumbar spine and she was to return for a follow up in three months time. (PX32).

Dr. Shawn Berkin testified via evidence deposition dated March 25, 2013. (PX30). Dr. Berkin performed an independent medical examination at the request of Petitioner's counsel. Dr. Berkin testified that he believed Petitioner had a cervical strain injury with bulging of the C3-4 and C5-6 discs due to the June 2, 2009 incident. (PX30 at 17). He opined that the July 28, 2011 incident caused Petitioner to have a recurrent sprain to the cervical spine, a lumbosacral strain, protrusion of the L4-5 intervertebral disc with a tear of the annulus, bulging of the L5-S1 intervertebral disc, and spondylolisthesis of L5 on S1. (PX30 at 18). Dr. Berkin testified that he believed Petitioner needed additional treatment from a spine surgeon. (PX30 at 21). On cross-examination Dr. Berkin testified that he did not believe Petitioner needed ongoing treatment for the June 2009 injury and that Petitioner reinjured her neck in July 2011. (PX30 at 33).

Dr. David Raskas testified via evidence deposition on March 5, 2014. (PX31). Dr. Raskas testified that Petitioner had two work-related injuries. Dr. Raskas testified Petitioner's diagnoses were spondylolisthesis at L5-S1 and disc protrusions at C5-6 and C6-7. *Id.* at 13. Dr. Raskas testified that he believed both accidents were contributing factors to Petitioner's conditions. *Id.* at 16. Dr. Raskas testified that he recommended Petitioner undergo a C5-6 disc arthroplasty. *Id.* at 19.

On May 27, 2014, Dr. Lee authored an addendum to his Section 12 report wherein he opined that the injury of July 28, 2011, aggravated Petitioner's preexisting condition and caused her current neck symptoms. Dr. Lee agreed with the proposed C5-6 total disc replacement as appropriate treatment and that light duty work restrictions were appropriate. (RX10, PX21). As a result of Dr. Lee's agreement Respondent authorized the cervical surgery.

Dr. David Raskas again testified via evidence deposition on February 23, 2015. (PX32). Dr. Raskas testified that he received authorization and performed a cervical disc replacement at C5-6 on July 2. 2014. *Id.* at 7. Dr. Raskas testified that Petitioner was at maximum medical improvement for her cervical spine. *Id.* at 8. Dr. Raskas testified that he believed Petitioner's June 2, 2009, and July 28, 2011, accidents contributed to Petitioner's neck condition and need for surgery. *Id.* Dr. Raskas testified that he also performed an anterior/posterior lumbar fusion on Petitioner in December 2014. *Id.* at 9. Dr. Raskas testified that he believed that Petitioner's June 2, 2009 and July 28, 2011 accidents both contributed to her back condition and the need for surgery. *Id.* at 11-12. Dr. Raskas testified that on February 6, 2015, he released Petitioner to return to work without restrictions with regard to her cervical spine and that Petitioner had responded well to the surgery. *Id.* at 14. Dr. Raskas testified that Petitioner wrote on her intake form that she was referred to him by Dr. Sawar, but that he did not know if he received any kind of referral notice or document. *Id.* at 18-19.

Dr. David Robson testified via evidence deposition on February 26, 2015. (RX12). Dr. Robson testified that Petitioner gave him a history of two work injuries: on June 2, 2009, Petitioner indicated she was slammed into a wall injuring her neck and lower back and on July 28, 2011, Petitioner indicated she was trying to break up a fight between two patients when she was pushed into a doorknob and developed low back and neck pain. *Id.* at 10. Dr. Robson testified that based on his review of the medical records imaging reports, and his physical examination of Petitioner, he believed her diagnosis was spondylolisthesis L5-S1. *Id.* at 11. Dr. Robson testified that he did not believe that Petitioner's lumbar condition was related to anything that occurred on June 2, 2009, or July 28, 2011. *Id.* at 13. Dr. Robson indicated that the basis of his opinion was as that he did not feel that

there was a temporal relationship between Petitioner's accidents and her complaints of low back pain. *Id.* Dr. Robson did not believe that either of the injuries aggravated or accelerated Petitioner's spondylolisthesis. *Id.* at 14. Dr. Robson testified that he did not believe that Petitioner's anterior/posterior fusion at L4-5 and L5-S1 was related to either of the work injuries of June 2, 2009, or July 28, 2011. *Id.* Dr. Robson testified that he did not see any significant herniated disc in Petitioner's lumbar spine. *Id.* at 20-21.

As of the date of hearing Petitioner remained under the care of Dr. Raskas regarding her lumbar spine for which she was still involved in post-operative follow up.

CONCLUSIONS OF LAW

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

It is undisputed Petitioner sustained an accidental injuries to her cervical spine on June 2, 2009 and July 28, 2011. Further, based upon the opinion of Respondent's Section12 examiner, Dr. Lee, Respondent does not contest the causal relationship between Petitioner's cervical spine condition and her work accidents. Petitioner has undergone treatment for her cervical spine and has been released to return to work without restrictions at maximum medical improvement as of February 6, 2015.

The Arbitrator found the Petitioner to be a credible witness. Both the Employee's Notice of Injury form and the supervisor's report of injury completed within days of the June 2, 2009, accident reflect Petitioner injured her back in addition to her neck. (PX33 at 2-3) It is not lost on the Arbitrator that the accident form completed following the July 28, 2011, accident simply reflects that Petitioner injured the back of her neck. (RX5) Petitioner testified that immediately following the accident her neck pain intensified significantly. She also indicated, however that her back pain increased as well and she eventually began to experience pain radiating down both legs which had not been present following the June 2, 2009, accident.

Both Dr. Raskas and Dr. Berkin testified that the accidents of June 2, 2009, and July 28, 2011, were contributing causes to Petitioner's cervical and lumbar conditions. Dr. Lee agreed with respect to the cervical spine condition. Dr. Robson did not believe that Petitioner's lumbar condition was related to anything that occurred on June 2, 2009, or July 28, 2011. He indicated that the basis of his opinion was as that he did not feel that there was a temporal relationship between Petitioner's accidents and her complaints of low back pain. As indicated above, the accident forms which were completed within days of the June 2, 2009, accident clearly indicate Petitioner complained of back pain at that time. The Arbitrator finds the testimony and opinions of Dr. Raskas and Dr. Berkin more persuasive than those of Dr. Robson.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met her burden of establishing that the conditions of ill-being in both her cervical and lumbar spine are causally related to the undisputed accidents of June 2, 2009 and July 28, 2011.

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?

Issue (O) **Has Petitioner exhausted her choices of physicians?**

Respondent does not dispute the medical charges related to treatment of Petitioner's cervical spine. Further, Respondent did not dispute the reasonableness and necessity of the lumbar treatment, but simply its liability therefore based upon the issues of causal connection and whether Petitioner exceeded her choices of physician.

Dr. Raskas testified that he performed an anterior/posterior lumbar fusion on Petitioner in December, 2014. Dr. Raskas testified that he believed that Petitioner's June 2, 2009, and July 28, 2011, accidents both contributed to her back condition and the need for surgery. Having found the testimony and opinions of Dr. Raskas and Dr. Berkin more persuasive than those of Dr. Robson, the Arbitrator finds Petitioner has met her burden of establishing that the medical treatment provided up to the date of Arbitration has been both reasonable and necessary.

Prior to the June 2, 2009, accident Petitioner had been treating with Dr. Moyers, her primary care physician for a number of conditions unrelated to this claim. She had also been treating with Dr. Koonce due to migraine headaches. Petitioner credibly testified that Dr. Moyers did not wish to become involved in treatment of the injuries sustained on June 2, 2009, because of the involvement of a workers' compensation claim. Petitioner testified that Dr. Moyers did however provide her with pain medication. Following the June 2, 2009, accident Dr. Koonce then began prescribing Petitioner pain medication for her neck and increased migraines. Dr. Koonce referred Petitioner to Dr. Cleaver and Dr. Karshner. The Arbitrator finds Petitioner did not exceed her choices of physician regarding her June 2, 2009, accident.

Petitioner sustained her second accident on July 28, 2011. Following this accident she presented to Dr. Koonce on August 23, 2011. Dr. Koonce's records from that date are clear in that he would not fill out Petitioner's workers' compensation paperwork, but would continue to treat her migraines. Thereafter, on August 26, 2011, Petitioner presented to Dr. Mark Austin at SIH Work Care. The Arbitrator finds Dr. Austin to have been the first choice of provider relative to Petitioner's accident of July 28, 2011. Dr. Austin referred Petitioner to Dr. Sawar, Dr. Newell, Dr. Prasad, and Trinity Neuroscience.

Petitioner also treated with Dr. Raskas. Dr. Raskas testified that Petitioner wrote on her intake form that she was referred to him by Dr. Sawar, but that he did not know if he received any kind of referral notice or document. The medical records in evidence indicate that on May 7, 2012, Petitioner was seen by Dr. Sawar who recommended a cervical spine MRI and again indicated Petitioner needed to be evaluated by a spinal neurosurgeon. On June 5, 2012, Dr. Sawar wrote Petitioner a note indicating that Petitioner was unable to work until she was evaluated by a neurosurgeon. On July 6, 2012, Petitioner underwent a CT myelogram at Memorial Hospital of Carbondale. Following this evaluation Petitioner presented to Dr. David Raskas on August 8, 2012. The Arbitrator finds that Dr. Raskas was seen, if not on the referral of, at least consistent with the recommendation of Dr. Sawar. However, even if Dr. Raskas were a separate choice of provider, he would only be Petitioner's second choice relative to the July 28, 2011, accident. The Arbitrator finds Petitioner did not exceed her choices of physician regarding her July 28, 2011, accident.

The record contains medical bills totaling $86,346.43. $55,040.77 of these charges were incurred prior to Petitioner's July 28, 2011, accident. $31,305.66 of the charges were incurred following the July 28, 2011, accident. (PX29)

Based upon the foregoing and the record taken as a whole, the Arbitrator finds the medical treatment provided to Petitioner from June 2, 2009, through July 27, 2011, which resulted in charges of $55,040.77 was both reasonable and necessary to treat the injuries sustained on June 2, 2009, and Respondent is liable for those charges. The Arbitrator further finds the medical treatment provided to Petitioner from July 28, 2011, through the date of hearing which resulted in charges of $31,305.66 was both reasonable and necessary to treat the injuries sustained on July 28, 2011, and Respondent is liable for those charges.

Respondent shall pay reasonable and necessary medical services of $86,346.43 as set forth in Petitioner's exhibit 29, 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 Sections 8(j) of the Act. Further, Respondent shall authorize and pay for Petitioner's continued follow up care with Dr. Raskas.

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

The parties stipulated that Petitioner is entitled to total temporary disability benefits from June 6, 2012, through February 6, 2015 (139 2/7 weeks). Petitioner was released to return to work without restrictions and at maximum medical improvement with regard to her cervical spine on February 7, 2015. At the time she was released from care with regard to her cervical spine Petitioner remained under the care of Dr. Raskas and unable to work due to her lumbar spine condition. As of the date of hearing, May 21, 2015, Petitioner remained unable to return to work due to her lumbar condition.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Respondent shall pay Petitioner temporary total disability benefits of $465.02/week for 154 1/7 weeks, commencing June 6, 2012, through May 21, 2015, as provided in § 8(b) of the Act. Respondent shall be given a credit of for temporary total disability benefits that have been paid.

STATE OF ILLINOIS)
) SS.
COUNTY OF ST. CLAIR)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LISA KEPPNER,

Petitioner,

vs.

NO: 12WC017114

CHOATE MHC,

Respondent,

17IWCC0089

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 17, 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.

17IWCC0089

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: FEB 14 2017
MJB/bm
o-2/6/17
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

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

KEPPNER, LISA
Employee/Petitioner

Case# **12WC017114**

12WC017113

CHOATE MHC
Employer/Respondent

17IWCC0089

On 3/17/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.51% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0686 GARY MATHENY LAW OFFICE
303 N JACKSON
FARMINGTON, MO 63640

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

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

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

MAR 17 2016

RHEALA ARASKIA, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF ST. CLAIR)

☐ 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)

Lisa Keppner
Employee/Petitioner

v.

Choate MHC
Employer/Respondent

Case # 12 WC 17114

Consolidated cases: 12 WC 17113

17IWCC0089

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Collinsville**, on **May 21, 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. ☒ 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 **Has Petitioner exhausted her selection of physicians?**

17IWCC0089

FINDINGS

On the date of accident, **07/28/2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$36,271.50**; the average weekly wage was **$697.53**.

On the date of accident, Petitioner was **39** years of age, ***single*** with **2** dependent children.

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

Respondent shall be given a credit of **$16,939.65** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$16,939.65**.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $31,305.66, 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 post-surgical follow up care, and/or further treatment recommended by Dr. Raskas, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $465.02/week for 154 1/7 weeks, commencing June 6, 2012, through May 21, 2015, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from June 6, 2012 through March 10, 2016, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $16,939.65 for temporary total disability benefits that have been paid.

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

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

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

Michael k. Nowak, Arbitrator

3/10/16
Date

ICArbDec19(b)

MAR 17 2016

BACKGROUND

Prior to the date of her first accident Petitioner was treating with Dr. Moyers, her primary care physician for a number of conditions unrelated to her neck and low back. Also prior to the accident date Petitioner was suffering from migraine headaches for which she received treatment from Dr. Aaron Koonce. A note of Dr. Koonce dated March 4, 2009, indicates Petitioner had been in a four-wheeler accident in 1990 which resulted in a neck injury. There was no medical treatment at that time and there is, no indication of any ongoing neck problems or treatment in the months prior to June 2, 2009. (PX1 at 1)

Petitioner is employed as a Mental Health Technician III for Choate Mental Health and Development Center. Petitioner sustained an undisputed accident on June 2, 2009, when she was pushed into a wall by a combative patient. She sustained a second undisputed accident on July 28, 2011, when she was pushed by a patient and struck a door. The claims arising from these accidents, 12 WC 17113 and 12 WC 17114, were consolidated at the time of Arbitration.

FINDINGS OF FACT

On June 2, 2009, Petitioner was escorting a patient back to his group room when he grabbed her and slammed her into a wall, scratched her face, bit her forehead, and stepped on her left foot. (RX1). Petitioner testified that immediately after the accident she felt pain in her foot, forehead, neck, and back. Her neck pain went from the top of her neck to the base of the neck and down below the back of her shoulders. The back pain was from her mid back to the tailbone.

Petitioner was initially evaluated by the medical staff at Choate and referred to the outpatient clinic at Union County Hospital where they sutured her head and x-rayed her face. No treatment was given for the neck or back. Petitioner testified that she contacted Dr. Moyers regarding the injuries she suffered on June 2, 2009, but the doctor would not treat her because a Workers' Compensation claim was involved. Petitioner did indicate that she had been on pain medication for her migraines and Dr. Moyer "prescribed a stronger one." (T. 16)

On June 3, 2009, Petitioner filled out an Employee's Notice of Injury form for her alleged June 2, 2009, injury. (RX1). That form indicates, in pertinent part, "…back hurts neck hurts…."*Id.*

On August 20, 2009, Petitioner followed up with Dr. Koonce regarding her migraines. Petitioner complained of headaches occurring once weekly and asked for a refill of Percocet. Petitioner also complained of pain in her back and neck. Petitioner denied tingling in the arms and legs. Petitioner's medications were renewed. (PX1 at 12-14). When Petitioner returned to Dr. Koonce on December 14, 2009, she complained of worsening headaches and neck pain. It was noted that her neck had been a problem since June, 2009, when a Patient threw her into a wall and that her headaches have been worse since that time. *Id.* at 15-17. On January 14, 2010, Petitioner returned to Dr. Koonce complaining of headaches, neck pain, and upper back pain. Dr.

Koonce continued Petitioner's prescriptions and added Imitrex. *Id.* Dr. Koonce referred Petitioner to Dr. Karshner.[1]

On January 26, 2010, Petitioner presented to Dr. Matthew Karshner. Dr. Karshner noted she was referred by Dr. Koonce for neck pain and low back pain. (PX2 at 1) Dr. Karshner noted Petitioner had a history of a four-wheeler wreck in 1990 which resulted in neck pain which resolved within two weeks. She began having migraines in 1993. She had another four-wheeler wreck approximately three years prior, and again experienced neck pain which resolved on its own. Petitioner was slammed into a wall at work in June 2009, but forewent therapy so she could change positions at work. *Id.* On physical examination, Dr. Karshner noted Petitioner had normal sensation and regular joint range of motion. Some tenderness revealed in the neck and shoulder muscle; however, no active trigger points identified. Neck range of motion was nearly normal in extension, decreased in flexion, and decreased somewhat with lateral rotation. *Id.* Dr. Karshner diagnosed Petitioner with neck pain, recurrent and chronic; no evidence of neuropathy or radiculopathy; no distinct evidence of myofascial pain; Axis I/II disorders, figuring significantly; and mental status alteration, possibly secondary to medication versus other. (PX2). Dr. Karshner recommended physical therapy for Petitioner's neck and indicated that he would see Petitioner back in two to three weeks and "we can talk about her back at that point." *Id.* at *3*.

On February 9, 2010, Petitioner presented to Outpatient Rehabilitation Services for physical therapy for chronic neck pain. (PX3). Petitioner filled out a medical History Progress Note and indicated pain in her neck at a two out of 10 on the pain scale. (PX3). Petitioner did a physical therapy evaluation and was recommended to do physical therapy two to three times a week for four weeks. (PX3). She did not attend further.

On March 10, 2010, Petitioner returned to Dr. Karshner. Petitioner complained of neck pain and low back pain. (PX2 at 5). Petitioner went to one physical therapy session for her neck, but indicated it hurt so much that she did not return. Petitioner indicated her low back pain was constant, sharp, dull, and with no radiation. Dr. Karshner's impressions were cervical pain and low back pain. Dr. Karshner recommended physical therapy for Petitioner's thoracic and lumbar spine and an MRI of the cervical spine. *Id.* at 1-2.

On March 25, 2010, Petitioner followed up with Dr. Koonce regarding her migraines. Petitioner also complained of continued neck pain. Dr. Koonce assessed Petitioner with migraines, tension headaches, and neck pain and gave petitioner six additional syringes of Imitrex. (PX1). When Petitioner next saw Dr. Koonce on June 8, 2010, Dr. Koonce assessed Petitioner with headaches and neck pain. On July 13, 2010, Petitioner returned to Dr. Koonce. Petitioner indicated that she had no change in her migraines and neck pain. The notes reflect that Petitioner stated "Dr. Moyers is running a bunch of new tests to make sure that nobody is missing anything. That's all next week, and I asked that all the copies of the results go to you and Dr. Karshner." *Id.* Dr. Koonce assessed Petitioner with migraines, chronic neck pain, and PTSD. *Id.*

[1] The Arbitrator notes that throughout her treatment for the work-related injuries which form the basis for these two claims, Petitioner continued to see Dr. Koonce regarding her preexisting migraine headaches. She also continued to see Dr. Moyer, her primary care physician regarding a number of conditions unrelated to the injuries at issue in this case. Although the records have been reviewed only visits which may have some relevance to the issues herein will be referenced in this decision.

On July 20, 2010, Petitioner underwent an MRI of her cervical spine without contrast, as ordered by Dr. Karshner and Dr. Moyers. (PX2). The impression was disc bulge at C3-4 and facet osteoarthritis particularly at C5-6 and C7-T1, no cervical disc herniation nor central stenosis. (PX2 at 13).

On December 16, 2010, Petitioner followed up with Dr. Koonce. Petitioner indicated that she had been doing well with her migraines until the previous week. Petitioner also complained of continued neck pain and requested a referral to pain management and "some pain medication until I can get in to see the pain physician." Petitioner was given a referral to pain management and given a prescription for Zanaflex. (PX1).

On December 17, 2010, Petitioner returned to Dr. Moyers complaining of pain in her legs and arms for three weeks. (PX4). Petitioner also complained about her balance. (PX4). On January 19, 2011, Petitioner returned to Dr. Moyers to review her lab work. (PX4). Petitioner also complained of congestion and body aches. *Id.*

On February 16, 2011, Petitioner presented to Dr. Terry Cleaver at the Brain and Neurospine Clinic of Missouri on the referral of Dr. Koonce. Petitioner complained of neck pain down to her middle back and lower back. Petitioner indicated that her neck pain is her most significant pain. Petitioner indicated that her pain had been exacerbated by increased household duties since her husband injured his knee. Dr. Cleaver recommended conservative treatment. He prescribed Lidoderm patches. Dr. Cleaver also recommended trigger point injections, but Petitioner declined at that time. Dr. Cleaver noted that he did not have any additional treatment to offer Petitioner, but she was welcome to contact the clinic if she chose to undergo the trigger point injections. (PX5).

On March 16, 2011, Petitioner returned to Dr. Cleaver indicating that she was interested in undergoing the trigger point injections. A trigger point injection was given to Petitioner in her right splenius capitus and right supraspinatus. Petitioner was to return in two weeks for a possible repeat injection. (PX5). On March 30, 2011, Petitioner followed up with Dr. Cleaver and received a trigger point injection in her cervical and thoracic paraspinous muscles. *Id.* On April 18, 2011, Petitioner followed up with Dr. Cleaver and received a trigger point injection in her bilateral trapezius and right splenius cervicus. *Id.*

On May 17, 2011, Petitioner presented to Dr. Annamaria Guidos at the Brain and NeuroSpine Clinic of Missouri. Dr. Guidos noted Petitioner was referred by Dr. Cleaver for muscle spasms. Dr. Guidos' impression was Petitioner had myofascial pain disorder and recommended aquatic physical therapy followed by land physical therapy. Petitioner was to follow up in one month. (PX5).

On June 9, 2011, Petitioner presented to St. Francis Health and Wellness Center for physical therapy as prescribed by Dr. Guidos. (PX7). Petitioner completed an initial physical therapy evaluation. Petitioner indicated that she was thrown against a wall and hit her head in 2009. *Id.* She attended one additional therapy appointment on June 15, 2011.

On July 28, 2011, Petitioner suffered her second undisputed accident when she was pushed backward by a patient and struck her head and low back on the bathroom door of a patient's room.

On August 2, 2011, Petitioner filled out an Employee's Notice of Injury form for her July 28, 2011, injury. (RX5). Petitioner indicated that she was attempting to block a female patient from going after another

female when she pushed through Petitioner and jarred her neck. (RX5). She wrote that she injured the "back of neck." *Id.*

On August 15, 2011, Petitioner underwent three view x-rays of her cervical spine at Union County Hospital. (PX8). No fracture or subluxation was found and Petitioner had normal vertebra, interspaces, posterior elements, and dens. (PX8).

On August 23, 2011, Petitioner returned to Dr. Koonce. (PX1 at 54). Petitioner indicated that her migraines have not increased, but that she was injured at work on July 28, 2011. Petitioner stated that she got between two patients and was "thrown against the wall" like she was two years prior. *Id.* Petitioner stated she had increased posterior neck pain and occipital headaches since. Dr. Koonce noted that he would not fill out Petitioner's workers' compensation paperwork, but would continue to treat her migraines. Dr. Koonce assessed Petitioner with migraines and neck pain Petitioner associated with her workers' compensation injury. *Id.*

On August 26, 2011, Petitioner presented to Dr. Mark Austin at SIH Work Care. (PX10). Petitioner indicated that she injured her neck at work on July 28, 2011, when she was splitting up an altercation between two females and she was pushed, jarring her neck. (PX10). Petitioner complained of worse migraines and a stiff neck. (PX10). Petitioner indicated that she had a prior work related injury to her neck in 2009. (PX10). Petitioner was diagnosed with cervical paraspinal strain and spasm and tender upper thoracic paraspinal muscles. (PX10). Dr. Austin recommended work restrictions and gentle stretching. (PX10). Dr. Austin referred Petitioner to Dr. Sawar. (PX10).

On September 23, 2011, Petitioner followed up with Dr. Austin. (PX10). Petitioner indicated she had no improvement of her neck pain and exacerbation of her migraines. (PX10). Petitioner also indicated she now had some numbness and tingling into her right upper extremity. (PX10). Petitioner indicated she was scheduled to see Dr. Sawar on October 3, 2011. (PX10). Dr. Austin recommended Petitioner undergo an MRI of her cervical spine and continued her work restrictions. (PX10).

On October 3, 2011, Petitioner presented to Dr. Amar Sawar at the Neurology and Arthritis Clinic on referral from Dr. Austin. Petitioner indicated on July 28, 2011, while working as a Mental Health Technician, she was trying to separate two females and, as a result, her neck was jarred. Petitioner also complained of lower back pain. Petitioner was assessed with neck pain following physical injury, low back pain following physical injury, possible post traumatic syndrome, and common migraine with increasing frequency after neck injury. Dr. Sawar recommended a cervical spine MRI, lumbar spine MRI, brain MRI, and nerve conduction studies of the upper extremity. (PX11).

On October 11, 2011, Petitioner underwent a cervical spine MRI without contrast. The impression was: mild cervical levoscoliosis; small left C6-C7 paracentral disc protrusion, no cord deformity or central spinal canal stenosis; no overt foraminal stenosis; and small T2 hyperintense lesions within both thyroid lobes, suggest thyroid ultrasound for further evaluation. (PX12).

On October 14, 2011, Petitioner followed up with Dr. Austin. Dr. Austin reviewed Petitioner's cervical spine MRI. Dr. Austin continued Petitioner's work restrictions and indicated he was referring Petitioner to Dr. Sawar for all further care. Dr. Austin also made a referral to Dr. Newell. (PX10).

On October 31, 2011, Petitioner returned to Dr. Sawar to obtain nerve conduction studies. Petitioner indicated she had three migraine episodes since her last appointment and lower back pain and tingling in the left ankle. The nerve conductions studies revealed evidence of mild bilateral carpal tunnel syndrome without active denervation. There was no evidence of ulnar mononeuropathy, cervical radiculopathy, lumbosacral radiculopathy, or large fiber peripheral neuropathy. (PX11).

On November 1, 2011, Petitioner presented to Dr. Brent Newell at the SIH Rehabilitation Institute. (PX13). Dr. Newell noted Petitioner was referred to him by Dr. Austin. Petitioner complained of severe neck pain and back pain. Petitioner indicated that in July, while at work she intervened between two aggressive patients and her neck was jarred. Petitioner also indicated that she suffered an injury in 2009 and had neck and back pain and was off for six months, but returned to work because she was up for a promotion. Petitioner indicated that she already had neck pain at the time of the July injury; but it has increased in severity since the time of the injury. Petitioner also complained of lower back pain, but that it was not aggravated by this incident and was preexisting from the June 2009 incident. *Id.* at 11. Dr. Newell reviewed Petitioner's cervical spine MRI and noted it revealed extremely mild degenerative changes in the cervical spine with no evidence of stenosis. Dr. Newell's impression was neck pain with cervical strain and myofascial pain, which he felt appeared to be an aggravation of her condition following the June, 2009, accident. Dr. Newell recommended trigger point injections followed by physical therapy. Dr. Newell noted that Dr. Sawar referred Petitioner to neurosurgery, but that he, Dr. Newell, did not believe that there were any neurosurgical indications at this time. Dr. Newell gave Petitioner two trigger point injections in the right upper trapezius, one in the low cervical paraspinals, and one in the mid cervical paraspinals. *Id.* at 13-14.

On December 1, 2011, Petitioner returned to Dr. Newell. Dr. Newell noted the trigger point injections seemed to aggravate Petitioner's symptoms, so they would not pursue that any further. Dr. Newell's impression was chronic neck pain, cervical myofascial pain, and cervical spondylosis. (PX13). Dr. Newell again recommended physical therapy indicating he was not sure why it had not yet been approved. (PX13).

On December 27, 2011, Petitioner attended a physical therapy evaluation at the SIH Rehabilitation Institute. (PX15). Petitioner indicated she was breaking up a fight at work and she is not sure what happened but her neck began hurting that night. (PX15). Her diagnoses were listed as neck pain and myofascial pain. (PX15). Petitioner was recommended to attend physical therapy two times a week for four weeks. (PX15).

On January 2, 2012, Petitioner returned to Dr. Sawar. (PX11). Petitioner indicated that her migraine frequency had decreased to one time a week, but her neck pain was unchanged. (PX11). Dr. Sawar assessed Petitioner with common migraine poorly controlled, post traumatic syndrome, bilateral carpal tunnel syndrome, cervical disc bulging, and low back pain. (PX11). Dr. Sawar recommended Petitioner use cock up splints for her wrists and indicated he was still waiting on the lumbar spine MRI. (PX11).

On January 4, 2012, Petitioner returned to Dr. Newell. Petitioner indicated that she went to a therapy evaluation, but it aggravated her symptoms and she did not see any benefit with that visit. Petitioner indicated that she has continued neck pain and numbness in both arms. Dr. Newell's impression was chronic neck pain and cervical spondylosis. Dr. Newell again noted he did not think there was any surgical indication here, but Petitioner would like to get a surgical opinion. Dr. Newell noted that epidural injections may be something the

neurosurgeon recommends, but he would prefer the recommendation to come from the surgeon at this point. (PX13).

On January 5, 2012, Petitioner underwent an MRI of her lumbar spine. (PX11). The impression was grade 1 anterolisthesis L5 on S1 due to bilateral L5 pars interarticularis defects, this is associated with a mild disc bulge that is more prominent right posterolaterally and laterally where there is an annular tear; small right paracentral disc protrusion L4-5; and simple cyst left kidney. (PX11).

On January 10, 2012, Petitioner underwent an MRI of her head with and without contrast. (PX11). The impression was no acute intracranial hemorrhage, mass or infarct and an old left lamina papyracea fracture. (PX17).

On February 6, 2012, Petitioner followed up with Dr. Sawar. (PX11). Petitioner indicated that she had one episode of migraine a month on average, but had continued neck pain. (PX11). Dr. Sawar noted they were awaiting consultation with a neurosurgeon. (PX11).

On February 15, 2012, Petitioner presented to Trinity Neuroscience Institute. (PX19). Petitioner was seen by Angela Arnold PAC. Petitioner indicated that on July 28, 2011, she intervened between two patients and her neck was jarred. (PX19). Petitioner complained of neck pain, thoracic pain, shoulder pain, lower back pain, and bilateral hand and feet parasthesias. (PX19). Petitioner's MRIs were reviewed and it was noted Petitioner had minimal cervical spine degenerative changes without stenosis and degenerative disc disease at the L4-5 level with an anterolisthesis of L5 on S1. (PX19). X-rays of Petitioner's cervical and lumbar spine were ordered. (PX19). It was noted Petitioner was referred to Trinity Neuroscience Institute by Dr. Sawar. (PX19).

On February 15, 2012, Petitioner underwent x-rays of her lumbar and cervical spine at Memorial Hospital of Carbondale at the referral of Trinity Neuroscience Institute. (PX18). The impression of Petitioner's lumbar spine was grade one anterolisthesis of L5 on S1 with bilateral pars interarticularis defects and spinal dysraphism posterior elements of L5. (PX18). The impression of Petitioner's cervical spine was no acute abnormality of the cervical spine. (PX18).

On February 16, 2012, Petitioner presented to Dr. Babu Prasad at Advanced Pain Management at the referral of Dr. Austin. (PX20). Petitioner was given a left transforaminal lumbar epidural. (PX20).

On March 22, 2012, Petitioner underwent a Section 12 examination with Dr. Thomas Lee at Tesson Heights Orthopedics for her cervical spine. (RX9, PX21). Petitioner indicated the injury occurred on July 28, 2011, when she tried to break up two female patients who were fighting. (RX9, PX21). Petitioner indicated that she is averaging four Percocet a day. (RX9, PX21). Petitioner provided a history of migraines prior to the July 28, 2011, incident, but they were worse afterwards for a while, and are now under control. (RX9, PX21). Petitioner indicated that she had a previous injury in 2009 where she injured her neck and back, but the case was closed because she returned to work. (RX9, PX21). Petitioner indicated she has had neck and back pain since. (RX9, PX21). On physical examination, Petitioner had decreased cervical range of motion and some pain with range of motion. (RX9, PX21). Dr. Lee diagnosed Petitioner with C6-7 disc bulge and ruled out left foraminal herniation at C5-6. (RX9, PX21). Dr. Lee opined the July 28, 2011, accident aggravated Petitioner's

pre-existing condition, causing her current symptoms in her neck. (RX9, PX21). Dr. Lee recommended a CT myelogram and that Petitioner return to work light duty. (RX9, PX21).

On April 9, 2012, Petitioner returned to Dr. Sawar. (PX11). Petitioner indicated she was having one migraine weekly and that her neck pain, low back pain, and the numbness and tingling in both hands and her right ankle were worse. (PX11). Dr. Sawar recommended a cervical spine MRI, lumbar spine MRI, and nerve conduction studies of the upper and lower extremities. (PX11). Dr. Sawar gave Petitioner a prescription for Vicodin. (PX11).

On April 17, 2012, Petitioner returned to Dr. Newell. (PX13). Petitioner indicated that she underwent an independent medical examination and an epidural injection was recommended, so she was interested in that. (PX13). Petitioner stated she returned to work light duty the day before and that had increased her symptoms some. (PX13). Dr. Newell's impression was cervical spondylosis and chronic neck pain. (PX13). Dr. Newell noted he would perform the epidural injection, but if there was no improvement with the injection, he will likely not have further interventions to offer. (PX13).

On April 19, 2012, Petitioner returned to Dr. Prasad. (PX20). Petitioner was given a left transforaminal lumbar epidural with fluoroscopic guidance. (PX20).

On May 7, 2012, Petitioner returned to Dr. Sawar. (PX11). Petitioner indicated she had one migraine since her last appointment, but her neck pain and numbness and tingling in both hands were worse. (PX11). Dr. Sawar recommended a cervical spine MRI and again referred Petitioner to a spinal neurosurgeon. (PX11). Dr. Sawar gave Petitioner a prescription for Vicodin. (PX11).

On June 5, 2012, Dr. Sawar wrote Petitioner a note indicating that she was unable to work until she was evaluated by a neurosurgeon. (PX22).

On June 6, 2012, Petitioner returned to Dr. Sawar. (PX11). Petitioner indicated she had one migraine a week on average and that her back pain was improved. (PX11). Dr. Sawar increased Petitioner's Lyrica and continued her Imitrex. (PX11).

On July 6, 2012, Petitioner underwent a CT myelogram at Memorial Hospital of Carbondale. (PX23, PX24). The impression was minimal central disc bulge at the C5-C6 level and minimal left paracentral disc bulge at the C6-C7 level, but no spinal canal or neural foraminal narrowing. (PX24).

On August 8, 2012, Petitioner presented to Dr. David Raskas at the Orthopedic Sports medicine & Spine Care Institute. (PX31). Petitioner complained of neck and low back pain. (PX31). Petitioner indicated she had two work injuries: on June 2, 2009, an aggressive male patient at work shoved her into a concrete wall and on July 28, 2011 she was trying to keep two female patients from fighting when she developed pain in her neck. (PX31). On physical examination, Petitioner was noted to have a minimally flat affect and limited range of motion of the cervical and lumbar spine. (PX31). Dr. Raskas recommended Petitioner undergo discography at L3-4, L4-5, as well as C4-5, C5-6 and C6-7. (PX31). Dr. Raskas noted Petitioner would at minimum need a fusion at L5-S1. (PX31). Dr. Raskas took Petitioner off of work. (PX31).

On September 6, 2012, Petitioner underwent a lumbar and cervical discogram. (PX25). The lumbar discogram impression was classically positive discogram at L4-5 with annular tear and reproduction of pain; negative L3-4 discogram. (PX25). The cervical discogram impression was classically positive C5-6 discogram with reproduction of neck and shoulder pain; negative C4-5 and C6-7 discographies. (PX25).

On September 10, 2012, Petitioner returned to Dr. Raskas. (PX32). Dr. Raskas reviewed the discographies and recommended Petitioner undergo an anterior/posterior fusion at L5-S1 and probably a fusion or disc replacement at C5-6. (PX32). Petitioner continued to follow up with Dr. Sawar regarding her migraines.

On December 13, 2012, Petitioner underwent an independent medical evaluation with Dr. Shawn L. Berkin at the request of Petitioner's counsel. (PX30). Petitioner indicated in June 2009, she injured her head and neck when she was pushed into a wall by a patient. (PX30). Petitioner indicated that in July, 2011, she was breaking up a fight between two patients when she was shoved backwards, striking her back against a bathroom door. (PX30). Petitioner's present complaints included severe pain and tenderness in her neck radiating to her right shoulder and limited range of motion of her neck. (PX30). Petitioner also complained of low back pain down to her buttock and right leg. (PX30). On physical examination, Petitioner had limited range of motion of her cervical and lumbar spine. (PX30). Dr. Berkin's impression of Petitioner was cervical strain, bulging of the C3-4 and C5-6 intervertebral discs, lumbosacral sprain, protrusion of the L4-5 intervertebral disc with annular tear, bulging of the L5-S1 intervertebral disc, and spondylolisthesis of L5 on S1. (PX30). Dr. Berkin opined he believed these conditions were causally related to Petitioner's June 2, 2009, and July 28, 2011, injuries. (PX30). Dr. Berkin recommended Petitioner see a spine surgeon for surgical intervention. (PX30).

On September 16, 2013, Petitioner returned to Dr. Raskas. (PX31). Petitioner continued to complain of significant neck pain. (PX31). Dr. Raskas recommended a cervical disc arthroplasty, but wanted to get a new MRI done first. (PX31). Dr. Raskas recommended putting treatment for the lower back on hold until after petitioner was done treating for her neck. (PX31).

On February 25, 2014, Petitioner returned to Dr. Raskas. (PX31). Petitioner continued to complain of neck pain. (PX31). Dr. Raskas noted that his recommendations were the same as the last time that he saw Petitioner. (PX31).

On May 27, 2014, Dr. Lee authored an addendum to his Section 12 report. (RX10, PX21). Dr. Lee outlined the additional medical records he reviewed and opined that the injury of July 28, 2011 aggravated Petitioner's preexisting condition and caused her current neck symptoms. (RX10, PX21). Dr. Lee agreed with the proposed C5-6 total disc replacement as appropriate treatment and that light duty work restrictions were appropriate. (RX10, PX21).

On June 24, 2014, Petitioner returned to Dr. Raskas for a pre-operative evaluation for her cervical disc replacement. (PX32). Petitioner complained of neck and low back pain. (PX32). Dr. Raskas assessed Petitioner with cervical discogenic pain and recommended an anterior cervical disc arthroplasty. (PX32).

In July 2014 Dr. Raskas performed a cervical disc replacement at C5-6. On July 15, 2014, Petitioner returned to Dr. Raskas for a post-operative follow up. (PX32). Petitioner indicated that she no longer had pain

in her neck going to her shoulder and the numbness in her hands was gone. (PX32). Dr. Raskas recommended a myelogram CAT scan to re-evaluate Petitioner's lumbar condition. (PX32).

On August 22, 2014, Petitioner followed up with Dr. Raskas. (PX32). X-rays of Petitioner's cervical spine showed no loosening about the prosthesis and the prosthesis was in good position. (PX32). Dr. Raskas recommended physical therapy for Petitioner. (PX32).

On September 9, 2014, Petitioner underwent a Section 12 examination with Dr. David Robson with regard to her lumbar spine. (RX11). Petitioner indicated she had two work injuries: on June 2, 2009, she stated she was slammed into a concrete wall jarring her neck and hurting her lower back and on July 28, 2011, Petitioner stated she was breaking up a fight between two female patients when she was pushed back into a doorknob and injured her lower back and neck. (RX11). Petitioner indicated that she underwent a disc replacement at C5-6 and has had considerable symptomatic relief of her neck pain, with just some residual achiness and soreness in her neck and shoulders. (RX11). Petitioner indicated that she had low back pain after the 2009 incident that was made worse by the 2011 incident. (RX11). Dr. Robson assessed Petitioner with lumbar spondylolisthesis L5-S1. (RX11). Dr. Robson opined that he did not believe Petitioner's lumbar spine condition was related to her June 2, 2009, or July 28, 2011, incidents. (RX11, RX12).

On October 21, 2014, Petitioner returned to Dr. Raskas. (PX32). Petitioner indicated that her neck was markedly improved, but she still had some right shoulder pain. (PX32). Dr. Raskas again recommended a myelogram CAT scan to re-evaluate Petitioner's lumbar condition. (PX32). Dr. Raskas continued Petitioner off of work. (PX32).

On December 1, 2014, Petitioner returned to Dr. Raskas. (PX32). Dr. Raskas reviewed the results of the myelogram CAT scan noting Petitioner had a protrusion at L4-5 and spondylolisthesis at L5-S1. (PX32). Dr. Raskas recommended Petitioner undergo an anterior fusion at L4-5 and L5-S1 which occurred in late December 2014. (PX32). Dr. Raskas recommended the post-operative use of a lumbar bone growth stimulator. (PX32).

On January 27, 2015, Petitioner returned to Dr. Raskas following her anterior/posterior lumbar fusion. (PX32). X-rays revealed anterior/posterior instrumentation L4 to S1 with anatomic alignment of the spine and marked reduction of Petitioner's spondylolisthesis. (PX32). Petitioner indicated she was having constipation problems. (PX32). Dr. Raskas recommended Petitioner undergo a CAT scan to ensure Petitioner did not have a big fluid collection. (PX32).

On February 6, 2015, Petitioner followed up with Dr. Raskas. (PX32). Dr. Raskas noted Petitioner has done well after her cervical disc arthroplasty. (PX32). Dr. Raskas also noted Petitioner was doing much better with regard to her anterior lumbar fusion. (PX32). X-rays of Petitioner's cervical spine revealed the artificial disc to be in good position with no loosening of the prosthesis. (PX32). Dr. Raskas released Petitioner to return to work with no restrictions and at maximum medical improvement with regard to her cervical spine. (PX32). Dr. Raskas outlined work restrictions for Petitioner for her lumbar spine and she was to return for a follow up in three months time. (PX32).

Dr. Shawn Berkin testified via evidence deposition dated March 25, 2013. (PX30). Dr. Berkin performed an independent medical examination at the request of Petitioner's counsel. Dr. Berkin testified that

he believed Petitioner had a cervical strain injury with bulging of the C3-4 and C5-6 discs due to the June 2, 2009 incident. (PX30 at 17). He opined that the July 28, 2011 incident caused Petitioner to have a recurrent sprain to the cervical spine, a lumbosacral strain, protrusion of the L4-5 intervertebral disc with a tear of the annulus, bulging of the L5-S1 intervertebral disc, and spondylolisthesis of L5 on S1. (PX30 at 18). Dr. Berkin testified that he believed Petitioner needed additional treatment from a spine surgeon. (PX30 at 21). On cross-examination Dr. Berkin testified that he did not believe Petitioner needed ongoing treatment for the June 2009 injury and that Petitioner reinjured her neck in July 2011. (PX30 at 33).

Dr. David Raskas testified via evidence deposition on March 5, 2014. (PX31). Dr. Raskas testified that Petitioner had two work-related injuries. Dr. Raskas testified Petitioner's diagnoses were spondylolisthesis at L5-S1 and disc protrusions at C5-6 and C6-7. *Id.* at 13. Dr. Raskas testified that he believed both accidents were contributing factors to Petitioner's conditions. *Id.* at 16. Dr. Raskas testified that he recommended Petitioner undergo a C5-6 disc arthroplasty. *Id.* at 19.

On May 27, 2014, Dr. Lee authored an addendum to his Section 12 report wherein he opined that the injury of July 28, 2011, aggravated Petitioner's preexisting condition and caused her current neck symptoms. Dr. Lee agreed with the proposed C5-6 total disc replacement as appropriate treatment and that light duty work restrictions were appropriate. (RX10, PX21). As a result of Dr. Lee's agreement Respondent authorized the cervical surgery.

Dr. David Raskas again testified via evidence deposition on February 23, 2015. (PX32). Dr. Raskas testified that he received authorization and performed a cervical disc replacement at C5-6 on July 2. 2014. *Id.* at 7. Dr. Raskas testified that Petitioner was at maximum medical improvement for her cervical spine. *Id.* at 8. Dr. Raskas testified that he believed Petitioner's June 2, 2009, and July 28, 2011, accidents contributed to Petitioner's neck condition and need for surgery. *Id.* Dr. Raskas testified that he also performed an anterior/posterior lumbar fusion on Petitioner in December 2014. *Id.* at 9. Dr. Raskas testified that he believed that Petitioner's June 2, 2009 and July 28, 2011 accidents both contributed to her back condition and the need for surgery. *Id.* at 11-12. Dr. Raskas testified that on February 6, 2015, he released Petitioner to return to work without restrictions with regard to her cervical spine and that Petitioner had responded well to the surgery. *Id.* at 14. Dr. Raskas testified that Petitioner wrote on her intake form that she was referred to him by Dr. Sawar, but that he did not know if he received any kind of referral notice or document. *Id.* at 18-19.

Dr. David Robson testified via evidence deposition on February 26, 2015. (RX12). Dr. Robson testified that Petitioner gave him a history of two work injuries: on June 2, 2009, Petitioner indicated she was slammed into a wall injuring her neck and lower back and on July 28, 2011, Petitioner indicated she was trying to break up a fight between two patients when she was pushed into a doorknob and developed low back and neck pain. *Id.* at 10. Dr. Robson testified that based on his review of the medical records imaging reports, and his physical examination of Petitioner, he believed her diagnosis was spondylolisthesis L5-S1. *Id.* at 11. Dr. Robson testified that he did not believe that Petitioner's lumbar condition was related to anything that occurred on June 2, 2009, or July 28, 2011. *Id.* at 13. Dr. Robson indicated that the basis of his opinion was as that he did not feel that there was a temporal relationship between Petitioner's accidents and her complaints of low back pain. *Id.* Dr. Robson did not believe that either of the injuries aggravated or accelerated Petitioner's spondylolisthesis. *Id.* at 14. Dr. Robson testified that he did not believe that Petitioner's anterior/posterior fusion at L4-5 and L5-S1 was

related to either of the work injuries of June 2, 2009, or July 28, 2011. *Id.* Dr. Robson testified that he did not see any significant herniated disc in Petitioner's lumbar spine. *Id.* at 20-21.

As of the date of hearing Petitioner remained under the care of Dr. Raskas regarding her lumbar spine for which she was still involved in post-operative follow up.

CONCLUSIONS OF LAW

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

It is undisputed Petitioner sustained an accidental injuries to her cervical spine on June 2, 2009 and July 28, 2011. Further, based upon the opinion of Respondent's Section12 examiner, Dr. Lee, Respondent does not contest the causal relationship between Petitioner's cervical spine condition and her work accidents. Petitioner has undergone treatment for her cervical spine and has been released to return to work without restrictions at maximum medical improvement as of February 6, 2015.

The Arbitrator found the Petitioner to be a credible witness. Both the Employee's Notice of Injury form and the supervisor's report of injury completed within days of the June 2, 2009, accident reflect Petitioner injured her back in addition to her neck. (PX33 at 2-3) It is not lost on the Arbitrator that the accident form completed following the July 28, 2011, accident simply reflects that Petitioner injured the back of her neck. (RX5) Petitioner testified that immediately following the accident her neck pain intensified significantly. She also indicated, however that her back pain increased as well and she eventually began to experience pain radiating down both legs which had not been present following the June 2, 2009, accident.

Both Dr. Raskas and Dr. Berkin testified that the accidents of June 2, 2009, and July 28, 2011, were contributing causes to Petitioner's cervical and lumbar conditions. Dr. Lee agreed with respect to the cervical spine condition. Dr. Robson did not believe that Petitioner's lumbar condition was related to anything that occurred on June 2, 2009, or July 28, 2011. He indicated that the basis of his opinion was as that he did not feel that there was a temporal relationship between Petitioner's accidents and her complaints of low back pain. As indicated above, the accident forms which were completed within days of the June 2, 2009, accident clearly indicate Petitioner complained of back pain at that time. The Arbitrator finds the testimony and opinions of Dr. Raskas and Dr. Berkin more persuasive than those of Dr. Robson.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met her burden of establishing that the conditions of ill-being in both her cervical and lumbar spine are causally related to the undisputed accidents of June 2, 2009 and July 28, 2011.

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?

Issue (O) Has Petitioner exhausted her choices of physicians?

Respondent does not dispute the medical charges related to treatment of Petitioner's cervical spine. Further, Respondent did not dispute the reasonableness and necessity of the lumbar treatment, but simply its

liability therefore based upon the issues of causal connection and whether Petitioner exceeded her choices of physician.

Dr. Raskas testified that he performed an anterior/posterior lumbar fusion on Petitioner in December, 2014. Dr. Raskas testified that he believed that Petitioner's June 2, 2009, and July 28, 2011, accidents both contributed to her back condition and the need for surgery. Having found the testimony and opinions of Dr. Raskas and Dr. Berkin more persuasive than those of Dr. Robson, the Arbitrator finds Petitioner has met her burden of establishing that the medical treatment provided up to the date of Arbitration has been both reasonable and necessary.

Prior to the June 2, 2009, accident Petitioner had been treating with Dr. Moyers, her primary care physician for a number of conditions unrelated to this claim. She had also been treating with Dr. Koonce due to migraine headaches. Petitioner credibly testified that Dr. Moyers did not wish to become involved in treatment of the injuries sustained on June 2, 2009, because of the involvement of a workers' compensation claim. Petitioner testified that Dr. Moyers did however provide her with pain medication. Following the June 2, 2009, accident Dr. Koonce then began prescribing Petitioner pain medication for her neck and increased migraines. Dr. Koonce referred Petitioner to Dr. Cleaver and Dr. Karshner. The Arbitrator finds Petitioner did not exceed her choices of physician regarding her June 2, 2009, accident.

Petitioner sustained her second accident on July 28, 2011. Following this accident she presented to Dr. Koonce on August 23, 2011. Dr. Koonce's records from that date are clear in that he would not fill out Petitioner's workers' compensation paperwork, but would continue to treat her migraines. Thereafter, on August 26, 2011, Petitioner presented to Dr. Mark Austin at SIH Work Care. The Arbitrator finds Dr. Austin to have been the first choice of provider relative to Petitioner's accident of July 28, 2011. Dr. Austin referred Petitioner to Dr. Sawar, Dr. Newell, Dr. Prasad, and Trinity Neuroscience.

Petitioner also treated with Dr. Raskas. Dr. Raskas testified that Petitioner wrote on her intake form that she was referred to him by Dr. Sawar, but that he did not know if he received any kind of referral notice or document. The medical records in evidence indicate that on May 7, 2012, Petitioner was seen by Dr. Sawar who recommended a cervical spine MRI and again indicated Petitioner needed to be evaluated by a spinal neurosurgeon. On June 5, 2012, Dr. Sawar wrote Petitioner a note indicating that Petitioner was unable to work until she was evaluated by a neurosurgeon. On July 6, 2012, Petitioner underwent a CT myelogram at Memorial Hospital of Carbondale. Following this evaluation Petitioner presented to Dr. David Raskas on August 8, 2012. The Arbitrator finds that Dr. Raskas was seen, if not on the referral of, at least consistent with the recommendation of Dr. Sawar. However, even if Dr. Raskas were a separate choice of provider, he would only be Petitioner's second choice relative to the July 28, 2011, accident. The Arbitrator finds Petitioner did not exceed her choices of physician regarding her July 28, 2011, accident.

The record contains medical bills totaling $86,346.43. $55,040.77 of these charges were incurred prior to Petitioner's July 28, 2011, accident. $31,305.66 of the charges were incurred following the July 28, 2011, accident. (PX29)

Based upon the foregoing and the record taken as a whole, the Arbitrator finds the medical treatment provided to Petitioner from June 2, 2009, through July 27, 2011, which resulted in charges of $55,040.77 was

both reasonable and necessary to treat the injuries sustained on June 2, 2009, and Respondent is liable for those charges. The Arbitrator further finds the medical treatment provided to Petitioner from July 28, 2011, through the date of hearing which resulted in charges of $31,305.66 was both reasonable and necessary to treat the injuries sustained on July 28, 2011, and Respondent is liable for those charges.

Respondent shall pay reasonable and necessary medical services of $86,346.43 as set forth in Petitioner's exhibit 29, 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 Sections 8(j) of the Act. Further, Respondent shall authorize and pay for Petitioner's continued follow up care with Dr. Raskas.

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

The parties stipulated that Petitioner is entitled to total temporary disability benefits from June 6, 2012, through February 6, 2015 (139 2/7 weeks). Petitioner was released to return to work without restrictions and at maximum medical improvement with regard to her cervical spine on February 7, 2015. At the time she was released from care with regard to her cervical spine Petitioner remained under the care of Dr. Raskas and unable to work due to her lumbar spine condition. As of the date of hearing, May 21, 2015, Petitioner remained unable to return to work due to her lumbar condition.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Respondent shall pay Petitioner temporary total disability benefits of $465.02/week for 154 1/7 weeks, commencing June 6, 2012, through May 21, 2015, as provided in § 8(b) of the Act. Respondent shall be given a credit of for temporary total disability benefits that have been paid.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RICHARD LUPARDUS,

Petitioner,

vs. NO: 15 WC 05924

MENASHA CORPORATION,

Respondent.

17IWCC0090

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical, temporary total disability benefits (TTD), and prospective medical, and being advised of the facts and applicable law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Indus. Comm'n, 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 of the testimony, exhibits, pleadings and arguments submitted by the parties.

Based upon the evidence, and in relation to the prospective treatment, the Commission affirms the award of the CT-myelogram but modifies the award thereafter. The Commission notes that without the CT-myelogram, there is no definite proposed course of treatment. Petitioner's treating physician, Dr. Matthew Gornet, diagnosed Petitioner with central disc herniations at C3-4 and C5-6, and foraminal narrowing secondary to disc pathology at C4-5 and C5-6. Dr. Gornet recommended cervical disc replacement at C3-4, C4-5, and C5-6. (PX6, pg. 14). He further suggested that Petitioner undergo a CT-myelogram prior to surgery to determine

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if he has facet joint arthropathy. If so, then a fusion and not disc replacement would be the better course of treatment. (PX6, pg. 41).

Respondent's Section 12 examiner, Dr. Sherwyn Wayne, stated that if Petitioner decided to proceed with surgery, he agreed that a CT-myelogram would be appropriate to determine whether the procedure would be disc replacement or fusion. (RX2). However, Dr. Wayne foreclosed the three-level cervical disc replacement surgery arguing that it would be "very, very unusual," "off-label," and not recommended by the FDA. (RX1, pg. 34).

The Commission is not bound by the Arbitrator's findings, and may properly determine the credibility of witnesses, weigh their testimony and assess the weight to be given to the evidence. R.A. Cullinan & Sons v. Indus. Comm'n, 216 Ill. App. 3d 1048, 1054, 575 N.E.2d 1240, 159 Ill. Dec. 180 (1991). It is the province of the Commission to weigh the evidence and draw reasonable inferences therefrom. Niles Police Dep't v. Indus. Comm'n, 83 Ill. 2d 528, 533-34, 416 N.E.2d 243, 245, 48 Ill. Dec. 212 (1981). Interpretation of medical testimony is particularly within the province of the Commission. A. O. Smith Corp. v. Indus. Comm'n, 51 Ill. 2d 533, 536-37, 283 N.E.2d 875, 877 (1972). "Moreover, it is worth remembering that the Commission is an administrative body, possessing unique skill and expertise in the areas of medical and workers' compensation issues." Flexible Staffing Servs. v. Ill. Workers' Comp. Comm'n, 2016 IL App (1st) 151300WC, P29 (1st Dist. 2016).

Pursuant to §8(a) of the Act, Petitioner is entitled to all reasonable and necessary medical services. The Commission finds that both doctors have recommended a CT-myelogram in order to determine the next course of treatment. The Commission, however, finds the opinion of Dr. Wayne persuasive relative to the proposed disc replacement surgery. Dr. Wayne testified that the proposed surgery has not been recommended by the FDA. The Commission is therefore hesitant to award treatment that has not been approved by the FDA, and is also hesitant to award the fusion given that a CT-myelogram has been recommended by both doctors to determine the definitive course of treatment.

Therefore, as to prospective treatment, the Commission finds that Petitioner is entitled to only the CT-myelogram at this time. Thereafter, appropriate consideration will be given to what surgical intervention, if any, should be authorized by the Commission. It is hoped that the parties will give due consideration to the results of the CT-myelogram and that an appropriate treatment plan can be agreed upon. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 22, 2016, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $336.00 per week for a period of 52 2/7 weeks, January 22, 2015 through January 22, 2016, that being the period of temporary total incapacity for work under §8(b), and

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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 is entitled to a credit in the amount of $13,002.53 for long and short term disability benefits paid; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit, as provided under §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay all reasonable and necessary medical expenses of $36,466.17, as provided in §8(a) and subject to the medical fee schedule contained in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit in the amount of $27,287.07 for medical benefits paid; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit, as provided under §8(j) 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.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $13,800.00. 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.

FEB 14 2017

DATED:

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/pm
O: 12-19-16
052

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

LUPARDUS, RICHARD
Employee/Petitioner

Case# **15WC005924**

MENASHA CORPORATION
Employer/Respondent

17IWCC0090

On 3/22/2016, 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:

2323 ROTH LAW OFFICES
GEORGE ALBERS
2421 CORPORATE CENTRE DR #200
GRANITE CITY, IL 62040

0734 HEYL ROYSTER VOELKER & ALLEN
TONEY J TOMASO
102 E MAIN ST SUITE 300
URBANA, IL 61803-0129

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(a)

RICHARD LUPARDUS
Employee/Petitioner

v.

MENASHA CORPORATION
Employer/Respondent

Case # 15 WC 05924

Consolidated cases: _____

17IWCC0090

An *Application for Adjustment 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 **January 22, 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, **January 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 **$26,208.00**; the average weekly wage was **$504.00**.

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

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

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

Respondent is entitled to a credit of **$27,287.07** under Section 8(j) of the Act.

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of **$336.00** per week for **52-2/7** weeks (366 days), commencing **January 22, 2015** through **January 22, 2016**, as provided in Section 8(b) of the Act.

Respondent shall be given credit for **$13,002.53** for long and short term disability benefits 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.

Medical benefits

Respondent shall pay reasonable and necessary medical services of **$36,466.17**, as provided in Section 8(a) and subject to the medical fee schedule contained in Section 8.2 of the Act.

Respondent shall be given a credit of **$27,287.07** 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.

Prospective Medical

Pursuant to Section 8(a) of the Act, Petitioner is awarded prospective medical care as recommended by Dr. Gornet, initially a CT Scan evaluation of the facet joints to determine if a three-level disc replacement surgery from C3 to C6 is indicated, and, if indicated, the C3 to C6 disc replacement surgery itself, and Respondent shall authorize same.

17IWCC0009

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

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

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

Signature of Arbitrator

March 18, 2016
Date

ICArbDec19(b)

MAR 22 2016

STATEMENT OF FACTS

Respondent operated a facility that received various products and repackaged them for use by retailers. Petitioner testified that he initially worked for Respondent as a temporary worker before being hired by Respondent directly in 2009. His job, along with other operators in Respondent's shipping and receiving department, involved the use of a seated forklift to bring pallets of product from one building to the building where line workers packaged the products, and to bring back unused corrugated materials that were put onto the unloaded pallets for loading into trucks. It appears that this main route was between Buildings 21 and 29. He would drive through doorways with overhead doors at both buildings. When carrying pallets and corrugate material, he would try to stack the pallets twenty one high, which would reach higher than the top of his forklift. Petitioner testified that he had to go through the doorways to traverse the route between Buildings 21 and 29 at least 15 times per day with the seated forklift.

Petitioner testified that he would have to drive the forklift between various buildings for various reasons, and would at times have to go outdoors. Some routes required crossing roads. Petitioner created drawings of Respondent's premises and Building 21, the building where his injury occurred (Petitioner's Exhibits 8 & 9) for purposes of explanation of his testimony. The parties and the Arbitrator agreed that these exhibits were being admitted into evidence for such explanatory purposes only, as the drawings were not to scale. The Arbitrator also notes the discrepancies with the Petitioner's drawings indicated by warehouse manager Mike Maraczi, but also notes that any such discrepancies were not relevant to the issues in this case. The drawings along with the testimony did assist in providing the Arbitrator with a better understanding of the layout of the relevant Respondent facilities.

At some point, because Respondent was going to be bringing in a number of "deep reach" forklifts, the Petitioner testified that his lead man, Abraham, began to train him on the machine. These lifts were stand-up, not seated, and involved different control mechanisms than the seated lifts. The deep reach machines were able to reach deeper into the pallet storage areas than seated machines, making it easier to access and obtain these deeper pallets. He described the operation of the machine as requiring the operator to stand facing perpendicular to the direction the machine was going. Turning in one direction would face the front of the machine, and turning in the other direction would face the back. A tall mast which supported the forks going up and down was at the back of the lift. The Petitioner testified that Mr. Maraczi was aware that Abraham was training him, and that this training was not being done pursuant to any set schedule. He would do the training when work was slow. There was no formal training video.

Petitioner testified he began training on the machine for approximately three weeks prior to January 21, 2015, for about two hours per day. He had operated a deep reach machine, practicing figure eights, only one time prior to starting this training. He had never brought the deep reach outside of the building he was training in, Building 21, but testified that someone named "Roy" indicated he should try the machine in a different building, Building 29, though he himself never attempted to do so. On cross examination, the Petitioner testified that it was possible he actually had been training on the deep reach machine for two months as opposed to three weeks.

On cross examination, Petitioner denied it was his understanding that as of January 21, 2015 he had completed his deep reach forklift training. At hearing, Petitioner produced a Basic Operator Training Authorization card, which indicated whether he had been certified/authorized to operate various lift machines. Boxes referencing certification/authorization of Petitioner to operate LP gas diesel and electric sit-down riders were checked, but the electric stand up rider was not checked, which Petitioner testified meant he had not yet been certified to operate it.

Petitioner testified that all seated forklifts had facility radios in them, but that the deep reach machine he was operating on January 21, 2015 did not. If it did, he was not aware of it. Respondent's Exhibit 5 contained photographs of both the seated and deep reach forklifts.

On January 21, 2015, Petitioner arrived for his shift at 7:00 a.m. He was working in Building 21, and indicated another leadman, Luciano, borrowed Petitioner's seated forklift to take it to Building 29, while Petitioner remained and stacked pallets. Petitioner testified he couldn't recall exactly why he started to use the deep reach machine that day. Someone, whose identity Petitioner couldn't recall, may have indicated they needed help. In any case, he was using the machine to move pallets from one area of the building to another. Other lift drivers would be notified of which pallets he was moving based on Petitioner scanning them, and would sometimes come over and take the needed deeper pallets to the line. Petitioner noted that it was important for the lift drivers to get the needed pallets to the packaging line to avoid the packaging line process from coming to a halt.

Petitioner had been operating the deep reach that day for 45 minutes to an hour when the machine lost its ability to lift product pallets with the forks. Petitioner noted a gauge indicated the battery was low, but the machine remained drivable. Seated forklift batteries would have to be changed daily from a low battery to a full battery, and the Petitioner had experience doing so. He drove the deep reach machine to the battery station area in Building 21 to get a fresh battery. There was only one additional deep reach battery at the station, and Petitioner testified that when he went to change it, he couldn't figure out how the battery could be removed and assumed it would have to be charged while installed in the machine. According to the Petitioner, he was not taught how to change out a deep reach battery during his training, just how to plug it in at the end of the shift. Noting he did not have a radio on the deep reach, he wanted to try to get hold of Luciano to see what he should do, as a pallet had to be moved so the packaging line wouldn't stall. On cross examination Petitioner agreed that the deep reach had a computer screen which would indicate the driver's assignments, but denied that it contained a radio, noting "they might have them on there now" (Tr. 113).

Petitioner testified he initially tried to honk at some lifts that had entered Building 21 from Building 29 to see if he could use one of their radios, but he was still near the battery station which was some distance from the doorway. After they entered they turned right, and none of them stopped in response to Petitioner's honking. He then drove towards the door to go to Building 29. As he attempted to exit Building 21, the top of the fork mast struck the top of the doorway and bottom of the overhead rolling door, causing the machine to stop suddenly and jerk the Petitioner's body back and forth. He could not say how fast he had been going, but that he was going full speed because he was afraid the battery would completely die out.

Petitioner testified that Mike Maraczi was coming through the door at that time. He asked Petitioner to stop and shut off the rolling door and to move the forklift. Petitioner attempted to do so but indicated he was shaken up and embarrassed after the accident. Petitioner was brought to the office and Respondent's human resource person, Vanessa, sent Petitioner for a drug test. He drove himself to the facility, and went home after that. He indicated that Vanessa had asked him to come back after the test, but that Maraczi asked him to return at 7 the next morning ready to work.

Petitioner agreed that the deep reach was likely over 14 feet tall, which based on the photos in Respondent's Exhibit 5 was due to the fork mast, and that it was significantly taller than his seated forklift. Petitioner testified that he did not know the clearance height of the Building 21 exit door, and reiterated that he had never taken the deep reach machine

outside of Building 21, and had never seen one taken out through the Building 21 exit door. Petitioner agreed he could have attempted to contact someone at the facility about the battery issue via radio rather than driving to do so.

Mike Maraczi testified that he was the warehouse manager on the date of accident, and was responsible for all shipping. He would spend the majority of his shifts on the warehouse floor. He was familiar with Petitioner as a forklift driver. He indicated he was familiar with both the seated and deep reach machines. Respondent began to make plans to switch to deep reach lifts in 2014, and had six of them at Petitioner's facility after a separate facility had shut down. Each had its own battery, and three extras were located at the battery station that could be changed out. He identified subpictures 1 and 2 in Respondent's Exhibit 5 as the crane used to change batteries and various chargers and batteries located in the battery station. Battery rotations for both the seated and deep reach lifts were performed in this area.

At approximately 12: 40 p.m. on January 21, 2015, Mr. Maraczi was in Zone 2 of Building 21 and headed for Zone 3, the location of the door to exit Building 21 and go to Building 29, when he heard a loud crash. He entered and saw that Petitioner had struck the door with a deep reach forklift. He did not see the actual impact. Maraczi believed the doorway was about ten feet tall, and the top of the forklift mast at its lowest point would be four feet above the bottom of the door, and testified that one could not drive it out of the building through the relevant door. He thus believed it should have been obvious to a driver that the machine would not fit through the doorway. There was one door the deep reach could be driven through, but this door was generally only used to bring machines/equipment in and out of the building. Seated forklifts, on the other hand, were routinely driving in and out of the relevant doorway. The deep reach lift would be driven with the forks, and mast, in the rear, so there should have been nothing obstructing Petitioner's view. He could not think of any reason why Petitioner would have needed to bring a deep reach out of the building, or how doing so could have further the interests of Respondent's business.

Mr. Maraczi testified that he had assigned Abraham Salgado to train Petitioner on the deep reach forklift, and that his training began in mid-November, 2014. As of January 21, 2015, Petitioner would have been very close to the end of training and getting his license. Other than the initial day of Petitioner's training, Mr. Maraczi did not specifically watch Petitioner being trained, and did not receive any written information from Salgado in this regard. Thus, he did not know exactly when and how Petitioner was being trained day to day, but he trusted that Salgado was doing the appropriate training. As to facility radios, he testified that all of the deep reach lifts in January 2015 were equipped with them, noting every piece of equipment at the facility was. Employees were also assigned a personal radio to keep on their person, and Maraczi believed one had been assigned to Petitioner. He identified the location of the radio within the deep reach in a photo contained in Respondent's Exhibit 5. He could not personally verify whether Petitioner had his personal radio with him on the date of accident, or even know for sure if one was assigned to Petitioner.

Mr. Maraczi also testified that, given how close to the end of training Petitioner was, he would have had to have had knowledge of how to change the battery. He stated: "I cannot say that anyone specifically said this is how you do this but over the course of two months a battery only lasts six to eight hours. He had multiple days of eight plus hours on the equipment. He would have had to have either seen it changed or assisted in changing the battery for it to be operational." That said, he agreed he could not personally verify that Salgado had actually trained Petitioner how to change a deep reach battery. Changing a deep reach battery in January, 2015 was a two person job. The Petitioner could have used his radio to call for assistance. When he asked Petitioner why he did not do so, he replied that he just wasn't thinking and planned to go find Luciano. On cross examination, Mr. Maraczi agreed that Petitioner would have been able to change out a seated forklift battery by himself.

Mr. Maraczi testified that the Petitioner told him he was ok but was shaken up and embarrassed. The Petitioner received a disciplinary write up for the incident. Mr. Maraczi testified that Petitioner never indicated he hit the door on purpose, and agreed that other forklift driver's have made mistakes and hit things with the lifts.

Petitioner testified he had no pain the night of the incident, but awoke with severe back and neck pain and spinal stiffness, indicating he needed help getting out of bed. He called off work and had a friend drive him to see chiropractor Dr. Woods. He testified he complained of severe neck and low back pain that was shooting into his right leg with pain, numbness and tingling into both arms, which is accurate per the report of Dr. Woods (Px2; Rx12). While the report notes his neck and low back pain were immediate, Petitioner denied telling Woods his pain was immediate after the accident occurred. Dr. Woods prescribed various chiropractic and conservative treatments, held Petitioner off work through February 19th and referred him to Dr. Gornet. He continued to follow up with Dr. Woods through April 3, 2015, during which time he also complained of significant headaches. There are notes which indicate Petitioner reported slight improvement at times, but overall it appears the Petitioner's neck and back conditions with radiating pain and numbness did not significantly improve with Dr. Woods' treatments, although it is noted he was undergoing injection treatments with Dr. Boutwell during this same time period.

Petitioner initially saw Dr. Gornet after the accident at issue on February 12, 2015. (Px1). He noted that Petitioner was already an established patient he last saw in 2012, at which time he had complained of neck and low back pain into the right leg following a motor vehicle accident where he was rear-ended. Symptoms had improved with injections, and he had not returned since that time. The Petitioner now reported backing up his forklift and hitting a door jamb and wall, and complained of headaches, neck and low back pain that radiated to the trapezius, arms and right leg, with tingling and numbness in the right leg and hands. He reported smoking a half pack per day, and reported no intervening slips, falls or other trauma since 2012, noting he had been working full duty since that time. Dr. Gornet noted the findings on cervical and lumbar x-rays, and compared the new cervical MRI with one from September 28, 2012. He believed Petitioner's accident aggravated his underlying condition, producing symptoms similar to what he'd had in the past, "but by all accounts his symptoms had gone away and he was not requiring any treatment". (Px1).

The cervical and lumbar MRIs were obtained on February 12, 2015. The cervical report reflects a C5/6 bulge with moderate to severe central canal and severe bilateral foraminal stenosis, a C4/5 bulge with superimposed bilateral foraminal herniations resulting in severe bilateral foaminal stenosis, and a C3/4 bulge with superimposed left foraminal herniation causing severe left greater than right foraminal and mild central canal stenosis. Lumbar films showed increasing thickness of L4/5 and L5/S1 herniations, resulting in increasing central canal and bilateral foraminal stenosis at both levels with developing bilateral lateral recess stenosis. Hypertrophy at L2/3 was unchanged versus April 28, 2011 films. Petitioner testified he did not recall discussing his February 12, 2015 cervical MRI, or its comparison with 2011 films, with Dr. Gornet. (Px3). In comparing the cervical films to September 28, 2012 MRI films, Dr. Gornet reported "no appreciable change" (Px1).

Petitioner saw company physician Dr. Knapp (Gateway Occupational Health) on February 23, 2015, complained of neck and back pain after running into the top of a door with his forklift, and was diagnosed with cervicalgia/neck pain and thoracic or lumbosacral neuritis or radi (presumably, radiculitis or radiculopathy). Dr. Knapp held Petitioner off work pending further evaluation by his treating physician. (Px7; Rx11). Dr. Gornet referred Petitioner to Dr. Boutwell for epidural injections, and back to Dr. Woods for post-injection therapy. Dr. Boutwell's records (Px4) indicate C3/4 (3/9/15) and C5/6 (3/23/15) epidural injections.

A lumbar MRI on April 16, 2015 (with noted comparison to the April 28, 2011 films) indicated increasing thickness of central herniations at both L4/5 and L5/S1 with increasing canal and bilateral foraminal stenosis with developing bilateral lateral recess stenosis at both levels. (Rx4). A June 25, 2015 repeat cervical MRI showed left foraminal protrusion at C3/4, bilateral foraminal protrusions at C4/5, and a C5/6 disc bulge with bilateral foraminal protrusions. This was noted to be slightly increased in size at C3/4 versus February 12, 2015, while C4/5 and C5/6 were stable. The various levels of central canal and foraminal stenosis were also stable. (Rx4).

Respondent had Petitioner examined by Dr. Wayne pursuant to Section 12 of the Act. Petitioner testified that he had prior neck and back problems, including a lumbar surgery approximately twenty five years ago with Dr. Wayne. Following an April, 2011 car accident, wherein he was rear ended while at a stop by a car traveling 55 to 60 miles per hour, Petitioner testified he had neck and back pain and treated with Dr. Russell and Dr. Gornet. Petitioner noted Dr. Gornet recommended cervical surgery at that time, but he did not undergo the surgery. He testified that Dr. Russell performed nerve blocks that relieved his pain and allowed him to return to work in July 2012. He noted that it took a couple weeks for the injections to work. He had a fishing incident ("I pulled a muscle in my back and in my rear") subsequent to that time where he fell and ended up being off work for 8 to 10 days. He saw primary care provider Dr. Nyazze at that time, but had no real treatment, and he returned to regular duty work.

On cross examination, Petitioner agreed that after the car accident in 2011 he treated with Dr. Nyazze, underwent cervical (July 22, 2011) and lumbar MRIs, and was referred to orthopedic surgeon Dr. Anderson. He agreed that he underwent cervical and lumbar epidurals in 2011 and was referred to Dr. Gornet. The Petitioner agreed he was a pack a day smoker at that time and was aware of its detrimental effects on his spine, and that his doctors had advised him to quit.

On further cross exam, Petitioner agreed that he had previously testified that nerve blocks with Dr. Randall relieved his neck pain after Dr. Gornet recommended cervical surgery after the motor vehicle accident. He was questioned about the July 16, 2012 surgical consult report with Dr. Gornet, and agreed that, based on the records, the surgical recommendation had been made *after* he had received the nerve blocks with Dr. Randall on April 3, 2012, not before.

Petitioner returned to Dr. Nyazze on July 16, 2013 complaining of low back pain, and on April 29, 2014 complaining of neck, upper back and shoulder pain. Asked by Respondent's counsel if it was accurate that he'd had waxing and waning neck and low back pain from 2011 to present, Petitioner responded "not like this" (Tr. 132). He testified that he believed he was 100% prior to the January 21, 2015 accident, and as to the visits with Dr. Nyazze prior to January 21st, he did recall having a slip and fall incident.

Respondent submitted multiple medical records of the Petitioner which predate the January 21, 2015 accident (Rx4, Rx7, Rx8, Rx9, Rx10 and Rx13). Petitioner saw orthopedic surgeon Dr. Anderson on April 26, 2011 with complaints of back pain into the right leg, occasionally to the foot, following an April 8, 2011 motor vehicle accident. He was neurologically intact on exam, but x-rays showed degenerative changes, so a lumbar MRI was prescribed, and SI joint injection was performed. (Rx10). Lumbar films from April 28, 2011 reflected postoperative changes at L5/S1 with evidence of severe right and moderate left foraminal stenosis secondary to residual disc bulging of a degenerative annulus and facet hypertrophy. At L4/5 there was a diffuse degenerative annular bulge with facet hypertrophy resulting in moderate bilateral foraminal and borderline central canal stenosis. (Rx4). On May 3, 2011 Dr. Anderson's report noted chronic low back pain down the right leg, and noted the MRI findings. Anderson recommended that he continue therapy and start lumbar epidurals, and that he be restricted to light duty. (Rx10).

A July 22, 2011 cervical MRI (Rx4) noted multiple disc bulges and other degenerative changes from C3 to C6, with severe bilateral foraminal stenosis at C4 to C6 and moderate bilateral foraminal stenosis at C3/4. There also was severe canal stenosis at C5/6, mild at C4/5. The history indicated pain radiating from the bilateral shoulders into the upper arms. (Rx4). A repeat MRI on September 28, 2012 indicated a C5/6 bulge with moderate to severe canal and severe bilateral foraminal stenosis, bilateral foraminal herniations at C4/5 causing severe right greater than left foraminal stenosis with no canal stenosis, and a C3/4 herniation causing no central canal stenosis with mild left foraminal stenosis. (Rx4).

Dr. Randle's treatment records indicate that a series of three lumbar epidurals were performed on May 23, June 6 and June 20, 2011, and trigger point injections were performed on September 28, October 18 and October 25, 2011. Cervical facet nerve block injections were administered on April 3, 2012 at C5/6. (Rx7 & 8). Cervical epidurals were prescribed in August 2011, but it appears there was concern due to the lumbar epidurals having been performed not long before. There is a report indicating one cervical epidural was performed on August 31, 2011, and there are no records indicating that further injections were ever performed. A May 15, 2012 report of Dr. Randle indicates that Petitioner was still complaining of ongoing severe pain, and a neurosurgical evaluation was recommended. Dr. Gornet saw Petitioner on July 16, 2012 for a surgical consult. Petitioner testified that he was significantly improved after the nerve blocks, even to the point where he was able to go back to his normal daily living activities and hobbies, including the ability to go back to work. Petitioner recalled returning to work in July 2012 and testified that when he did he was experiencing no pain in his neck. Petitioner recalled having a conversation with Dr. Gornet wherein Dr. Gornet recommended surgery in July 2012. The July 16, 2012 report of Dr. Gornet noted complaints of neck pain into both arms with numbness and tingling in the hands and headaches, as well as bilateral low back pain that radiated into both hips, particularly into the right leg. Petitioner noted constant symptoms since the motor vehicle accident. Dr. Gornet noted significant spinal cord compression at C5/6 due to herniation, and opined that C5/6 disc replacement surgery was required based on this finding. (Rx13). At a September 28, 2012 follow up it was noted that the surgery had been approved, noting a CT scan would first be needed to make sure his facets were of required quality, and Petitioner indicated he wanted to move forward with surgery due to ongoing pain. A surgical date was tentatively set. The next time Dr. Gornet's records indicate he saw Petitioner was the February 12, 2015 visit after the deep reach forklift accident. (Rx13).

The Petitioner saw Dr. Nyazee on August 6, 2013, complaining of off and on lumbar muscle spasms, with weakness and an inability to work. Flexeril was prescribed. Nothing was indicated about the back at his next visit on October 25, 2013, and there was no further refill of Flexeril prescribed. Multiple notes of Dr. Nyazee in 2013 and 2014 indicate complaints of coughing and wheezing, but nothing regarding neck or back complaints. On April 29, 2014 Petitioner complained of left upper back pain when raising his arm overhead. The diagnosis for that was intercostal myalgia, and no treatment was initiated beyond warm, moist heat. Nothing was noted about this condition at Petitioner's next visit on July 30, 2014. (Rx9).

Dr. Gornet testified via deposition on July 6, 2015. (Px6). His current diagnosis is C3/4 and C5/6 herniated discs, foraminal narrowing secondary to disc pathology at C4/5 and C5/6, and three level disc replacement surgery has been recommended from C3 to C6. Dr. Gornet opined that the January 21, 2015 accident aggravated a preexisting condition, and thus caused the Petitioner's current cervical and lumbar symptoms. He testified that the aggravation is inflammatory based. Dr. Gornet acknowledged that Petitioner's cervical complaints were in the same areas and pattern as they were in 2012, that his current objective cervical MRI films showed no appreciable change versus 2012 films, and that his abnormal examination findings were in the same muscle groups. He also acknowledged that he had prescribed

C5/6 disc replacement surgery back in 2012. However, based on the following facts, he believed that a significant change in condition occurred with the January 21, 2015 accident: Petitioner ultimately declined surgery in 2012; he was not taken off work in 2012; he returned to full duty work after 2012; he sought no further treatment with Gornet after 2012 until 2015; he has not been able to work since the current accident; the same muscle groups are impacted now as in 2012, but examination reflected some slight worsening with subtle examination changes after the 2015 accident; while C5/6 surgery had previously been recommended, the current post-accident recommendation is for surgery at C3/4, C4/5 and C5/6. As such, his opinion presumed Petitioner's complaints of significant worsening after the accident were factually correct, and he had no reason to believe they were not. (Px6).

Dr. Gornet testified that his records indicated that Petitioner had agreed with and been penciled in for September 2012 cervical surgery; Petitioner denied that this was true. Petitioner did agree the current surgery recommended by Dr. Gornet in 2015 includes the same level he had recommended surgery for in 2012. On cross examination, Dr. Gornet agreed that Petitioner was a smoker and obese, and acknowledged that these conditions, along with aging, can cause spinal degeneration. However, he noted that MRI films showed minimal changes since 2012. He also testified that a normal progression of degeneration was not the cause of the current symptoms because Petitioner had been continuing to work full duty with no further treatment until the January 21, 2015 accident. Dr. Gornet agreed that he had no specific details about the forklift accident other than that Petitioner had struck a doorway. He did not know the speed at which Petitioner had been traveling, or whether Petitioner was restrained or not.

As to the lumbar spine, Dr. Gornet testified, again, that the change in symptoms and work status supported his opinion that the lumbar condition is causally related to the January 21, 2015 accident. However, he indicated that it was hard to single out the lumbar spine versus the cervical spine, and that because Petitioner's cervical symptoms were significantly more severe than his lumbar symptoms, he was not yet treating the lumbar condition. He also testified that he believed the lumbar MRI findings in 2015 were somewhat worse than the findings in 2012 films as to an L4/5 herniation. He was hopeful that by the time of recovery from the cervical surgery, the back condition would no longer be an issue. He opined that Petitioner's ongoing need to remain temporarily totally disabled was based on the entire spine condition.

Dr. Wayne testified on behalf of Respondent on August 28, 2015 (Rx1). He examined Petitioner on April 28, 2015. He testified that there was no appreciable change in cervical and lumbar pathology between Petitioner's post-motor vehicle accident condition in 2011 and his post-January 21, 2015 condition, other than a normal degenerative process. He saw no herniations or other indicies of trauma to the cervical or lumbar spines which he would relate to the January 21, 2015 work accident. He further noted that had the January 21, 2015 incident involved a significant trauma, he questioned why Petitioner did not have immediate pain. He noted that any surgery at this point would be elective, in terms of the main consequence being pain and discomfort as opposed to life or death, and he believed that Petitioner's smoking and possible psychological issues made the surgery efficacy of such surgery questionable. He believed a psychological evaluation was appropriate. Dr. Wayne noted that Petitioner had done well previously with injections, and given that there were no significant structural changes due to the January 21, 2015 accident, that cervical injections would again be appropriate. He agreed that if the surgery recommended by Dr. Gornet were performed, Petitioner would require an advance cervical CT scan to evaluate the level of facet degeneration as a prerequisite to the surgery. If the degeneration was too significant, disc replacement would not be indicated, though a fusion could be or a combination fusion/disc replacement procedure. Interestingly, he testified that a three level cervical disc replacement surgery would be considered "off label", and not approved by the FDA. (Rx1).

17IWCC0090

On cross examination, Dr. Wayne agreed that epidurals and other conservative treatments in 2011 and 2012 appeared to have helped Petitioner and he had been able to return to work until the January 21, 2015 accident. While he believed that Petitioner's failure to return to work was his own choice, he agreed that Petitioner had not previously made such a choice until the 2015 work accident. He did agree that subtle changes were noted in the lumbar spine between 2011 and 2015 MRI films. He agreed it was possible that an incident where Petitioner's body was jerked back and forth could possibly aggravate a back condition. Dr. Wayne believed that the work accident may have resulted in a temporary aggravation of Petitioner's preexisting spine condition, but could not point to exactly when that temporary aggravation may have ended, just that it had ended by the time of his April, 2015 examination. (Rx1).

Petitioner testified that he continues to have neck pain into the shoulders with numbness and curling of his left 3rd, 4th and 5th fingers, noting he believed the latter began after steroid injection. He also has burning pain in his right fingertips, which had begun right after the accident. He has difficulty sleeping or staying in one position for too long. Petitioner continues to treat with Dr. Gornet, but no surgery has been scheduled. He hasn't worked for Respondent or anywhere else since the January 21, 2015 accident. Petitioner testified that he wants his pain relieved and wants to have surgery and return to work.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner sustained accidental injuries arising out of and in the course of his employment with Respondent on January 21, 2015. On that date the Petitioner attempted to drive a forklift, the deep reach, that had a high fork mast through a doorway that was too short for the machine, and ended up crashing it into the top of the doorway, including the actual roll down door.

It is clear to the Arbitrator that this incident occurred during the course of the Petitioner's employment. The Respondent argues that the incident was a personal deviation, or an exceedingly marked and unusual deviation, such that it took the Petitioner out of the scope of his employment. The Arbitrator does not agree. The Petitioner was working on deep reach forklift that he had been trained on, but which it appears he was not generally using in the course of his work duties. He was used to driving in and out of the doorway at issue with his seated forklift repeatedly throughout his workdays, so this was not an unusual activity in any way. There was nothing personal about the Petitioner's attempt to go through the doorway to seek assistance from a supervisor. Instead, the Petitioner's testimony was credible that his attempt to drive the deep reach lift through the doorway was in furtherance of the Respondent's business. While the result ended up costing the Respondent money for overhead door repairs, the Petitioner's intent certainly appears to have been to do his job, not some sort of personal task.

The Arbitrator does not believe the case of *Dodson v. Industrial Commission*, 308 Ill.App.2d 572, 720 N.E.2d 275 (1999), is applicable to the case at hand. In that case, the claimant chose to take a more dangerous short cut route out of her building to her car than was necessary, as a sidewalk was available, and the court determined that the Petitioner had taken on a personal risk that did not benefit the employer. Here, on the other hand, there was nothing about the Petitioner's attempt to exit the door to the next building with the deep reach machine that indicated an intent to benefit or convenience himself personally. Again, clearly a mistake was

made, but it appears to the Arbitrator that the Petitioner's intent here was to benefit the employer, and there was nothing unreasonable about his belief that he was doing so at the time.

The Arbitrator believes this case is more closely analogous to the *J.S. Masonry, Inc.* case (*J.S. Masonry, Inc. v. Industrial Comm.*, 369 Ill.App.3d 591, 861 N.E.2d 202, 208 Ill.Dec. 137 (2006)) than to the *Saunders* case (*Saunders v. Industrial Comm.*, 189 Ill.2d 623, 727 N.E.2d 247, 244 Ill.Dec. 948 (2000)). In the former, the claimant worked on a scaffold and had to keep tying a gate shut each of the many times he had to exit and enter the scaffolding for supplies. Despite being warned by his supervisor, he left the gate open and was injured. The Court noted that while the claimant acted for his personal convenience, he did so in furtherance of performing work for the employer, and the case was found compensable. In the latter case, the claimant was improperly riding on a forklift on his way to a break and jumped off of the moving machine, in violation of a safety rule, and injured himself. In that case, in denying benefits, the court stated: "Saunders' job description included using a forklift, by himself, to move machine parts from one part of the plant to another. Saunders' job description *did not* include hitching a ride to the break room on a passing forklift." Here, the Petitioner's job did involve riding a forklift between buildings, and while Petitioner had a radio he could have used to request assistance, he was going from one building to another seeking such assistance for purposes of continuing to do his job.

There also was nothing that would lead the Arbitrator to conclude that this was an exceedingly marked or unusual deviation. Again, the Arbitrator's impression of Petitioner's job is that he took a forklift in and out of the impacted door often on a daily basis. The Arbitrator found Petitioner credible and believes that he simply misjudged that the deep reach machine would fit through the doorway. He was trying to act quickly so that the packaging line would not have to be shut down due to the forklift drivers' failure to move product to the line. He testified he didn't know how to change out the battery on the deep reach. Mr. Maraczi testified that while he believed the Petitioner should have been trained on how to do so, but also testified he had no way of knowing this with any degree of certainty. There was no formal training procedure, and no logs were submitted indicating that Petitioner had participated in training on how to change the battery. It makes no sense to the Arbitrator that the Petitioner would have failed to change the battery had been trained on how to do so. Thus, it appears that the Petitioner was doing what he normally would have done in seeking to find help while using his seated forklift, and didn't realize the machine would not fit through the doorway. Mr. Maraczi testified that other forklift workers have crashed their machines into different items on the Respondent's facility floor, and the Arbitrator does not view this accident as being any different, in that the Petitioner made a mistake, but not one that rose to the level of reckless conduct or a deviation from his employment.

If negligence were at issue in a workers compensation matter, or if contributory negligence was a defense in such matter, the Respondent would have a more solid argument in this case against the finding of accident. However, under current law, neither the negligence nor contributory negligence of the Petitioner are factors in a workers compensation matter in Illinois. The Arbitrator finds that the Petitioner sustained accidental injuries arising out of and in the course of his employment with Respondent on January 21, 2015.

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, by a preponderance of the evidence, that his current condition is related to the January 21, 2015 accident.

"It has long been recognized that, in preexisting condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been causally-connected to the work-related injury

and not simply the result of a normal degenerative process of the preexisting condition." *Sisbro v. Industrial Commission*, 797 N.E.2d 665, 207 Ill.2d 193, 278 Ill.Dec. 70 (2003). Our Supreme Court has thus ruled that, even if an employee has a preexisting condition that may make him more vulnerable to injury, the claimant can still recover if it can be shown that the employment was also a causative factor. All that needs to be shown is the injury was a causative factor in the resulting condition of ill-being, not necessarily the sole or primary causative factor. *Id* at 672-673.

Here, the issue of causation was a difficult determination for the Arbitrator. It is clear that the Petitioner has significant and longstanding problems in both his neck and low back. He had a lumbar surgery decades ago. He sustained a 2011 motor vehicle accident where he was rear ended at a high rate of speed with what appears to have been a very significant impact. He had multiple injections at both spinal levels in 2011 and 2012, Dr. Gornet had prescribed a C5/6 disc replacement surgery in 2012, and his records indicate the surgery had actually been at least in the process of being scheduled. Dr. Gornet has testified that, objectively via MRI, there was no appreciable difference structurally between the Petitioner's pre-accident (prior to January 21, 2015) and post-accident films. Dr. Wayne, who performed Petitioner's prior lumbar surgery, opined that there was no real change in the cervical or lumbar films pre and post-accident.

While it therefore appears that objective films show no significant changes to Petitioner's spinal condition as a result of the January 21, 2015 accident, the chain of events indicates that there was a symptomatic change. The Petitioner had been working his regular job from his 2012 release until the January 21, 2015 accident, other than one period of time where he had been off work for eight to ten days, apparently in 2013, at which time Petitioner testified he had a fall while fishing. Otherwise, he appears to have been able to work full duty for Respondent.

Additionally, while it is very likely the accident at issue here was not as significant an impact as the 2011 motor vehicle accident, it still appears to the Arbitrator as involving a significant impact. The Petitioner was driving the deep reach forklift as fast as he could to try to get assistance before the battery ran out, and it appears that he came to a rapid if not dead stop when his machine hit the top of the doorway. The Arbitrator thus believes the Petitioner was credible in terms of his body jerking back and forth when the impact occurred. Pursuant to the Court's reasoning in *Sisbro*, despite the significant preexisting conditions the Petitioner had in his neck and back, it is difficult for the Arbitrator to find, based on the noted evidence, that Petitioner's current disability is based solely on a degenerative condition. Whether the Petitioner could have gone on to have the same symptoms and receive the same surgical recommendation as a result of solely the degenerative process, in the Arbitrator's reading of *Sisbro*, is not relevant if the work accident nevertheless was a cause of those symptoms and surgical recommendation. There is no indication in the evidence at bar that, but for the accident he sustained, the Petitioner had worsening symptoms or that he was seeking or planning to seek treatment for any such symptoms. Instead, the accident, which again appears to the Arbitrator to have involved fairly significant impact, appears to have been the impetus for increased symptoms and the Petitioner's actions in seeking medical treatment.

Dr. Wayne agreed with Dr. Gornet that the Petitioner's preexisting condition was aggravated by the forklift accident, but Dr. Wayne believed this aggravation was only temporary. Notably, he could not state when he believed the temporary aggravation ended and Petitioner returned to his baseline 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 is entitled to Respondent's payment of the medical expenses contained in Petitioner's Exhibit 5, which total $36,466.17, as provided in Sections 8(a) and 8.2 of the Act. The parties have stipulated that Respondent is entitled to a credit of $27,287.07 for medical benefits that paid via group health coverage pursuant to Section 8(j) of the Act. The Arbitrator notes that regardless of the credit amount, all of the bills contained in Petitioner's Exhibit 5 are the responsibility of the Respondent, and the Respondent shall hold the Petitioner safe and harmless from any claims for payment by any of the medical providers listed in Px5, as well as any claims for payment by the group health insurer or any of its collection agents.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Pursuant to Section 8(a) of the Act, Petitioner is awarded prospective medical care as recommended by Dr. Gornet, initially a CT Scan evaluation of the facet joints to determine if a three-level disc replacement surgery from C3 to C6 is indicated, and, if indicated, the C3 to C6 disc replacement surgery itself, and Respondent shall authorize same. If the CT Scan indicates that the C3 to C6 disc replacement surgery is not indicated, the Arbitrator has no basis to award any specific prospective treatment based on the evidence presented.

It should be noted that Dr. Wayne testified that a three level cervical disc replacement surgery would be considered "off label", and not approved by the FDA. While on its face this gives caution to the Arbitrator in ordering the surgery, no evidence was presented regarding how this impacts the reasonableness or necessity of the surgery.

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 findings above regarding accident and causation, and Dr. Woods and Dr. Gornet holding Petitioner off work starting on the day after the January 21, 2015 accident, and continuing through the date of hearing, the Arbitrator finds that the Petitioner is entitled to TTD from the Respondent from January 22, 2015 through the January 22, 2016 hearing date, a total of 52-2/7 weeks.

The parties have stipulated that the Respondent is entitled to credit pursuant to Section 8(j) of the Act of $13,002.53 for long and short term disability benefits previously paid to Petitioner.

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

Gregory A. Schneider,

Petitioner,

vs.

NO: 12 WC 19455

City of Elgin,

17IWCC0091

Respondent.

DECISION AND OPINION ON REVIEW

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

For the reasons set forth below, the Commission modifies the Arbitrator's Decision by finding that the Petitioner was entitled to temporary total disability from September 5, 2012 through May 4, 2014.

So that the record is clear, and there is no mistake as to the intentions or actions of this 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. We have considered all of the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent. One should not and cannot presume that we have failed to review any of the record made below. Though our view of the record may or may not be different than the Arbitrator's, it should not be

presumed that we have failed to consider any evidence taken below. Our review of this material is statutorily mandated and we assert that this has been completed.

The Petitioner testified that he stopped treating with his psychologist and psychiatrist, Dr. Chesney and Dr. Waliuddin, respectfully, in the beginning of 2013 because he could not afford to pay them. He also testified that from August 2013 through April 2014 he did not see his treating physicians because he could not financially afford to see them. The Petitioner still had symptoms of irritability and sleeplessness during that time period. He would also have flashbacks about his work incident a couple of times per month. He was not released back to work during the August 2013 through April 2014 time period, but he was actively looking for a new job. He ultimately found full-time employment as a security assistant beginning May 5, 2014 with Huntley School District 158, supervising construction renovation and doing background checks on the contractors. (Tr. 82-88, 98-106)

Petitioner's Exhibit (5) contains the Petitioner's treatment records from Dr. Waliuddin for the period of September 11, 2012 through February 8, 2013. Dr. Waliuddin diagnosed the Petitioner with post-traumatic stress disorder ("PTSD") and ordered him off of work beginning on September 11, 2012. Dr. Waliuddin's letter dated February 8, 2013 states that the Petitioner's work related shooting caused his PTSD and that the Petitioner could not perform regular police officer duties.

Petitioner's Exhibit (7) contains the deposition of Dr. Malina, a neuropsychologist, who the Petitioner saw on August 1, 2013. Dr. Malina conducted a neuropsychological evaluation of the Petitioner. He reviewed the Petitioner's medical records from other physicians, he clinically interviewed the Petitioner, and then he conducted a battery of tests on the Petitioner. Dr. Malina ultimately diagnosed the Petitioner with PTSD, which he deemed related to the Petitioner's work related shooting incident. Dr. Malina testified that on August 1, 2013, the Petitioner presented with active PTSD symptoms and needed more treatment and medication. He opined that it was not appropriate or safe for the Petitioner to work as an armed police officer at that time because he was actively symptomatic. (Dep. 11-13, 56-57)

The Commission finds that the Petitioner's PTSD condition was not stabilized as of August 1, 2013. At that time, Dr. Malina opined that the Petitioner presented with active PTSD symptoms and that he needed further treatment. Dr. Malina also opined that the Petitioner was not ready to return to work as a police officer. The Petitioner testified that he stopped seeing his two mental health treaters because their bills were not paid through workers' compensation coverage and he could not afford to pay them himself. He further testified that he had symptoms of irritability, irregular sleep, and flashbacks through April 2014. The Petitioner further testified that he began full-time employment as a security assistant with the Huntley School District on May 5, 2014.

Therefore, based upon the totality of the evidence and the factual findings above, the Commission modifies the Petitioner's entitlement to temporary total disability. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

17IWCC0091

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision, filed on February 2, 2016, is hereby modified.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the Petitioner temporary total disability benefits of $1,110.43 per week for 86 and 4/7 weeks, from September 5, 2012 through May 4, 2014, as provided in Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of his causally related condition through May 5, 2014, pursuant to Sections 8 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.

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.

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

DATED: FEB 14 2017

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

O: 12/13/16
TJT/gaf
51

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

SCHNEIDER, GREGORY A
Employee/Petitioner

Case# **12WC019455**

CITY OF ELGIN
Employer/Respondent

17IWCC0091

On 2/2/2016, 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 0.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1497 MORICI FIGLIOLI & ASSOC
DAVID FIGLIOLI
150 N MICHIGAN AVE SUITE 1100
CHICAGO, IL 60601

5541 FRED J BEER LAW OFFICES
2295 VALLEY CREEK DR
UNIT K
ELGIN, IL 60123

17IWCC0091

STATE OF ILLINOIS)
)SS.
COUNTY OF Kane)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
AMENDED ARBITRATION DECISION
19(b)

Gregory A. Schneider
Employee/Petitioner

v.

City of Elgin
Employer/Respondent

Case # 12 WC 19455

Consolidated cases: None

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Geneva**, on **November 9, 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. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[x] TPD [ ] Maintenance [x] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **March 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 through August 1, 2013, *is* causally related to the accident. SEE DECISION

In the year preceding the injury, Petitioner earned **$86,665.80**; the average weekly wage was **$1,665.65**.

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

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

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

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

ORDER

The respondent shall pay the petitioner temporary total disability benefits of $1,110.43 per week for 47-1/7 weeks, from September 5, 2012 through August 1, 2013, as provided in Section 8(b) of the Act. Respondent shall receive credit for amounts paid, if any.

The respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of his causally related condition through August 1, 2013 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid, if any.

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

2/2/16
Date

ICArbDec19(b)

FEB 2 - 2016

FINDINGS OF FACT

Petitioner, a 40 year old police officer for the city of Elgin, testified that on 3/17/12, he had been employed 16 years for Respondent. Petitioner worked as a patrol officer. Prior to his employment with Respondent, Petitioner worked as an auxiliary deputy for the McHenry County Sheriff's department for one year. He had police powers in that capacity. Petitioner served in the Coast Guard reserves from 2003 to 2009, which overlapped with his time with Respondent. His position with the reserve was as a port security specialist working domestic port security in Milwaukee as well as overseas in Kuwait from June to December 2008. He did not have combat exposure during this time overseas.

Petitioner testified that he underwent a psychiatric evaluation as a teenager with an inpatient stay period in the late 1980's. Petitioner testified that as part of the employment process for the Elgin Police Department he was sent to meet with a mental health professional and was administered mental health testing and interview. Petitioner passed the examination and was hired. In 2001, Petitioner was sent for psychiatric testing by the Elgin Police Department following an excessive force complaint. Petitioner was evaluated and sent to several sessions of counseling. Thereafter, Petitioner was returned to the force as a police officer.

Petitioner testified that his duties as a patrol officer included responding to radio dispatch calls and emergency situations, following and enforcing local, state and federal statutes and conducting investigations of traffic complaints and collisions. Petitioner was also required to make arrests as necessary. Petitioner testified that he received no training from the Elgin Police Department, the coast guard or the McHenry County Sheriff on how to handle shooting incidents or residual feelings from such incidents. Petitioner testified that during his 16 years worked as a police officer prior to 3/17/12, he never discharged his firearm at an individual.

On cross exam, Petitioner testified that while in the Police Academy in 1996 and while on the force he received training on how to fire a gun and use deadly force. Petitioner also testified that he received training on how to transport prisoners and on standard operating handcuffing procedures which required cuffing prisoners behind their back. Petitioner testified that he did not receive training on how to handle escaped prisoners. Petitioner also spent time on the Elgin Police Department swat tactical response team which required him to pass a physical exam and demonstrate superior gun firing talent. Petitioner resigned from the swat team in 2001 after an internal affairs investigation in 2000 and 2001 following two excessive force complaints. The investigations concluded that Petitioner did use excessive force on those occasions and Petitioner was ordered to psychological evaluation in June 2001 with Dr. Ostrov. Dr. Ostrov concluded Petitioner needed remedial counseling with Dr. Brown. In October 2001 following more testing with Dr. Ostrov, a full duty return was recommended. Petitioner returned and worked full duty without incident until March 2012.

On 3/17/12 Petitioner was working the day shift starting at 6:30 am. His initial assignment at roll call was as a beat officer. However, during his shift he was reassigned to transport two prisoners from the Elgin lock up to the Cook County Court in Rolling Meadows for the Saturday morning bond call. Petitioner was assigned to work this duty alone. He was assigned a cage squad car which had a cage between the front and back seat of the car but no cage, bars or extra protection on the back passenger windows of the vehicle. Petitioner testified that he gathered all of the necessary paper work for the prisoners including all warrants and charging documents. The prisoners were obtained from their cells by a guard from the jail and then walked to the booking area. Petitioner testified that the prisoners were not handcuffed when brought from their cells to Petitioner obtained the "jail handcuffs" to cuff the prisoners before putting them in the car. Petitioner did not use his own assigned cuffs. Petitioner testified that he was in a hurry to get the prisoners to court so they would not be late.

Petitioner testified that he cuffed each prisoner's hands in front of their bodies for optimal comfort on the long drive to Rolling Meadows. Specifically, Petitioner testified that he chose to cuff them in front because he was alone in the transport and reasoned that if they were cuffed in the back he might have had to pull off the road to adjust their hands so he chose to cuff in front to avoid prisoner complaints while performing the transport alone.

Petitioner testified that he had performed this type of transport in the past and that it was unusual to have been assigned to work the transport alone without another officer. Petitioner testified that he was not comfortable performing the transport alone. However, Petitioner further testified that he had transported multiple prisoners on his own before on 2 to 3 occasions but that he always had concerns when transporting prisoners without another officer in the car. He further estimated that he transported prisoners with a partner on 25 occasions.

Petitioner testified that during the drive from Elgin to Rolling Meadows he traveled North on Route 53 in the right lane. He testified that he was driving at 65 mph. Petitioner testified that while driving north on Route 53 the prisoner in the seat behind his began kicking out the passenger window of the car. Petitioner testified that he slowed the vehicle to pull off to the right shoulder of the road. He testified that in a matter of seconds, as he was slowing the vehicle, the prisoner successfully kicked out the passenger window and jumped out of the passenger window. Petitioner testified that the prisoner jumped from the car while the car was still moving. Petitioner testified that he saw the prisoner in the traffic lane to his left and in front of the squad car. Petitioner testified that he pulled the squad car across traffic lanes to protect the prisoner lying in the road. He tried to call for assistance with the car radio but could not get any radio connection so he then pressed the emergency button on the radio hoping that would work. Petitioner then got out of the squad car and took out his personal cell phone and called 911 while the prisoner was still on the ground in front of the car. Petitioner testified that the prisoner got up from the ground and Petitioner pulled his gun and ordered the prisoner to stay where he was in an attempt to control the situation. Petitioner testified that 3 to 4 cars per minute were passing on both sides of the squad car at 35 to 40 mph. Petitioner testified that he ordered the prisoner to stay down so that he could watch both prisoners and keep everyone safe from traffic.

The prisoner did not stay on the ground. The prisoner stood up and began to run toward another car that was stopped in the traffic on the right hand shoulder of route 53. Petitioner began to run after the prisoner telling him to stop. The prisoner ran up to the passenger car stopped on the right shoulder of the road and tried to enter that car pulling first on the driver door and then running around the car to pull on the passenger door. Petitioner followed the prisoner who did not stop his attempts to get into the stopped car. When he was close enough to the prisoner, Petitioner tried to spray the prisoner with pepper spray to stop the prisoner's attempts to get into the car but Petitioner was not successful. The prisoner continued to run and Petitioner followed him worried that the situation would worsen if the prisoner got into the neighboring residential area. Petitioner testified that with no help on the scene he fired at the prisoner and struck him twice. The prisoner fell to the ground in a grassy area down a small grade from the shoulder of the road about 15 to 20 feet apart and about 3 to 4 car lengths away from the squad car. The prisoner tried to get up again but eventually stayed down when ordered. Petitioner testified that he again called for help and that another officer showed up after Petitioner stood over the prisoner for about 1 minute. The prisoner did not die from the gun shots. Petitioner testified that his first thought was that he just killed someone's father because he himself had just become a father. The initial portion of the incident as testified to by Petitioner was captured on dash cam video viewed by the Arbitrator. RX 22.

Petitioner testified that the ambulances arrived at the scene. He testified that he experienced a rapid heartbeat and could not catch his breath. He testified that he was fatigued and that he had never experienced these symptoms before this occurrence. Petitioner also testified that at some point his legs were brushed by a passing car. Paramedics took Petitioner to the ER at Northwest Community Hospital. Upon exam he appeared to be mildly anxious and very pleasant. He had no acute respiratory distress. He had normal, non-labored

respirations. His breath sounds were normal, with good equal air movement. The primary diagnosis was acute stress disorder. He was prescribed and took Ativan. Upon disposition he felt better with the Ativan. He was discharged in stable condition with no work restrictions and instructed to follow-up with his primary care physician if he had any problems. PX 1.

Petitioner testified that an Elgin Police Department supervisor met with him at the hospital followed by the arrival of the chief and deputy chief. They told Petitioner to go home and wait for contact. Petitioner was placed on administrative leave. Petitioner was on administrative leave from 3/18/12 to 4/1/12 and received full salary. During this two week period Petitioner had trouble sleeping and was irritable, anxious, and distant with his 3 month old baby. He testified that he only slept a few hours at a time and that once he woke up he stayed up feeling anxious and depressed. He testified that he was unable to sit still or relax, that he paced and that he had dull hearing in his right ear.

Petitioner sought treatment with his family doctor, Dr. Tanna. On April 2, 2012, Dr. Shital Tanna, M.D. of Signature Medical Associates examined petitioner. He reported the shooting incident and emergency room visit but did not feel like he had "emotionally recovered from the event". He also found the recovery stressful because of the criminal and internal affairs investigation which typically take place after the fact in this type of scenario. He complained of mood swings. His wife stated he was impatient, irritable, restless at times, and overreacted to small issues. He had poor memory and felt like he did not enjoy or find interest in daily activities. He was not as interactive with his son. He had similar issues when he returned from military tour. His concentration was mildly impaired. He could not focus enough to work out every day as previously. He had difficulty staying asleep and woke up 4 to 6 times per night, often sweating when he woke up. He had decreased energy. He lost 7 pounds since his last visit and his appetite decreased. He complained of a sore, scratchy throat and right side ear pain described as fullness and "underwater feeling" with occasional crackling noises in the ear. On his ENT exam his right ear TM was retracted but no effusions were noted and there was no redness. The assessments were: 1. Hearing loss NOS. 2. Posttraumatic stress disorder. 3. Pharyngitis, Streptococcal. His treatment recommendations were: 1. Hearing loss NOS to start Nasonex spray intranasally, undergo Tympanagrom, and hearing screen. 2. Posttraumatic stress disorder to start citalopram and a referral to see a counselor and psychologist. 3. Pharyngitis, Streptococcal start amoxicillin after a positive Lav: Strep A, Rapid. She issued a note indicating he was medically able to return to work. He was on no medication which would interfere with his duties. PX 2.

When Petitioner went back to work on 4/3/12 he was assigned to the evidence room of the police department. His job required him to assist the assigned evidence custodian and perform only paperwork. Petitioner testified that he felt like he was in a fish bowl and isolated as he worked with only 1 to 2 civilians in the evidence room. Petitioner testified that he was not told why he was given this assignment and that he felt very betrayed and isolated by the department. He further testified that the chief told him to discuss the case with anyone and that he was not offered counseling recommendations or help from the department.

On April 16, 2012, Dr. Tanna re-examined petitioner. He complained of his mood and did not feel like the medication made any difference for him. He experienced mood swings, irritability, impatience and loss of interest in parenting and work to some extent. He was doing more administrative work at the police department. His wife felt there was no change in his disposition. He still complained of decreased hearing on the left side with occasional crackling noises. On exam his right ear was still retracted. She referred him to Dr. Alvi for an ENT consultation and prescribed Paxil. PX 2.

On April 18, 2012, Dr. Aijaz Alvi of the Specialty Care Institute & the Hearing Institute examined petitioner. (PX3). He reported the shooting incident and decreased hearing in the right ear. Upon exam there was fluid

present and decreased mobility in the right ear. The assessment was otitis media-serous. He had a combination of otitis media and possible noise induced mild HL. They tried prednisone and nose spray and re-test hearing at the next visit.

On April 19, 2012, licensed clinical professional counselor Karen S. Chesney, LCPC, CAADC, of Comprehensive Care, P.C. counseled petitioner. (PX4). He told her about the shooting incident and his subsequent problems sleeping, anxiety, and being easily frustrated. As far as he knew the prisoner was still alive and there would be an internal investigation. He was doing paperwork at work. He kept reliving the incident which sometimes interfered with his concentration and distracted him. Petitioner reported sleep difficulties and night sweats. He had one EAP session and he was called to return to work. He felt betrayed by EAP and the police department and relayed that he was not given any support by the police department. The police department wanted him back at work so that was "not so isolated." His wife said he was distant from his four-month-old son. Counselor Chesney stated that he needed to make a better transition from work to home.

On April 24, 2012, Counselor Chesney prepared a letter to Dr. Tanna thanking him for the referral of petitioner and informing him that she first saw him on April 19 and will continue to see him on a weekly basis. She would be evaluating him for PTSD. He reported he was taking paroxetine for his symptoms. PX 4.

On April 26, 2012, Counselor Chesney counseled petitioner. He took Paxil at night. He reported headaches and stated that towards the end of the day, he was not as focused. His memory was still poor. He experienced de-personalization. Petitioner reported that he did not want to go back to work and did not like it at work. Petitioner also reported feelings of paranoia. PX 4. On May 10, 2012, Counselor Chesney counseled petitioner. He was a doing a lot of yard work and was off work the prior week on vacation. She noted that Petitioner's "attitude about work was not good at work." He is a self reflective person. He can fall asleep but did not stay asleep. His wife said he moved a lot, yelled, and talked in his sleep. His sleep problem was not in his control. He reported that he left his work at work.

On May 16, 2012, Dr. Alvi re-examined petitioner for "hearing loss after a gun shot." Dr. Alvi noted that Petitioner had "improved hearing" and advised Petitioner that it may not improve further. Petitioner was advised to wear ear protection. Re-testing of his hearing revealed that his right ear had a mild SNHL. PX 3.

On May 17, 2012, Counselor Chesney counseled petitioner. He tossed, turned, thrashed, yelled, and breathed heavy during his sleep. He was exhausted during the day. Sometimes he had to sleep in another room so as to not to disturb his wife's sleep. He would talk to Dr. Tanna about it. Petitioner stated that he still felt ignored at work and thought the administration and other police would be more empathetic and supportive. Petitioner stated that he wanted to do some writing about what an officer should do right after the shooting in that such training was not offered. He felt that would be cathartic for him. He needed to work harder at communication with his wife because of his hearing loss. He reported that his marriage was doing well and that is wife was very supportive.

On May 18, 2012, Dr. Tanna re-examined petitioner. Dr. Tanna noted that Petitioner stopped taking Paxil 10 days earlier and still had mood swings but much better than previously. He occasionally felt down and was still irritable and fairly impatient. He was really enjoying parenting again. He bought a new house. He was doing more administrative work at the police department. His wife felt he was slightly depressed and often got agitated. He could fall asleep but had difficulty staying asleep. He sweated at night and his wife said he was restless and moves and talks a lot during the night. His energy decreased. His concentration was mildly impaired. He started exercising daily for 15 minutes. He saw a counselor one time per week. He was to start on

SNRI and continue with his counseling. Dr. Tanna noted Petitioner "can certainly work his regular duties" at that time and that he had written a note to that effect. PX 2.

On May 24 2012, Counselor Chesney counseled petitioner. She noted that Petitioner tried to separate work from home. Dr. Tanna changed his medication and he was only on the new medication for a couple of days. He experienced annoyance and frustration. Dr. Tanna noted that Petitioner was told not to talk about the incident at work and that the incident consumed his frame of reference. He had been to the shooting range two times since the incident. Petitioner testified that he used his own weapon at the range. Dr. Tanna noted that the State still had his weapon or it was returned to the respondent.

On May 25, 2012, Counselor Chesney prepared a letter to Marianne Veltri of Claim Management Consultants indicating Dr. Tanna referred petitioner to her for treatment of PTSD. Her initial assessment of him occurred on April 19, 2012 when he described a shooting incident while he was at work. Since then, he had been attending therapy on a weekly basis "to deal with the aftermath of the incident". On May 31, 2012, Counselor Chesney counseled petitioner. His work was still the same. Ms. Chesney noted that Petitioner reported receiving an email from Deputy Chief Cecil Smith to return to work. Petitioner reported that Commander Wolf and the Chief called him and said the email was not an order although initially Petitioner thought it was an order to return to work. His new medication did not seem to help with his sleeping. PX 4.

On June 18, 2012, Dr. Tanna re-examined petitioner. The Effexor was working well for his mood. Dr. Tanna noted that Petitioner's wife still complained of slight mood swings but that Petitioner reported he felt more in control over his emotions and much better than previously. He was fairly active at work and enjoyed his family life and parenting. He bought a new house. The support stages of the legal investigation was nearly complete. Petitioner reported continued sleep difficulties, night sweats, occasional restlessness and decreased energy. His concentration was normal. He was still exercising daily for 15 minutes and seeing a counselor one time per week. For the PTSD he ordered that he should refill the Effexor. Dr. Tanna noted that Petitioner was "medically stable and appeared to be healing well. He may return to his regular duties at work and may actually benefit from his regular duties to normalize his work life". He would CPM for the next three months and then follow-up in September. They would consider tapering the medication at that time. In the interim, Dr. Tanna noted that Petitioner should continue with his counseling. PX 2.

On June 21, 2012, Counselor Chesney counseled petitioner. There was no change in his work status. He was still moody. Ms. Chesney noted that Petitioner was reading a workbook about how his personality may have changed. He had dreams where he was shooting but not the same as the shooting incident. He was still moving around a lot in his sleep. Ms. Chesney noted that Petitioner would need some notice before going back on the street as a police officer. He saw Dr. Tanna the prior Monday and he was to stay on the same medication until the end of the summer and titrate down. Petitioner reported that he had three years to make his 20 year pension and that he felt he could stay in the evidence room and not go back on the street. He enjoyed his time with his wife and son.

On June 27, 2012, Dr. Tanna re-examined petitioner. He complained of a headache for the past week. He assessed tension headache and ordered that he start Anaprox, adequate oral hydration, and regular sleeping hours. If his headaches persisted after one week, he was to call then or in the interim if there was a worsening.

On July 27, 2012, Dr. Tanna re-examined petitioner. Dr. Tanna noted that Petitioner was in counseling and taking his medication but felt that his symptoms were at a plateau. He felt when he took his medication in the morning he had anxiety at night and if he took them in the evening his daytime symptoms were not controlled. Petitioner was wondering if he should see a psychiatrist. Under the diagnosis of post traumatic stress disorder

Dr. Tanna referred him to see a psychiatrist and advised him to increase his medication. He could continue to see the counselor.

On August 15, 2012, Dr. Alvi re-examined petitioner. He noted Petitioner was doing well with a continued diagnosis of hearing loss. He had turned his head at times to better hear. Dr. Alvi recommended ear plugs to help avoid further hearing loss and an annual hearing test. This was Petitioner's last visit to Dr. Alvi. PX 3.

On August 28, 2012, the respondent Elgin Police Department issued Notification of Charges regarding petitioner's performance during the March 17, 2012 shooting incident stating that based on the investigation thus far it would appear that petitioner's use of deadly force against the prisoner was not in compliance with certain Rules and Regulations, and Policies and Procedures of the police department, or with applicable law and that it appeared that petitioner used unnecessary and excessive force in subduing the prisoner. He also failed to comply with the police department policy regarding the handcuffing of a detainee. He would be questioned about possible violations of specific Rules and Regulations and Standard Operating Procedures. (RX2). On August 30, 2012, the respondent issued an administrative warning to petitioner advising him that he was the subject of an administrative investigation and a formal interrogation under oath. (RX3) On August 30, 2012, the respondent provided both RX2 and RX3 to petitioner.

On September 5, 2012, Dr. Tanna re-examined petitioner. Dr. Tanna noted, "41 year old male presents with c/o Mood anxious, worried about everything, irritable. Denies weight change, suicidal ideations. Stressors served with charges last week by Internal Affairs Dept. support from spouse. Sleep disturbance, difficulty falling asleep, difficulty staying asleep, does not sleep more than 3h per night. Energy change decreased energy. Appetite change decreased. Concentration mildly impaired. Has trouble driving b/c he states his thinking is scattered. Pt is not exercising at this point. Has appt with psychiatrist on 9/11." Under a diagnosis of post traumatic stress disorder, Dr. Tanna increased the Effexor and started Xanax. He notes, "Written note for work absence until appt with psychiatrist since he has such trouble focusing and even driving." Petitioner was told to call the office if he felt worse in the interim. PX 2. Dr. Tanna issued a noted dated September 5, 2012, stating "Greg is unable to work for medical reasons. He has an appt with a specialist on 9/11/12." Petitioner provided the respondent with the September 5, 2012 work status note from Dr. Tanna and stopped working in the evidence room starting on September 5, 2012. Patricia Bosio testified for Respondent at trial in her capacity as the property and evidence room custodian. She worked with Respondent in the evidence room and did not observe Petitioner having any difficulty performing the job. She found him sociable.

On September 11, 2012, psychiatrist, Dr. Syed Waliuddin, M.D. of Valley Psychiatry & Counseling, LLC, examined petitioner. (PX5). His chief complaint was having "trouble sleeping." He reported the shooting incident, symptoms and work history since the incident. He had been second-guessing himself and felt tense all the time. He had not been able to concentrate and felt overwhelmed easily. He experienced marked distress when he hears about the shootings on the news and started experiencing physical symptoms such as palpitations and feeling dizzy. He was avoiding outdoor activities, situations and talks relating to the incident that happened. He had been isolating himself from his family and friends. He wakes up in the middle of the night and has difficulty falling asleep. Upon mental status exam his motor activity included some fidgety behavior and his speech was fluent. He described his mood as "Anxious" with mood congruent affect. His thought process was goal directed. He denied having suicidal and homicidal ideation, no overt psychosis noted. He had difficulty performing serial 7's. His immediate, recent and long-term memory appear to be intact. He had limited insight and fairly intact judgment. The diagnosis was Axis I Post Traumatic Stress Disorder, Axis II deferred, Axis III none acute, Axis IV social, occupational and Axis V 48. The treatment plan was: 1. Continue Venlafaxine, Xanax Prn Anxiety. Add Intermezzo to target insomnia. 2. Continue individual therapy

with Counselor Chesney. 3. Patient to remain off work until September 25, 2012 and tentatively return to work on September 26, 2012. 4. Return to clinic in two weeks or earlier if needed.

On 9/17/12 Petitioner again saw Dr. Tanna for his last visit. Dr. Tanna noted, "41 year old male presents with c/o anxiety f/u moods are gradually improving, esp with better sleep patterns. " Petitioner denied weight or appetite changes. Dr. Tanna noted, "mood improving gradually, awaiting final resolution of the internal investigations and alleged charges. Sleep disturbance improving, using new RX. Energy change mirrors sleep patterns. Concentration mildly impaired. Anhedonia mild. Seen by Dr. Wally (Waliuddin) on 9/11 and was given new sleeping RX. He agrees with DX and to continue with current meds, given time off work until 9/26, next appt is 9/25." Petitioner was told to continued medication, follow up with Dr. Waliuddin and follow up with Dr. Tanna prn. PX 2.

Petitioner followed up with Dr. Waliuddin on 9/25/12. The history indicates that Petitioner continued "... to feel anxious, difficulty sleeping at night, reportedly he is shouting in his sleep. c/p drenching sweats at night. States Intermezzo helped him somewhat but was able to sleep half of the time. He continues to second guess himself a lot lately. Continues to have startle response when he thinks to the incident and has difficulty not reliving thoughts of the incident." Petitioner's medication was continued. Dr. Waliuddin noted that Petitioner was to remain off work "till 10/16/12 as of now." PX 5. Dr. Waliuddin also issued a handwritten note indicating "this is to certify that Gregory Schneider is receiving treatment under my care for post traumatic stress disorder. He is advised to have rest until 10.16.12 due to worsening of his symptoms." PX 5.

On September 25, 2012, petitioner also appeared for a formal interrogation at respondent's City Hall. He was represented by an attorney. Petitioner presented respondent with the September 25, 2012 Dr. Waliuddin note indicating that he could not work. Petitioner testified that he and his attorney watched a video of the incident on Commander Wolf's laptop computer during the hearing. Petitioner testified that his attorney also watched the video on a break in the hearing but that Petitioner did not see the video during the break. Petitioner denied that he joked and laughed during a break in the interrogation. Commander Wolf testified that both Petitioner and his attorney watched the video during a break and that Petitioner had no emotional reaction to the video at any point during the hearing. He described Petitioner's demeanor as "low key".

On October 12, 2012, Dr. Waliuddin re-examined petitioner. He reported that he underwent an interrogation through work and that it triggered the anxiety. He also was shown a video about the incident that gave him the reliving experience. Dr. Waliuddin noted that Petitioner "states he got tense and had a hard time talking about the incident at that time. Pt reports returning to clinic the same day due to excessive anxiety. States he was feeling light headed. Continues to feel restless." Petitioner reported sleep was interrupted with nightmares and drenching sweats. His appetite was so-so. During this mental status exam his mood was "Anxious". In regard to his concentration/attention span, he had difficulty with serial 7's. Dr. Waliuddin recommended Ambien, Seroquel bipolar medication, cognitive behavioral therapy-identification modification of cognitive distortions, supportive therapy-improve coping ability with stressors, and that he remain off work until November 6, 2012 due to his ongoing symptoms. He also noted "return on 11.7.12."

On October 25, 2012, Dr. Waliuddin re-examined petitioner. He continued to feel anxious on a daily basis and felt tense all the time. He experienced nightmares and flashbacks. His spouse told him he was shouting in his sleep. He was compliant on medications and tolerating them well. Petitioner noted that his counselor was out of town but that he would see her the following week. He also avoided watching news since it brings him anxiety. He avoided the place where the incident happened. He recommended continued therapy with Counselor Chesney and continued medication under the same diagnosis.

On November 1, 2012, Counselor Chesney counseled petitioner. Petitioner advised that he was off work and filing for disability. He was still having "restless" sleep and that he needed to work on "life stressors." Petitioner reported that he went through an "interrogation process and saw a video of shooting- more trauma- saw himself backing into a car and falling to his knees, something he hadn't realized."

On November 6, 2012, Dr. Waliuddin issued a note indicating that petitioner was under his care and that due to worsening of his symptoms, it was recommended that he remain off work at this time. His next visit was set for 11/15/12. PX 5.

On November 8, 2012, Counselor Chesney counseled petitioner. She noted that he "went to hearing- sustained internal charges – very stressful week. He'll have to see 3 doctors to get disability- not getting workman's compensation they want him to use up sick time- worried about finances.... Looking into homeopathic ways to deal with anxiety- still not getting good sleep- nightmares – no motivation to work-out- dreams about falling, getting hurt, highway- he sleeps downstairs not waking as a couple and that his wife said its like being his roommate." PX 4.

On November 15, 2012, Counselor Chesney counseled petitioner. The Effexor made him feel "lazy." He used the Xanax PRN. He had a workbook. He listened to ocean sounds instead of "white noise". They discussed self-talk and questions about how to use this strategy. Petitioner noted that he might write a book about this experience with a co-author. His father-in-law offered him a job as a car salesman. He further reported that "they" would consider his workman's comp after he sees "their" doctor. They wanted him to use his FMLA leave. He discussed how he was able to compartmentalize better now. He felt that medication helped with sleeping problems. He was able to look at the incident from different perspective "now than at first." PX 4.

On November 15, 2012, Petitioner also saw Dr. Waliuddin. He continued to feel anxiety and experience nightmares (he is shooting someone in his sleep) and flashbacks. He continued to have the intrusive thoughts about shooting when he hears or see something around him. He reported he felt tired and fatigued during the day. He was compliant on medications and tolerating them well. He had no motivation to do anything. He was doing a workbook on PTSD. Dr. Waliuddin recommended adding Abilify to the medications. PX 5.

On November 28, 2012, Counselor Chesney counseled petitioner. She noted that the city was denying the workman's comp claim and that Petitioner had to use up vacation and sick days. Petitioner reported feeling hopeless, depressed, and angry. Petitioner advised he was denied prescriptions and could not afford the sleep meds. He was trying to "scrounge out money for bills." He was working on self–talk. He was more aware of the negative self-talk and tried to look for blessings. He did not sleep the previous night. He was cognizant of potential bad habits. He watched what he ate more. PX 4.

On December 3, 2012, Dr. Steven D. Horwitz, M.D., F.A.C.S. of Northside Ear, Nose & Throat, SC (part of the North Shore University Health System Medical Group) examined petitioner, conducted hearing tests, and reviewed his treatment records regarding his alleged hearing loss to the right ear. (RX7). The hearing tests showed that qualitatively the left ear heard better than the right ear. His hearing levels on the right ear were 20 db at Hs, 25 db at 2000 Hs and 40 db at 3000 Hz and on the left ear were 10 db at 1000 Hz, 5 db at 2000 Hz and 10 db at 3000 Hz. Dr. Horwitz opined that one time loud acoustic trauma can improve up to one year after the event. He noted that Petitioner was at maximum medical improvement 8 months after the event although there may be a slight improvement in his hearing over the next three months. In a subsequent letter dated 1/18/13, Dr. Horwitz opined that using the Illinois Workers' Compensation Guideline for Disability, petitioner's hearing loss in the right ear is actually 0%. RX 7.

On December 6, 2012, Counselor Chesney counseled petitioner. Petitioner noted that he went to a hearing test that "turned out the same". He further advised that in mid January he had testing for two hours with the city doctor. His nightmares increased and he had restlessness that woke him up. His nightmares have been about dangerous situations. He had flashbacks and used guarding techniques. He avoided highway travel when going to Skokie for hearing tests. PX 4.

On December 7, 2012, Dr. Waliuddin re-examined petitioner. His anxiety was still high and became worse on certain days when he did the workbook on PTSD. He reported having nightmares and flashbacks. He was applying grounding techniques but still ended up getting anxious. He felt tense when he thought of work and started day dreaming. He could not start Abilify because he could not afford it. He was compliant on the other meds and tolerating them well. He encouraged him to start the Abilify and Ambien. PX 5.

Petitioner met with Respondent's Section 12 examining physician Dr. Obolsky on two occasion, 12/18/12 and 1/8/13. Dr. Obolsky testified on three different continued evidence deposition dates regarding his findings and opinions. Based on his interview of Petitioner and on a review of Petitioner's medical records and on numerous forensic psychiatric tests, Dr. Oblosky opined that Petitioner was not suffering from Post Traumatic Stress Disorder and was malingering. He further opined that Petitioner was suffering from emotional difficulties consistent with anxiety and depression caused by the difficulties he encountered after the shooting incident of March 17, 2012 and specifically his employment problems. (Respondent's Exhibit #10; p.72) He further testified on cross examination stating; "He does have post traumatic stress, there is no question about it. He does not have post traumatic stress disorder." (Respondent's Exhibit #10; p.249). Dr. Obolsky further testified that he believed the shooting incident the petitioner was involved in on March 17, 2012 did not fit the criteria as a sufficiently traumatic incident outlined in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition-DSM-IV. It was his opinion that you have to look at the individual and his or her type of employment and experience to determine if a specific event is to be considered a traumatic event, especially when dealing with first responders such as police officers and firefighters. (Respondent's Exhibit #10; p.127-129).

Petitioner met with Dr. Waliuddin for that last visit on 1/10/13. At that time he reported becoming easily frustrated and a high anxiety level. He reported having attended the Section 12 with Dr. Obolsky and undergoing testing. He stated he was shown the incident video which gave him a startled response. He reported continued fatigue, sleep disturbance, nightmares and anger over the incident. On 2/8/13, Dr. Waliuddin wrote a letter stating that Petitioner suffered from "post traumatic syndrome which was caused by involvement in an on duty shooting on March 17, 2012. He is not able to return to his job/duties as a police officer at this time." PX 5.

Petitioner saw Ms. Chesney in January, February and March 2013. These visits document the continued complaints of anxiety and frustration along with escalating tensions in his home life and financial issues. During his last visit with Ms. Chesney on March 7, 2013, she noted Petitioner "discussed how his nuclear family has been effected by the way he is being treated over the incident." PX 4.

Dr. Aaron Malina, a board certified neuropsychologist, was called as a witness by the petitioner and testified by evidence deposition. Dr. Malina saw Petitioner on 8/1/13. Dr. Malina, in evaluating the petitioner, chose to administer the same battery of tests utilized by Dr. Obolsky in order to determine if there was consistency in findings across time. (Petitioner's Exhibit #7; p.17, p. 29) Additionally, he reviewed the records from his treating physicians and psychologist as well as the report authored by Dr. Obolsky. Dr. Malina then testified that although Dr. Obolsky administered a number of appropriate tests to determine PTSD, he questioned why Dr. Obolsky administered such a large number of cognitive tests to specifically see if the petitioner was malingering. (Petitioner's Exhibit #7; p.31-32). Dr. Malina testified that Petitioner presented with emotional

concerns and therefore he did not agree with Dr. Obolsky's performance of cognitive effort measures. PX 7, p. 32.

Nevertheless, Dr. Malina performed the same cognitive effort tests and determined that Petitioner scored in the normal range and did not exhibit any signs of exaggeration or malingering. (Petitioner's Exhibit #7; p.33-37) With respect to the tests that specifically measured whether the petitioner had PTSD; the Detailed Assessment of Posttraumatic Stress-DAPS, the Trauma Symptom Inventory-TSI-2 and the Minnesota Multiphasic Personality Inventory, 2nd Edition-MMPI-2, the results showed that the petitioner 's performance was valid, it was interpretable and he presented with significant PTSD symptoms. (Petitioner's Exhibit #7; p.38-50) Dr. Malina also testified that the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition-DSM-IV, is the definitive manual utilized by psychologists, neuropsychologists and psychiatrists for diagnosing mental health disorders. The DSM-IV provides the criteria for formulating a diagnosis of PTSD and based upon his evaluation of the petitioner and his review of the records provided to him, he met the criteria as outlined in this manual. (Petitioner's Exhibit #7; p.63-70, Deposition Exhibit #3) Dr. Malina diagnosed post-traumatic stress disorder based on his clinical interview, medical records, and supportive objective test findings. PX 7, pp. 54-55. Dr. Malina this condition to the shooting incident he was involved in on March 17, 2012, and stated Petitioner was in need of further treatment for his PTSD and that he was unable to return to work as a police officer at that time given his continued symptoms. (Petitioner's Exhibit #7; p.54-56). Finally, Dr. Malina further testified that he could not explain why Dr. Obolsky's test results were completely opposite but it may have been that the petitioner became disengaged from the testing process while at Dr. Obolsky's office because it took so long to complete. (Petitioner's Exhibit #7; p.60-61).

At trial, Petitioner testified that his experience seeing Dr. Malina was better than his experience with Dr. Obolsky. He felt he was treated better by Dr. Malina and was therefore more comfortable.

The Arbitrator notes here that in the course of his application for disability, Petitioner was seen by two additional doctors, Drs. Weine and Harris. Dr. Richard Harris, a psychiatrist hired by the pension board to evaluate the petitioner was called as a witness by the respondent and testified by evidence deposition in the instant matter. Dr. Harris evaluated the petitioner on two occasions; March 21, 2013 and September 10, 2013. He also reviewed the records from the petitioner's treating physicians and psychologist, the reports from Dr. Obolsky and Dr Malina, and the petitioner's personnel file. He then offered his opinion in his report that the petitioner was not suffering from Post Traumatic Stress Disorder. Rather, he was suffering from anxiety and depression and was not disabled from returning to work as a police officer. (Respondent's Exhibit #12). During his deposition, Dr. Harris testified that 95% of the examinations he performs are at the request of employers, insurance companies and pension boards. He is also not qualified or trained to administer or score psychological tests and rarely utilizes them to render opinions. (Respondent's Exhibit #17; p. 16-19) He did however, confirm that there are specific tests that can be utilized to determine if an individual is suffering from PTSD and he did not recall if he reviewed the petitioner's test results from those specific tests, i.e. the DAPS and the MMPI-2 when he formulated his opinions in this case. (Respondent's Exhibit #17; p.28-32)

Dr. Harris further testified that the petitioner's involvement in the shooting incident on March 17, 2012 did not rise to the level of the type of traumatic incident as stated in the criteria outlined in the DSM-IV for a diagnosis of PTSD because there was no apparent threat to petitioner's life. However, he did not recall if the petitioner had related to him in one of the interviews that he was afraid he was going to be hit by a speeding car while trying to stop the prisoner from escaping. If he had this fear or if the video of the incident shows that he was brushed by a vehicle, then it would fit the criteria as outlined by the DSM-IV as a sufficiently traumatic incident. (Respondent's Exhibit #17; p.48-49). Dr, Harris then testified that his diagnosis of the petitioner's condition is that he was suffering from depression. He further testified as to the cause of petitioner's

depression; "I think that as far as I can tell the incident set off a whole chain of reaction." (Respondent's Exhibit #17; p.77, 95)

Dr. Stevan Weine, another psychiatrist hired by the pension board was called as a witness by the respondent and testified by evidence deposition in the instant matter. Dr. Weine authored a report dated April 23, 2013 wherein he opined that the petitioner did not meet the diagnostic criteria for Post Traumatic Stress Disorder even though his involvement in the shooting incident of March 17, 2012 could be classified as a moderate intensity traumatic event according to the DSM-IV criteria. It was his opinion that the petitioner was suffering from an Adjustment Disorder with Mixed Anxiety and Depressed Mood which was caused by the trauma exposure and multiple other work and personal stressors. He further opined that the petitioner was not disabled from police work but he needed additional treatment with a psychiatrist or psychologist in order to receive weekly psychotherapy sessions for at least six months. (Respondent's Exhibit #11)

Dr. Weine then testified at his evidence deposition that the majority of the cases he is involved with are at the request of defendants, employers, insurance companies and pension boards. He last treated an individual in a clinical setting for any type of psychiatric condition in 2001. (Respondent's Exhibit #19; p.35, 45) He further testified that he is not qualified to administer and score psychological tests. RX 19, p. 68. He further testified that he was unfamiliar with the DAPS test. RX 19, p. 70. He further testified that he was not familiar with the portion of the MMPI-2 that could be utilized to diagnose PTSD. RX 19, p. 70-71. He also was not provided with any of the opinions or the report from Dr. Malina outlining his tests results and opinions. (Respondent's Exhibit #19; p.75- 76)

Dr. Weine also testified that he utilized the DSM-IV to come to his diagnosis in this case that the petitioner was suffering from adjustment disorder, mixed anxiety and depression and that a major cause of his condition was the traumatic shooting incident he was involved in on March 17, 2012. (Respondent's Exhibit #19; p. 119-120) HE testified that the shooting "was a major but not the only contributant." RX 19, p. 128. He did not believe however, that the petitioner met the criteria under the DSM-IV for Post Traumatic Stress Disorder because even though he had many of the symptoms identified in the various categories listed to render that diagnosis, in his opinion those symptoms did not cause impairment or impact petitioner's psychosocial functioning. (Respondent's Exhibit #19; p.101-102) Specifically, Dr. Weine opined that his condition following the incident is best categorized as Adjustment Disorder with Mixed Anxiety and Depressed Mood. (Weine Dep. 99-110). Lastly, Dr. Weine testified that putting the petitioner in the evidence room upon his return to work and ordering him not to discuss the shooting incident could cause or exacerbate his symptoms. (Respondent's Exhibit #19; p.115-116)

Petitioner also testified that the Elgin Police Department asked the Illinois State Police to look into the legality of the shooting. Thereafter, on July 12, 2012 it was determined by the Cook County State's Attorney's Office that no criminal charges would be appropriate against Petitioner. PX 6. As a result of the Elgin Police Department's own internal affairs investigation of Petitioner's conduct, Petitioner's employment was terminated on July 29, 2013, based on found violations of Department rules and regulations and standard operating procedures. RX 26. Petitioner withdrew his request for duty disability from the pension board in February 2014.

Petitioner testified that although he had not been released to work he began to look for work in order to pay his bills. Petitioner testified that he still experienced sleep difficulty and flashbacks a few times per month. From August 2013 through April 2014 Petitioner worked as a doorman at a restaurant in Rosemont. Petitioner worked door security and bar safety and advised management on safety and security issues. Petitioner supervised 12 other doormen, checked id's and enforced the rules. He testified that he worked a 6 hour shift 2

to 3 days per week. In May 2014 he got a job with Huntley School District as a security assistant. Petitioner testified that he started the job on 5/5/14 and supervises the renovation of the high school, performs background checks on construction personnel and monitors construction personnel.

Petitioner testified that he currently has occasional loss of sleep a few times per month, anxiousness, day dreams and occasionally relives the incident. He currently takes no medication or prescription drug. He uses his own PTSD book and uses strategies on how to manage PTSD on his own. Petitioner testified that he feels he is improving in relation to his psychiatric symptoms and that the frequency and intensity of the symptoms have decreased.

CONCLUSIONS OF LAW

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

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

Based on the testimony and evidence summarized above, the Arbitrator finds that Petitioner sustained an accident arising out of and in the course of his employment with Respondent on 3/17/12. In so finding, the Arbitrator notes that the entire incident which initially involved a prisoner escaping from a moving vehicle on a highway and ultimately resulted in Petitioner firing shots at the prisoner to restrain him in order to protect both the prisoner, himself and the general public, was sufficiently traumatic in nature and constituted as sudden and severe emotional shock. *Pathfinder Company v. Industrial Commission,* 62 Ill.2d 556, 343 N.E.2d 910 (1976). *Diaz v. Illinois Workers' Compensation Comm.et al. (Village of Montgomery)* 2013 Il.App.(2d) 12029WC. No evidence was offered to refute Petitioner's version of the incident as partially supported by the video. Petitioner's complaints of emotional distress began immediately after the occurrence and he treated consistently thereafter. Accordingly, the Arbitrator finds that this incident constitutes an accident that arose out of and in the course of petitioner's employment by the respondent on 3/17/12.

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

The Arbitrator finds that the petitioner's Post Traumatic Stress Disorder condition, as diagnosed by his treating physicians and counselor is causally related to the work accident he sustained on March 17, 2012, up through the ultimate plateau and stabilization of his symptoms as of August 1, 2013. The Arbitrator also finds that to the extent Petitioner sustained a loss of hearing in his right ear following the accident, that condition is also causally related to the accident of 3/17/12 through his last date of treatment for the condition on December 3, 2012. Again, Petitioner's ear complaints started immediately after the accident and no evidence of a prior ear problem was admitted at trial. The Arbitrator's finding of causal connection for his diagnosed condition of PTSD is based upon the testimony of the petitioner as buttressed by the medical records and opinions of Drs. Tanna and Waliuddin and of Counselor Chesney. In so finding causal connection for the diagnosed condition of PTSD, the Arbitrator places greater weight, based on a review of the evidence as a whole, on the opinions of Drs. Tanna, Waliuddin and Malina than on the opinions of Drs. Obolsky, Weine and Harris.

In finding causal connection for Petitioner's PTSD condition through August 1, 2013, the Arbitrator first notes that Petitioner complained immediately of symptoms including anxiety, depression, sleep difficulty, concentration difficulty, and flashbacks. These same symptoms continued, while waxing and waning based on his life and employment circumstances after the shooting, and the symptom continuation was well documented

by his treaters through his last medical treatment date in March 2013. The Arbitrator notes that as of his last visit to his treating physician in March 2013, Petitioner's overall condition, complaints, treatment and diagnosis had not substantially changed since his initial treatment began in March 2012. The Arbitrator further notes that while all physicians ultimately indicated that Petitioner should continue some medication and counseling, Petitioner, subsequent to March 2013, sought no additional medical treatment, discontinued therapy and discontinued the use of his medication. At trial, Petitioner testified he was no longer taking medication or prescription drugs and that he currently has occasional loss of sleep a few times per month, anxiousness, day dreams and occasionally relives the incident. He uses his own PTSD book and uses strategies on how to manage PTSD on his own. Finally, Petitioner testified that he feels he is improving in relation to his psychiatric symptoms and that the frequency and intensity of the symptoms have decreased.

Further evidencing the condition plateau and stabilization as of August 1, 2013 is the fact that Petitioner began working as a security supervisor at a bar/restaurant on or about that date. Specifically, the Arbitrator notes that Petitioner was able to return to some employment and voluntarily did so as of August 2013. In addition, the Arbitrator notes that Petitioner returned to a job where he was required to display authority in order to keep control of possibly volatile situations in the bar. He was also able to manage 12 other people and enforce the facility rules which he testified on occasion required him to physically interact with customers and remove them from the premises. This demonstrable ability further buttresses the Arbitrator's finding of condition plateau and stabilization on August 1, 2013 and causal connection through that date. Accordingly, the Arbitrator finds that Petitioner's condition of ill-being through August 1, 2013 is causally related to the accident of 3/17/12.

L. What temporary benefits are in dispute? TTD/TPD

Based on the Arbitrator's findings on the issue of causal connection and on the off work authorizations provided by Petitioner's treating physicians commencing 9/5/12, the Arbitrator further finds that Petitioner is entitled to TTD of 47-1/7 weeks commencing 9/6/12 through 8/1/13. Respondent shall receive credit for amounts paid, if any.

Based on the Arbitrator's findings of causal connection for Petitioner's condition of ill-being through August 1, 2013 only, the Arbitrator denies Petitioner's request for TPD subsequent to that 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?

Respondent's dispute regarding medical expenses was based on liability. ARB EX 1. 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 connection with his causally related medical treatment through August 1, 2013 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid.

M. Should penalties or fees be imposed upon Respondent?

Based on the totality of the evidence, the Arbitrator finds that Respondent's conduct was neither so unreasonable nor vexatious so as to justify the imposition of the requested fees and penalties under the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Edward Holmes,
Petitioner,

vs. NO: 15 WC 34431

CTS,
Respondent.

17IWCC0092

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, temporary total 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 May 2, 2016 is hereby affirmed and adopted.

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: FEB 14 2017

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-02/01/17
jdl/wj
68

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

HOLMES, EDWARD
Employee/Petitioner

Case# **15WC034431**

CTS
Employer/Respondent

17IWCC0092

On 5/2/2016, 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 0.40% 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:

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

2674 BRADY CONNOLLY & MASUDA PC
NOAH P HAMANN
211 LANDMARK DR C-2
NORMAL, IL 61761

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Edward Holmes
Employee/Petitioner

v.

CTS
Employer/Respondent

Case # **15** WC **34431**

Consolidated cases: **n/a**

17IWCC0092

An *Application for Adjustment 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 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 **Prospective Medical Treatment**

17IWCC0092

FINDINGS

On **September 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 not*** sustain an accident that arose out of and in the course of employment.

In the year preceding the injury, Petitioner earned **$4,642.53**; the average weekly wage was **$1,547.51**.

On the date of accident, Petitioner was **44** years of age, ***single*** with **1** dependent child.

The parties stipulated at the time of arbitration that Respondent paid **$0** for TTD, **$0** for TPD, **$0** for maintenance, **$0** in non-occupational indemnity disability benefits and **$16,190.02** for other benefits, for a total credit of **$16,190.02.**

ORDER

Petitioner failed to prove that he sustained an accident that arose out of and in the course of his employment with Respondent and, as such, all benefits are denied. The remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, **$0** in non-occupational indemnity disability benefits and **$16,190.02** for other benefits, for a total credit of **$16,190.02.**

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

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

Melinda M. Gore-Sullivan

Signature of Arbitrator

4/29/16

Date

ICArbDec19(b)

MAY 2 – 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Edward Holmes
Employee/Petitioner

Case # 15 WC 34431

v.

Consolidated cases: N/A

CTS
Employer/Respondent

17IWCC0092

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner claims he sustained injuries to his bilateral shoulders, cervical spine and lumbar spine as a result of an accident allegedly occurring on September 23, 2015. On the date of accident, Petitioner was 44 years old and worked for Construction Turnaround Services ("CTS") at an oil refinery in Wood River, Illinois that was owned by Phillips 66. CTS was hired by Phillips 66 to disassemble and assemble oil refinery parts as part of a refinery maintenance project. Petitioner was a union boilermaker laborer in that process.

Petitioner testified that on September 23, 2015 he was standing on scaffolding ten feet off the ground while a channel head was being delivered by a crane to his work area. He testified that a channel head weighed 18,000-20,000 pounds and was the size of a pick-up truck. He testified that in layman's terms, a channel head was a cap that plugged a hole on an oil refinery pipe. He testified that the channel head was coming towards him quickly on a crane when it began to move awkwardly. He testified that as a reflex he attempted to stop the channel head with his hands and he pushed against it. He testified that he fell and hit a handrail with his neck. He testified that he fell to avoid being "smooshed" between the channel head and the handrail of the scaffolding. He testified that he slid underneath the channel head. He testified that when he fell it was from an upright position down to the floor of the scaffolding. He testified that another co-worker named "Richard" was present when the accident occurred. The Arbitrator notes that Richard's last name was not given, nor was Richard called to testify. Petitioner testified that he experienced immediate pain.

Petitioner testified that he reported the accident immediately to his foreman, Don Schexnider, on the date of accident. He testified that Don Schexnider told him not to report the accident to CTS because if he did, he would be fired. He testified that he asked Mr. Schexnider to report the injury, but that Mr. Schexnider would not let him leave the work area.

Petitioner testified that his pain immediately was a 5 or 6 out of 10 and that over the next few days it worsened to the point that he could not stand the pain on October 1, 2015. He testified that his pain was so severe that on either September 24th or 25th, he had difficulty working with his right leg. He testified that at that time he was walking from his work area to a break area and that his leg "stopped." He testified that when he first went to a doctor on October 1, 2015, his pain was so bad that he had difficulty washing his hair because movement of his arms and neck during that process caused pain.

Petitioner testified that because Don Schexnider would not allow him to treat or stop working, he called Phillips 66's Safety Department on September 30, 2015 to speak with a safety representative by the name of Stefanie Genevese. He testified that the Phillips 66 Safety Department did not answer. He testified that on October 1, 2015, he met with CTS safety coordinator Grant Dalton to report his accident and injury. He testified that Mr. Dalton told him to treat under his group health insurance.

Petitioner testified that after Grant Dalton denied his treatment, he called Phillips 66 again and was still unable to speak with anyone. He testified that later in the day on October 1, 2015, he was summoned by Grant Dalton. According to Petitioner, at that time Mr. Dalton fired him for not following company procedures. He testified that he has not worked since October 1, 2015.

On cross-examination, Petitioner admitted that he took and passed a safety orientation test at the time of hire on September 10, 2015. He agreed that the test specified that all injuries were to be reported immediately to an employee's supervisor and the CTS safety department. He testified that he could not report the work injury to anyone above Don Schexnider because Mr. Schexnider would not let him leave his work area to report an injury. He testified that he notified co-workers Colby Newman and "Richard" about the injury as well as his union steward, "Aaron." The Arbitrator notes, however, that none of these individuals were called to testify at the time of arbitration on behalf of Respondent.

On cross-examination, Petitioner admitted having a prior workers' compensation case in Louisiana and that he reported that accident on the date it occurred.

On cross-examination, Petitioner testified that he worked nights for CTS from 5:00 p.m. to 7:00 a.m. and that he was free in the daytime hours. He testified that after the alleged date of accident, he continued working full duty until October 1, 2015. He testified that his job was heavy duty and that it involved lifting of up to 50 pounds for half of the day and standing for 90% of the day.

On cross-examination, Petitioner testified that he saw an attorney on September 30, 2015 before he first sought any medical care on October 1, 2015. He testified that his attorney recommended the first person from whom he sought treatment, Dr. Eavenson. He testified that he saw Dr. Eavenson in the morning on October 1, 2015 before he reported the accident to CTS Safety Manager Grant Dalton. He testified that on October 1st when he reported the work accident to Grant Dalton, he complained of shoulder pain, not low back pain.

Carrie Fisher was called to testify by Petitioner at the time of arbitration. She testified that she is Petitioner's fiancée. She testified that she traveled with Petitioner to Illinois while he was working for CTS. She testified that on September 27, 2015, she received a phone call from Don Schexnider. She testified Don Schexnider asked her to influence Petitioner not to report his work injury. She testified that before the date of accident, Don Schexnider called her to demand that she cook and do laundry for him in exchange for Petitioner's continued employment.

On cross-examination, Ms. Fisher testified that she did not work for CTS and that she was not present on the alleged accident date.

Luther Fisher was called to testify by Petitioner at the time of arbitration. He testified that he is Carrie Fisher's brother and is soon to be Petitioner's brother-in-law. He testified on December 13, 2015, he was with Petitioner at his campsite in Louisiana. He testified that Don Schexnider and Chris Chandler were at a neighboring campsite. He testified that Mr. Schexnider and Mr. Chandler directed "slanderish" comments towards Petitioner for reporting a work injury.

Mr. Fisher testified that Petitioner loves hunting and fishing and that since the alleged accident, he has been unable to hunt or fish. He testified that in late January of 2016, he and Petitioner helped Chris Chandler remove Mr. Chandler's vehicle from the mud. He testified that during that exchange, Mr. Chandler claimed he had not been aware of any work injury to Petitioner until that conversation.

On cross-examination, Mr. Fisher testified that he did not fill out any witness statements or police reports during the exchange on December 13, 2015. He agreed that no arrests were made.

Don Schexnider was called to testify by Respondent at the time of arbitration. He testified that he worked as a foreman for CTS on September 23, 2015. He testified that he was Petitioner's supervisor. He testified that to his knowledge, no accident occurred on September 23, 2015. He disputed that Petitioner reported an accident to him on September 23, 2015 or on any day thereafter. He testified that he first learned of Petitioner's alleged work injury on October 1, 2015 when he was questioned by Grant Dalton.

Mr. Schnexider described the scene when a channel head was being delivered by crane to boilermakers. He testified that employees stand to the side of the channel head with tag lines approximately 10-15 feet away. He testified that the crane moved the channel head at "turtle speed." He testified that the crane operator positioned the channel head and then the boilermakers approached it. He testified that at that point, the channel head was hanging in place and while stationary it moved only a matter of inches. He testified that during this process, he was on the ground supervising the scene to make sure employees did not get hurt and to make sure the job was done properly.

Mr. Schexnider testified that he did not notice any pain behaviors from Petitioner after September 23, 2015 and that Petitioner kept working full duty as Mr. Schexnider's subordinate until September 29, 2015. He testified that on that date the two stopped working together because of an argument that took place at work. He testified that on September 29, 2015 while driving to the job site, he asked Petitioner if he was planning to work another job with a different company when the CTS work ended. He testified that when they arrived at the job site, Petitioner became angry, cursed and threatened him. He denied that the argument was about Petitioner's alleged work accident.

Mr. Schexnider testified about the police incident in Louisiana in December of 2015. He denied that he harassed Petitioner. He testified that he first met Petitioner in 2014 and that their relationship was personal before it was professional. He testified that he helped get Petitioner the job with CTS and that the two had been hunting friends prior to the date of accident.

On cross-examination, Mr. Schexnider admitted calling Carrie Fisher on September 27, 2015.

On cross-examination, Mr. Schexnider was questioned about the altercation on September 29, 2015. He testified that the argument was reported to CTS on the date it occurred and that forms documenting the altercation were not completed until the following day.

On redirect examination, Mr. Schexnider testified that when he spoke with Ms. Fisher on September 27, 2015, he was unaware that Petitioner was alleging a work accident or injury from September 23, 2015. He testified that he did not recall what he spoke with Ms. Fisher about on that date, but that he might have called to invite her and Petitioner to shoot pool and have a drink because it was their day off and they had been social as a group before while in Illinois.

Chris Chandler was called to testify by Respondent at the time of arbitration. He testified that he is a boilermaker. He testified that prior to his career as a boilermaker, he worked as a state trooper in Louisiana. He testified that he worked for CTS on September 23, 2015, and that he was on the same crew

as Petitioner and Don Schexnider. He testified that he was not aware of any accident involving Petitioner at any point in time. He testified that he generally worked within eyesight of Petitioner.

Mr. Chandler testified that subsequent to September 23, 2015, he continued working with Petitioner and that he did not display any signs of pain or any difficulty performing his job. He testified that Petitioner performed his job full duty.

Mr. Chandler described the scene when a channel head was being delivered by crane to the boilermakers. He testified that the boilermakers were not to be underneath the load when it was being moved by a crane. He testified that boilermakers used tag lines to guide the channel head when the crane was moving the load and that while the crane was moving, the speed was a "snail's pace."

Mr. Chandler testified that hypothetically if a 20,000 pound channel head was moving to the point that it caused an employee to fall, the accident would have been reported. He testified that there were enough people working nearby that such an incident would have been reported by someone.

Mr. Chandler testified that the proper chain of command for reporting a work accident on his crew would have been to Don Schexnider, then to safety manager Grant Dalton and then possibly to the job superintendent. He also testified that in addition to those CTS employees, the boilermakers also had access to a union steward on the job site to serve as a liaison with management. He testified that he found Don Schexnider to be safety-conscious. He testified that Mr. Schexnider treated Petitioner like all of the other employees.

Mr. Chandler testified about the argument on September 29, 2015. He testified that he was riding in a work vehicle with Don Schexnider and Petitioner on the way to the job site. He testified that in the vehicle, Mr. Schexnider asked Petitioner if he was going to accept a job with another employer after the CTS work ended. He testified that when the men arrived at the job site, Petitioner began yelling at Mr. Schexnider about the way he felt he was being talked to. He testified that Petitioner was the aggressor.

Mr. Chandler testified about the incident in Louisiana in December of 2015. He testified that he was camping and hunting with Mr. Schexnider. He admitted that the police were called, but denied that there had been any altercation.

On cross-examination, Mr. Chandler admitted that he roomed with Mr. Schexnider during the project for CTS in September of 2015. He admitted having a conversation with Luther Fisher in January of 2016 when the two men worked to extricate his truck from the mud in Louisiana. He testified that during that conversation, he told Mr. Fisher that he had been unaware that Petitioner had a back injury requiring surgery.

On cross-examination, Mr. Chandler testified that he never saw Petitioner hunt or fish after September 23, 2015. He further testified that it was possible for an employee to touch a channel head to help move it, and that it was possible channel heads moved slightly.

On cross-examination, Mr. Chandler was asked about a lip injury he had while working for CTS. He testified that the lip injury occurred before October 1, 2015. He testified that he did report his lip injury to Don Schexnider. He testified that Mr. Schexnider asked if he wanted medical attention, but he refused the offer. He admitted that his lip injury was the type of injury that should be reported to CTS.

On redirect examination, Mr. Chandler testified that if his lip injury had required medical attention and if Mr. Schexnider denied treatment, he would have reported the incident to Grant Dalton or his union steward. He testified that his lip injury was only a bloody lip.

Jacob Rucker was called to testify by Respondent at the time of arbitration. He testified that he was a crane operator. He testified that he was the only crane operator that worked on Petitioner's jobsite on the date of accident. He testified that he was unaware of anything out of the ordinary occurring on September 23, 2105.

Mr. Rucker testified about the process of when a channel head was moved by a crane. He testified that when the crane was in motion with a channel head, the speed was "turtle" speed. He testified that while the crane was moving, the employees were out of the way. He testified that as the crane operator, he was watching the load. He testified that he never saw any employee fall on September 23, 2015 while the crane was operating. He testified that while the crane was moving, he did not witness any employees push on the channel head. He testified that on the alleged date of accident, he recalled that the channel head was being removed instead of being delivered. He testified that the procedure was the same for removal and delivery, only it was reversed.

Mr. Rucker testified that he knows Don Schexnider and that Mr. Schexnider was nice, easy to get along with and that he knew what he was doing.

On cross-examination, Mr. Rucker admitted that as a crane operator he relied, in part, on hand signals from other employees. He testified that a channel head was approximately the size of a desk and that his view was only obstructed if someone was directly behind the channel head, but that an individual could not be behind the channel head because that was the area where the channel head bolted to other equipment.

On cross-examination, Mr. Rucker testified that boilermakers used strength to line up channel heads to apply bolts. He testified that he has never worked as a boilermaker, but he knew what the job entailed from his observations. He testified that it was possible his view could have been obstructed. He testified that there were always two men on the scaffolding.

On redirect examination, Mr. Rucker testified that if his view was obstructed, he relied on hand signals from other employees working as spotters. He estimated that his view was obstructed approximately 10% of the time. He testified that hand signals were in place on September 23, 2015. He testified that if he was about to cause an injury, he would be alerted by hand signals.

Grant Dalton was called to testify by Respondent at the time of arbitration. He testified that he is a lead safety coordinator. He testified that he was working as a safety coordinator for CTS on the same project as Petitioner. He testified that his job duties included investigation and reporting of work accidents.

Mr. Dalton testified that he first learned of a work accident involving Petitioner on October 1, 2015. He testified that on that date, he was approached by Petitioner. He testified that Petitioner told him that he had reported the incident to his supervisor, Don Schexnider, on the date of accident, but that Mr. Schexnider told Petitioner not to report it or he would be fired. He testified that Petitioner discussed a personal dispute with Mr. Schexnider in which Mr. Schexnider was allegedly requiring Petitioner's fiancée to cook meals in exchange for continued employment.

Mr. Dalton testified that he began the process of investigating Petitioner's claims. He testified that his investigation found Petitioner's allegations to be unsupported because there had been no report of injury prior to October 1, 2015, that no one observed an accident, that there were no injuries observed, and that there had been a prior disturbance with Petitioner at the work site on September 29, 2015.

Mr. Dalton testified that during his investigation he received a call from Stefanie Genevese at Phillips 66, who advised him that Petitioner called Phillips 66 to report a work accident at CTS. He testified that employees had an "open door policy" with the safety department and that a safety employee was accessible to Petitioner at all times prior to October 1, 2015. He testified that CTS elected to terminate Petitioner for not following accident reporting protocol. He testified that he advised Phillips 66 on October 2, 2016 that Petitioner was terminated, and that Phillips 66 agreed with his decision.

Mr. Dalton testified that he has worked with Don Schexnider on three or four jobs in the past. He testified that Mr. Schexnider had reported other accidents and injuries on those prior jobs. He testified that he was confident in Mr. Schexnider's version of the events. He testified that he did not feel a work injury ever occurred in this case.

On cross-examination, Mr. Dalton testified that CTS was a client of Phillips 66 on the date of accident. He testified that Chris Chandler's injury was never reported to him and that it should have been according to company procedures. He admitted that Petitioner was terminated for not reporting a work accident, but that Chris Chandler was not. He also admitted that Don Schexnider was not terminated for failing to report Mr. Chandler's injury.

On cross-examination, Mr. Dalton testified that he offered medical care to Petitioner at a company doctor on October 1, 2015. He testified that during his investigation, he was told by Petitioner that Mr. Schexnider demanded that Carrie Fisher cook for Mr. Schexnider in exchange for continued employment.

On cross-examination, Mr. Dalton testified that his investigation relied on interviews done by fellow safety employees Brad Carter and Ed Anderson and that he did not interview any witnesses directly. He also testified that he was not present during the night shift on September 23, 2015 when the accident was alleged to have occurred.

On redirect examination, Mr. Dalton testified that he found the injuries of Petitioner and Chris Chandler to be distinguishable. He testified that Mr. Chandler's injury was minor and that he did not want medical treatment, as opposed to Petitioner's situation in which he described as a significant event. He testified that in addition to late reporting, the basis of Petitioner's termination was that a false accident was reported.

On redirect examination, Mr. Dalton testified that other employees had been hurt while working for CTS at a Phillips 66 location and that CTS had accepted work injuries that occurred on Phillips 66 projects.

On further cross-examination, Mr. Dalton testified that his decision to terminate Petitioner occurred during his investigation, which took place between 10:30 a.m. and 4:00 p.m. on October 1, 2015.

On rebuttal, Petitioner testified that when he reported the incident to Grant Dalton on October 1, 2015, Mr. Dalton told him to treat under his group insurance. He denied that any medical care was offered by Mr. Dalton on October 1, 2015.

On cross-examination, Petitioner testified that he reported a union grievance to his union steward.

The Application for Adjustment of Claim was entered into evidence at the time of arbitration as Arbitrator's Exhibit 2. The Application alleged a date of accident of September 23, 2015 and alleged that

Petitioner "[f]ell over scaffold when pushed by load" and that he sustained injuries to his right shoulder and man-as-a-whole. The Application was signed by Petitioner on September 30, 2015. (AX1).

The Employment Identification Badge was entered into evidence at the time of arbitration as Petitioner's Exhibit 1.

The office notes of MultiCare Specialists were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. Petitioner was seen on October 8, 2015 with chief complaints of both right shoulder pain and low back pain. Petitioner stated that he had developed neck pain as well as left shoulder pain over the weekend, and that his right hand had been bothering him. It was noted that Petitioner continued to have back pain as well, which radiated from the lower back to the right foot. It was noted that Petitioner initially told Dr. Eavenson that his other complaints were much more noticeable than the left shoulder, neck and right hand, and that was why he was bringing it to his attention on that date. Petitioner denied any prior history of any injury to the other areas. Petitioner was recommended to undergo an MRI of the cervical spine and left shoulder, and he was instructed to continue physical therapy. (PX2).

The records of MultiCare Specialists reflect that Petitioner was seen on October 6, 2015, at which time the same complaints were noted as those contained in the October 8, 2015 visit. Petitioner was recommended to undergo an MRI of the cervical spine and left shoulder, and he was instructed to continue physical therapy. (PX2).

The records of MultiCare Specialists reflect that Petitioner was seen for physical therapy on October 5, 2015, at which time he reported a lot of low back pain which was his primary complaint. Petitioner stated his pain could get up to a 9/10, that the intensity of the pain varied and that it was random. Petitioner stated his neck was also sore and rated his pain as 4/10. Petitioner further stated that his shoulders were "okay" at rest but his pain went to 7/10 if he moved wrong. The records reflect that Petitioner was also seen by Dr. Eavenson on that date as well, which contained the same complaints as noted in the October 6th and October 8th records. The assessment was that of a left rotator cuff tear, right shoulder pain, cervical disc protrusion, lumbar disc protrusion and contusion to the right hand. Petitioner was recommended to undergo an MRI of the cervical spine and left shoulder, and he was instructed to continue physical therapy. (PX2).

The records of MultiCare Specialists reflect that Petitioner was seen on October 1, 2015, at which time he presented for evaluation and examination of injuries sustained on September 23, 2015. It was noted that Petitioner and other workers were trying to position a 20,000 pound bundle. Petitioner stated that it was coming at him in an odd angle, that he had to shift the bundle away from him to avoid being pinched between the bundle and the wall, and that he fell as a result. Petitioner reported that he was on scaffolding about 10 feet off the ground, and that when he fell he struck the bottom of the hand rail. It was noted that at the time of the injury he was told by his employer that he could not report the injury, so Petitioner continued working as long as he could. It was noted that Petitioner had reached the point where the shoulder, lower back and leg pain had become unbearable and that he was getting worse. Petitioner denied any previous injury to the right shoulder or lumbar spine, and indicated that his pain was aggravated by sitting, standing and bending. Petitioner described the pain as sharp and shooting in the lower back and right leg and sharp in the right shoulder, and it was noted that it limited him from performing a lot of his daily activities. Petitioner had difficulty reaching above his head to wash his hair or reach behind his back. The assessment was that of right rotator cuff/labral tear, lumbar disc protrusion and right lower extremity radiculitis. Petitioner was recommended to undergo MRIs of the right shoulder and lumbar spine and to begin physical therapy. Work restrictions were also issued at that time. (PX2).

The radiology reports of MRI Partners of Chesterfield were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The MRI of the left shoulder performed on October 6, 2015 was

interpreted as revealing (1) mild acromioclavicular arthropathy without impingement; (2) intact rotator cuff. The MRI of the cervical spine performed on October 6, 2015 was interpreted as revealing (1) disc bulge at C3-4 but with a small focal left herniation extending towards the left foramen, possibly with some accompanying osteophytes which may affect the left C4 root; (2) broad based disc bulge at C4-5 with mild impression upon the dura but no cord compression or root involvement. The MRI of the right shoulder performed on October 2, 2015 was interpreted as revealing (1) acromioclavicular arthropathy, perhaps creating mild impingement, but without rotator cuff tear, though there is mild tendinopathy. The MRI of the lumbar spine performed on October 2, 2015 was interpreted as revealing (1) central and left sided disc herniation L5-S1 with annular tear, likely impinging the left L5 root; (2) mild disc bulging L4-5. (PX3).

The office notes of Dr. Matthew Gornet were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. Petitioner was seen on October 7, 2015, at which time he reported main complaints of low back pain to both sides, bilateral buttock pain, and bilateral groin pain with pain down both legs to his knees. Petitioner also had neck pain to the base of his neck, bilateral trapezial pain and bilateral shoulder pain. Petitioner stated that his problem began on September 23, 2015 when he was working as a boilermaker. Petitioner was working at the Conoco Phillips area and was on a scaffold, and there was a crane moving a large "bundle" which was a channel head. Petitioner estimated the weight to be 18,000 pounds. The crane was moving and began to push him toward a wall and he was concerned he would be pinned against the wall, so he pushed back as hard as he could. Petitioner initially had more low back and right leg pain, but his symptoms developed over the next several days. Petitioner stated that he reported the event that day to his supervisor and was told not to fill out a work slip, to come back to work and to take care of it on his own insurance. Petitioner stated that he continued to work over the next seven days, but that his pain became more severe and went back to them but was told that he was terminated. It was noted that the medical records of Dr. Eavenson were available for Dr. Gornet's review, and that the history provided to him was similar to that obtained on that date. Dr. Gornet indicated that he believed that Petitioner suffered a disc injury, particularly in the lumbar spine and that there were objective findings on MRI which correlated with his subjective complaints, particularly the groin pain, bilateral buttock, bilateral hip and leg pain. Medications were dispensed on that date, and Petitioner was placed under work restrictions at that time. Petitioner was recommended to undergo chiropractic and physical therapy services for both his neck and low back. (PX4).

The records of Dr. Gornet reflect that Petitioner was seen on January 28, 2016, at which it was noted that he continued to be on light duty and that he was not able to work as a boilermaker. It was noted that Petitioner had tried and failed some physical therapy and that it had not given him any sustained relief. Petitioner's symptoms continued to be "neck and low back" and it was noted that Dr. Gornet wanted to move forward with injections at L4-5 in his lumbar spine and at C5-6. Petitioner was referred to Dr. Boutwell for the injections. Petitioner was again issued work restrictions, and was dispensed medications. (PX4).

The records of Dr. Gornet reflect that Petitioner was seen on March 8, 2016, at which time it was noted that he continued to have neck and low back pain. It was noted that the "working diagnosis" in his low back was disc injury at L4-5 and L5-S1. Petitioner felt his pain and symptoms affected all aspects of his life and his quality of life. Dr. Gornet recommended an anterior lumbar fusion at L5-S1 and a disc replacement at L4-5. Dr. Gornet also recommended discography and MRI spectroscopy. It was noted that Petitioner's work status remained unchanged, and that they would "place his neck on hold." Medications were again dispensed. (PX4).

The Operative Reports dated February 1, 2016 and January 29, 2016 at Timberlake Surgery Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The report dated January 29, 2016 reflects that Petitioner underwent a bilateral lumbar epidural injection with fluoroscopy on that date for a pre- and post-operative diagnosis of bilateral lumbar radiculopathy. The report dated

February 1, 2016 reflects that Petitioner underwent cervical C6-C7 ILESI to treat C5-C6 epidural area on that date for a pre- and post-operative diagnosis of left cervical radiculopathy. (PX5).

The medical records of Hardtner Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. Petitioner was discharged from physical therapy on January 15, 2016, he did not progress well with therapy, his symptoms had not changed with prior physical therapy sessions and he reported worsening symptoms. Petitioner underwent an evaluation on December 7, 2015, at which time it was noted that Petitioner was referred to physical therapy for ongoing back and neck pain. Petitioner reported working on a scaffold and a large "bundle" was coming towards him and he pushed back and fell. It was noted that Petitioner reported that his pain in his low back "switches sides" at times. The Patient Chart Report indicated that Petitioner underwent a total of 7 physical therapy sessions. (PX6).

The wage records were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 8. Phone records were entered into evidence at the time of arbitration as Petitioner's Exhibit 9.

A police report from Tensas Parish Sheriff Office was entered into evidence at the time of arbitration as Petitioner's Exhibit 10.The first page noted that Kerry [*sic*] Fisher called the jail and advised of trespassing and harassment, and that a deputy was needed at Bob's Campground. Per the report, both parties were advised to say away from each other. (PX10).

The Witness/Victim Statement Form completed by Carrie Fisher noted that on December 13, 2015 she "went to get cigerettes [*sic*] and I was told that I was sueing [*sic*] Don Schexnider for not cooking him pantcakes [*sic*]." The report further noted that on December 12, 2015, she asked Don Schexnider and Chris Chandler not to cross her property line, that they had crossed the property line more than once, that she had asked them not to let their trash stay on her property and that she had to continuously pick up their trash on her property. (PX10).

Additionally, the Witness/Victim Statement Form completed by Edward Holmes indicated that Don Schexnider was "repeatedly slandering his name around to people around [his] address" and that he was driving across his property line after repeatedly being told not to. The report noted that Don Schexnider was telling people that he and his fiancée were suing him because his fiancée would not cook him "pantcakes," and that he would like for the slander and harassment to stop. (PX10).

Petitioner's timesheets were entered into evidence at the time of arbitration as Petitioner's Exhibit 11. The Arbitrator notes that the timesheets indicate that Petitioner had a scheduled day off on September 27, 2015. (PX11).

The October 1, 2015 notes of Grant Dalton were entered into evidence at the time of arbitration as Respondent's Exhibit 1. The notes indicated that at 10:30 a.m. on October 1, 2015, Mr. Dalton had just completed his safety audit with Phillips 66 and that when Mac Overholt picked him up, Petitioner was in the backseat. He noted that introduced himself to Petitioner and did not recognize him as one of the night shift employees. He noted that Mr. Overholt dropped him off at the office, and that Petitioner got out with him and asked if he could speak to him personally. It was noted that they walked up to a private area, that Petitioner informed him he was a night shift boilermaker and was returning from the doctor. It was noted that Petitioner handed him a doctor's note taking him off work and he asked what the injury was. Petitioner reported that he hurt his shoulder, and that the injury occurred on or about September 23rd. Petitioner told him that he was told not to report it, and that he would be fired. Mr. Dalton asked who told him not to report it, and Petitioner responded Don Schexnider and referred to a personal situation involving Don Schexnider asking his wife to cook for him or Petitioner would be fired. It was noted that the conversation was moved to the Safety Trailer, and that Petitioner told him the same story

and that Chris Chandler, another boilermaker, had injured his lip pulling on a wrench and that it occurred prior to Petitioner's injury. It was noted that Petitioner stated Chris Chandler was told by Don Schexnider not to report the injury. It was noted that Mr. Dalton discussed filing a first report of injury and that he would take Petitioner to his doctor, and that Petitioner stated that he had insurance and was a team player. It was noted that there was a noticeable difference in Petitioner's demeanor, that he broke eye contact and in a firm voice stated that he mainly wanted him to know that they had a foreman ordering people not to report injuries. It was further noted that an investigation and follow-up would occur, and that Petitioner was working with a different crew. (RX1).

Mr. Dalton's notes dated October 1, 2015 at 1:30 p.m. noted that Brad Carter had been called and had no knowledge or reports of any kind of injury from Don Schexnider or Petitioner, and that Petitioner had created some other problems for him by not getting along with others. At 3:30 pm, the P66 Contractor Safety Manager Stephanie Genovese was noted to have called inquiring about Petitioner, and that Petitioner had called "P66" medical trying to report an injury to them. Mr. Dalton advised that they had an employee that was attempting to make a "late" report of injury, that they were investigating and that they would have more information after meeting with the personnel involved. At 4:00 p.m., the decision was made to deactivate Petitioner's badge and to terminate employment for not following procedure for false/late reporting of an accident. At 5:30 p.m., Mr. Dalton asked Chris Chandler about the comment Petitioner made about his lip injury, and he said he did hit his lip with his hand when a wrench slipped but it was not an injury. Chris Chandler stated that Don Schexnider asked him if he needed it looked at, and Chris Chandler said no. (RX1).

The Witness Statement of Don Schexnider was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The Witness Statement dated October 1, 2015 noted that Petitioner was having a general discussion and that out of the blue, Petitioner got out of the truck and jumped in the foreman's face (*i.e.*, Don Schexnider) and "went off, cursing and screaming at the foreman, threatening to beat his ass" and that he was going to catch him in the parking lot and the motel. It was noted that Don Schexnider was trying to get him away from him, and that Chris Chandler stepped in and broke it up. On the second page of the report, Don Schexnider noted that at no time "wutsoever" did Petitioner ever mention or act like he had any injury to himself other than serious issues with taking any kind of orders from supervisors. (RX2).

The Witness Statement of Clarence "Chris" Chandler was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The statement noted that on September 29, 2015 at approximately 9:00 p.m., he, Don Schexnider, Lacey Harman, Petitioner and "John" pulled up to the gang box to gather tools and rigging. He noted that as they exited the vehicle, he saw Petitioner walk quickly from the rear of the vehicle to where Don Schexnider as walking around the front of the truck and that he stepped directly in front of Don Schexnider, causing him to stop walking. He noted that Petitioner leaned forward putting his face approximately two inches from Don Schexnider's and started yelling. Petitioner stated he was going to meet Don Schexnider in the parking lot and was going to beat him up, then stated that he would find Don Schexnider at his deer camp and knew how to "take care of people." He noted that he stepped between Don Schexnider and Petitioner and pushed them back, and that Don Schexnider walked away. He noted that he had never heard anything unusual between them and had never heard negative words from Don Schexnider to Petitioner or from Petitioner to Don Schexnider. He went on to further noted that Petitioner never stated anything about getting injured on the job, that he never saw Petitioner do anything that appeared to cause any pain to himself, and that they rode to work every day and that Petitioner never made any comments about being treated unfairly or about getting hurt at work. (RX3).

The 2015 Safety Orientation Test completed by Petitioner was entered into evidence at the time of arbitration as Respondent's Exhibit 5.

A photo of typical material loads lifted by cranes at CTS jobsites was entered into evidence at the time of arbitration as Respondent's Exhibit 6.

CONCLUSIONS OF LAW

With respect to disputed issue (C), the Arbitrator finds that Petitioner failed to prove that he sustained an accidental injury on September 23, 2015 that arose out of and in the course of his employment with Respondent.

In Illinois, it is well-settled that a party seeking an award under the Workers' Compensation Act must prove by direct and positive evidence, or by evidence from which the inference can be fairly and reasonably drawn, that the accidental injury arose out of and in the course of his employment. *Corn Products Refining Co. v. Industrial Commission*, 6 Ill. 2d 439, 442-443 (1955). The burden is upon the applicant to establish by a preponderance of competent evidence all of the essential elements of his right to compensation. *Id.* at 443.

In the present case, the Arbitrator finds that Petitioner failed to prove by a preponderance of evidence that he sustained an accident on September 23, 2015 that arose out of and in the course of his employment, as Petitioner's testimony regarding the history of accident is not supported by the record in its entirety and is further undermined by the lack of credibility in his testimony.

The Arbitrator notes that Petitioner is claiming a serious accident in which he was almost allegedly crushed by an object weighing 18,000-20,000 pounds as it quickly approached him at an angle. During the accident he allegedly pushed with significant force against the channel head before falling to the ground and striking his neck on a hand rail. The Arbitrator finds Petitioner's described mechanism of injury is not an innocuous event. Instead, it is significant enough that if it occurred, Petitioner would be able to produce a witness in support of his claim. Petitioner claims his accident was witnessed by "Richard," but no individual by the name of Richard was called to testify on behalf of Petitioner at the time of arbitration. In fact, no witnesses testified concerning the accident itself on behalf of Petitioner, which causes the Arbitrator to question his credibility.

The Arbitrator finds the testimony of crane operator Jacob Rucker to be very persuasive. He testified that his view was rarely obstructed and when it was, he relied on hand signals. He testified that he never witnessed an accident like the one described by Petitioner nor was he ever notified of any accident by hand signals from a safety spotter. Petitioner claims when the accident happened, only the crane operator and "Richard" could see him. The Arbitrator notes, however, that Mr. Schexnider testified that he always watched his employees from the ground to oversee safety and that the work was done correctly. The Arbitrator further notes that Mr. Chandler testified that all employees were always within eyesight of each other. This also causes the Arbitrator to question the credibility of Petitioner.

Furthermore, the Arbitrator finds that the testimony of Respondent's witnesses indicates Petitioner's alleged mechanism of injury is arguably implausible. Don Schexnider, Chris Chandler and Jacob Rucker all testified that when a crane is swinging a channel head, the load is moving at a very slow pace akin to a turtle or a snail. The witnesses testified while the channel head is moving, the boilermakers are standing off to the side at a safe distance of 10 to 15 feet with tag lines, that the men are not close enough to the channel head while it is in motion to be in danger of being crushed, and that the boilermakers only approach the load when it is stationary so they can begin to affix the channel head to the oil refinery. The Arbitrator finds Petitioner's assertion that the channel head came in quickly and at an angle not to be credible.

The Arbitrator acknowledges the witness testimony from Jacob Rucker and Chris Chandler that when the channel head is stationary, the boilermakers can push against the load with force to complete their work. The Arbitrator notes, however, this is not how Petitioner claims he was hurt. Petitioner testified, and the histories of accident as contained in the medical records reflect, that Petitioner claims he was hurt in a specific near-crush incident resulting in a fall and a blow to the neck. The Arbitrator finds that the preponderance of the evidence in this case does not support Petitioner's version of the alleged events.

The Arbitrator notes that the timeline of events also contradicts Petitioner's allegations. Petitioner testified that his pain immediately was a 5 or 6 out of 10 and that over the next few days it worsened to the point that he could not stand the pain on October 1, 2015. Petitioner testified that his pain was so severe that on September 24th or 25th he had difficulty working with his right leg at work. Specifically, he testified that at that time he was walking from his work area to a break area and his leg "stopped." Petitioner testified that when he first went to a doctor on October 1, 2015, the pain was so bad that he had difficulty washing his hair because movement of his arms and neck during that process caused pain. In sum, Petitioner's testimony suggested that he experienced significant pain between September 23, 2015 and the date of first medical treatment, which was that of October 1, 2015. The mere fact that Petitioner was able to work full duty for seven days before seeking medical treatment, however, forces the Arbitrator to question Petitioner's credibility.

Related thereto, Petitioner testified that his work was heavy duty and that he lifts up to 50 pounds for half of the day and stands for 90% of the day. If Petitioner was in 9 out of 10 pain and if his leg was not working, the Arbitrator questions whether Petitioner would have been able to perform the heavy duty tasks of a boilermaker or, at the very least, the Arbitrator would expect to receive testimony from a co-worker that Petitioner was noted to be unable to complete his job duties. Rather, Respondent's witnesses in this case -- Chris Chandler, Don Schexnider and Grant Dalton -- all testified that Petitioner did not display any type of pain behavior between the alleged date of accident and October 1, 2015.

Additionally, the Arbitrator also finds it to be significant that Petitioner's fiancée, Carrie Fisher, offered no testimony whatsoever concerning Petitioner's reported pain or her observations of his behavior in the timeframe immediately after the alleged accident. She testified that she was staying with Petitioner in Illinois when the accident allegedly occurred, but did not describe any limitations or complaints during that time, which the Arbitrator finds to be further support of calling into question the credibility of Petitioner's testimony in this matter.

Furthermore, the Arbitrator finds it to be significant that Petitioner claimed he was prevented from leaving the worksite to seek treatment by Don Schexnider. This testimony is contradicted, however, by the fact that Petitioner testified that he worked nights and was presumably available during daytime hours to seek out medical attention for his alleged injuries. Moreover, Petitioner had a scheduled day off on September 27, 2015. (PX11). In sum, the Arbitrator surmises that Petitioner had ample opportunity to seek medical care for his alleged injuries prior to October 1, 2015, and the fact that he did not do so negatively affects his credibility in this case.

Moreoever, the Arbitrator finds the timing of the altercation on September 29, 2015 between Petitioner and Don Schexnider to be highly significant in this case. Petitioner signed his Application for Adjustment of Claim on September 30, 2015 and then sought medical treatment on October 1, 2015, both of which occurred after the altercation. (AX2; PX2). Aside from Petitioner's testimony, there was no supporting evidence that the fight was about the work accident. Rather, the testimony of Chris Chandler, Don Schexnider and Grant Dalton suggested that Petitioner was actually the aggressor. That said, the evidence shows that only after starting an argument at work did Petitioner report a work accident.

From the Arbitrator's perspective, there certainly appears to be some type of personal conflict between Petitioner and Don Schexnider. The nature of that conflict is in dispute. Petitioner alleges it was caused because Don Schexnider would not allow him to report the alleged accident. Don Schexnider, on the other hand, maintains that the conflict arose because Petitioner's injury did not occur. Petitioner also asserted allegations against Don Schexnider claiming that he required his fiancée, Carrie Fisher, to cook meals and do laundry in exchange for continued employment. It seems clear to the Arbitrator that this conflict escalated in Louisiana when the police were called by Petitioner and the witness statements were filed. (PX10).While the personal conflict is noted, it does not persuade the Arbitrator. In the Arbitrator's eyes, the far more persuasive evidence is that Respondent presented four witnesses to testify that no accident occurred, that Petitioner worked full duty for seven days after the alleged accident while allegedly in significant pain, and that the timeline of events contradicts Petitioner's complaints in this case.

The Arbitrator finds that the testimony showed that Respondent had a clear-cut reporting procedure for work accidents. The Arbitrator suggests that if one were to assume that Don Schexnider truly prevented Petitioner from reporting his injury, Petitioner certainly would have had other avenues available at his disposal for reporting his alleged accident. The testimony from numerous witnesses was consistent in that CTS had a safety representative present at all times, Phillips 66 had a safety department, and that Petitioner had access to the site superintendent as well as a union steward. Petitioner's assertion that he was blocked from reporting the injury by Don Schexnider until October 1, 2015 is simply not plausible in this case. Additionally, Petitioner stopped working on Mr. Schexnider's crew on September 29, 2015 following the altercation and therefore was not under Mr. Schexnider's supervisory control on either September 29th or September 30th, and yet Petitioner did not report the injury until October 1, 2015. The Arbitrator finds this to negatively affect Petitioner's credibility even further in this matter.

Finally, the Arbitrator also does not find Petitioner's allegation that Grant Dalton attempted to cover up Petitioner's injury to be substantiated. Mr. Dalton completed a thorough two-page accident investigation on October 1, 2015 and witness statements were taken from Don Schexnider and Chris Chandler. (RX1; RX2; RX3). If CTS and Mr. Dalton were attempting to cover up a work accident, it would be illogical that detailed accident reports and investigations would have been completed by CTS on the same day Petitioner reported the incident to Mr. Dalton.

Based upon the foregoing and the record as a whole, the Arbitrator concludes that Petitioner has failed to prove that he sustained an accidental injury on September 23, 2015 that arose out of and in the course of his employment with Respondent.

In light of the Arbitrator's findings with disputed issue (C), the Arbitrator makes no findings with respect to disputed issues (F), (J), (K) and (O), as those issues are rendered moot. The claim 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

James O'Hara,
Petitioner,

vs. No: 13 WC 13451

17IWCC0093

State of Illinois,
Vienna Correctional Center,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on January 22, 2016, is hereby affirmed and adopted.

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

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

17IWCC0093

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: FEB 14 2017

o-01/31/17
jdl/wj
68

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

O'HARA, JAMES
Employee/Petitioner

Case# **13WC013451**

STATE OF ILLINOIS/VIENNA CORR CTR
Employer/Respondent

17IWCC0093

On 1/22/2016, 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 0.37% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 THOMAS C RICH PC
6 EXECUTIVE DR
SUITE 3
FAIRVIEW HTS, IL 62208

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

0558 ASSISTANT ATTORNEY GENERAL
AARON L WRIGHT
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT SYSTEMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JAN 22 2016

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

JAMES O'HARA
Employee/Petitioner

v.

STATE OF ILLINOIS/VIENNA CORR. CTR.
Employer/Respondent

Case # 13 WC 13451

Consolidated cases: ____

17IWCC0093

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **November 12, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0093

FINDINGS

On **February 20, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$59,928.00**; the average weekly wage was **$1,152.46**.

On the date of accident, Petitioner was **50** years of age, ***single*** with **3** 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 $- for TTD, $- for TPD, $- for maintenance, and $- for other benefits, for a total credit of $-.

Respondent is entitled to a credit of **$any benefits paid through group** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of **$919.00**, as provided in § 8(a) of the Act.

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

Respondent shall pay Petitioner temporary total disability benefits of **$768.31**/week for **3/7** weeks, commencing **February 21, 2013**, through **February 27, 2013**, as provided in § 8(b) of the Act.

Respondent shall not pay Petitioner permanent partial disability benefits.

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

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

Edward Lee
Signature of Arbitrator

1/20/16
Date

JAN 22 2016

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JAMES O'HARA
Employee/Petitioner

v.

Case # 13 WC 13451

STATE OF ILLINOIS/VIENNA CORR. CTR.
Employer/Respondent

17IWCC0093

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On February 20, 2013, Petitioner sustained accidental injuries when he stepped on the edge of the sidewalk, bending the front of his foot backward, and injured the top of his left foot. (T.8, 9) Petitioner testified that at the time of the accident, he was carrying paperwork to the shift commander's office and surveying the prisoners moving around him. (T.10) He stated, "I was looking at my surroundings. There were inmates moving around. Working in a prison, you have to, you know, be on the lookout for any type of suspicious activity." (T.10) He testified that remaining alert and watching for suspicious activity was part of his job duties as well as a matter of personal safety. (T.11) Petitioner testified that he was not paying attention to the ground at this time. (T.10) Petitioner candidly testified to a prior left foot injury, but testified that he was fully recovered from same and had no difficulty performing the full scope of his job duties prior to the accident in question. –T.9, 10.

Following the accident, Petitioner treated with Dr. Smith at Logan Primary Care, who noted that Petitioner's foot sprain caused pain rated 6 on scale of 10 while walking. (PX3) Dr. Smith cared for Petitioner's left foot conservatively with medication. Petitioner testified that medication and time off work helped to ease his foot pain. (T.13) At the time of Arbitration, Petitioner testified that he made a complete recovery from his foot injury. –T.13, 14.

CONCLUSION

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

The Supreme Court holds that the term "accident" encompasses anything that happens without design or any event that is unforeseen by the victim. *E. Baggot Co. v. Indus. Comm'n,*

125 N.E. 254, 255 (1919). An injury is also accidental within the meaning of the Act if "a workman's existing physical structure, whatever it may be, gives way under the stress of his usual labor." *Laclede Steel. Co. v. Indus. Comm'n*, 128 N.E.2d 718, 720 (1955). If the injury coincides with these definitions and is traceable to a definite time, place, and cause, then said injury is accidental within the meaning of the Act, *Id.*

It is clear that Petitioner's injuries occurred in the course of his duties. The question before the Arbitrator is whether Petitioner's duties arose out of his employment. An injury arises out of one's employment if its origin is in a risk connected with or incidental to the employment so that there is a causal relationship between the employment and the accidental injury. *Orsini v. Indus. Comm'n*, 509 N.E.2d 1005 (1987). In order to meet this burden, a claimant must prove that the risk of injury is peculiar to the work *or* that he or she is exposed to the risk of injury to a greater degree than the general public. *Id.* This increased risk may be **qualitative**, such as some aspect of employment that contributes to risk, or quantitative, such as the number of times they are required to encounter the risk. *Springfield Urban League v. Illinois Workers' Comp. Comm'n*, 2013 IL App (4th) 120219WC, 990 N.E.2d 284, 290 (4th Dist. 2013). A claim for injuries is not barred where a claimant can prove an increased risk of injury by a neutral risk. *Village of Villa Park v. Illinois Workers' Comp. Comm'n*, 3 N.E.3d 885 (2nd Dist. 2013).

The Arbitrator finds Petitioner's claim analogous to *Randy Kram v. State of Illinois/Vienna Corr. Ctr.*, 15 I.W.C.C. 0286 (2015), in which the claimant was found to have sustained compensable injuries due to the qualitative distraction created by inmates in the performance of his job duties. Similarly, Petitioner testified that he was not watching where he was walking while delivering paperwork to the shift commander's office because he was surveying the prisoners moving around him. (T.10) The Arbitrator finds that this high-security environment constituted an increased qualitative risk which increased the likelihood of Petitioner's injury. Therefore, the Arbitrator finds that Petitioner met his burden of proof on the issue of accident.

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

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

Respondent only disputed medical and TTD based on its accident dispute. Based on the above findings resolving the legal question in favor of Petitioner, the Arbitrator hereby awards the medical expenses contained in Petitioner's group exhibit, as well as 3/7 weeks of temporary total disability for Petitioner's period of disability from February 21, 2013, through February 27, 2013.

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

Based upon the evidence the Arbitrator finds the Petitioner made a complete recovery from his accident and therefore, awards no benefits for permanent partial disability for his left foot.

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

Julia Hightower
Petitioner,

vs.

NO: 12 WC 26786

17IWCC0094

VSI/Vonachen 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 temporary total disability, medical expenses, prospective medical expenses, penalties and attorney 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 March 8, 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.

17IWCC0094

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $18,900.00. 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: FEB 14 2017

Joshua D. Luskin

o-01/18/17
jdl/wj
68

Ruth W. White

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

HIGHTOWER, JULIA
Employee/Petitioner

Case# **12WC026786**

17IWCC0094

VSI/VONACHEN SERVICES
Employer/Respondent

On 3/8/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.47% 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:

1824 STRONG LAW OFFICE
HANIA SOHAIL
3100 N KNOXVILLE AVE
PEORIA, IL 61603

1454 THOMAS & ASSOCIATES
ROBERT A HOFFMAN
300 W MADISON ST SUITE 2900
CHICAGO, IL 60606

STATE OF ILLINOIS	)	____Injured Workers' Ben. Fund – Sec. 4(d)
	)	____Rate Adjustment Fund – Sec. 8(g)
COUNTY OF PEORIA	)	____Second Injury Fund – Sec 8(e)18
		_X_ Nome of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
Corrected ARBITRATION DECISION

JULIA HIGHTOWER,
Employee/Petitioner,

-vs- 12-WC-26786

VSI/VONACHEN SERVICES,
Employer/Respondent

17IWCC0094

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. This matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Peoria, Illinois**, on **October21, 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 the Petitioner's employment by respondent?
D.___What was the date of 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 the petitioner reasonable and necessary? Has Respondent paid appropriate charges for all reasonable and necessary medical services?
K._X_What Temporary benefits are in dispute?
___TPD ___Maintenance ___TTD
L._X_What is the nature and extent of the injury?
M._X_Should penalties or fees be imposed upon Respondent?
N.___Is Respondent due any credit?
O.___Other

FINDINGS:

On **July 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 related to the accident
In the year next preceding the accident, Petitioner earned $_____; the average weekly wage was **$625.62**
On the date of the accident, Petitioner was **36** 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 **$17,430.03** for TTD/ TPD, **$0.00** for maintenance and **$0.00** for other benefits, for a total credit of **$0.00.**
Respondent is entitled to a credit of **$0.00** under Section 8(j) of the Act.

ORDER:

The Respondent shall pay reasonable and necessary medical services incurred prior to May 9, 2013, subject to the provisions of the medical fee schedule, to the extent that said awarded medical bills have not already been paid.

The Respondent shall pay Petitioner temporary partial disability benefits of **$263.04**/week for 41 6/7**ths** weeks commencing July 20, 2012 through May 9, 2013, except for one day in early August 2012 when the Petitioner testified that she worked, as provided in Section 8(a) of the Act.

The Respondent shall pay the Petitioner permanent partial disability benefits of **$375.37** /week for 25.05 weeks because the injuries sustained caused a **15%** loss of use of the Right Foot pursuant to Section 8(e) 11 of the Act, taking into account the Respondent's earlier credit from the 2007 accident

The Respondent shall pay the Petitioner permanent partial disability benefits of **$375.37/** week for **25** weeks because the injuries sustained caused a **5%** loss of the person-as-a-whole, as provided by Section 8(d)2 of the Act.

The Petition for Penalties field by the Petitioner 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. Douglas McCarthy 12/21/2015

Douglas McCarthy – Arbitrator

MAR 8 - 2016

Findings of Fact:

The Petitioner was hired by the Respondent in June, 2012 as a housekeeper. At that time she was also working in a clerical position for the Lutheran School Services, a position she had held since 2009.

She sustained a work accident on July 19, 2012 while working for the Respondent. She was working in a janitorial capacity. She testified that she entered an exam room to clean it and slipped on some water. She testified that she fell on her buttocks and twisted her right ankle when she fell. She testified that she tried to continue working. She also testified that she did not seek medical care until the following day.

Petitioner testified that she had previously injured her right ankle in a workplace accident in 2006 or 2007. She further said that she had received a settlement in a related workers compensation claim, and was paid based upon a 70 % loss of the right foot. She further testified that after approximately 2008, she had no symptoms involving the right ankle.

A medical record from the Return to Work center dated March 1, 2010 indicated that the Petitioner was limited to light work as a result of her right foot and ankle injuries. She had just completed a course of work hardening, and upon her release reported discomfort in the right leg, ankle and lower back. The report also indicated that in 2008 she had received a spinal cord stimulator in surgery for her diagnosis of reflex sympathetic dystrophy of the right lower extremity. (PX 19)

Also admitted into evidence was a medical report from the Ruskusky Foot and Ankle Clinic concerning treatment received from November 29, 2010 through February 21, 2011. (PX 28) The initial examination notes of November 29 contain a detailed history of the Petitioner's prior accident of August 22, 2007. She reported to the doctor that she was only able to work four hours a day due to her injury. She said that her ankle swells after four hours of work. Her examination revealed decreased strength in the right ankle at all planes of motion. She reported having numbness along the lateral aspect of the ankle, along with diffuse tenderness. The physician diagnosed some nerve damage

and muscle weakness, and referred the petitioner to another physician for possible compartment syndrome. The final diagnosis was neuritis, Reflex Sympathetic Dystrophy, edema and pain of the right ankle. She was seen for several follow up visits, and no change in her symptoms was noted. As an example, on January 31, 2011, she was found to have numbness and pain along the lateral aspect of the right foot around the sural nerve and stiffness of the subtalar joint. (Id)

The day following her accident of July 19, 2012, the Petitioner was seen for treatment at the Methodist Medical Center. She provided a history consistent with her description at arbitration. She complained of lower back and right ankle pain. Her examination revealed moderate tenderness of those areas, mild to moderate point pain with movement of the lateral malleolus, moderate tenderness to palpation of the later malleolus with no swelling or effusion. She had mild to moderate spasms of the low back to the left side with a decrease in lumbar range of motion. She was diagnosed with an ankle sprain and lower back pain.

On July 23, 2012, she was seen for treatment by her family physician, Dr. Hoffman. Again she gave a consistent history of accident and reported pain in the right ankle and low back. His examination showed tenderness in the lower back and the lateral and medial aspects of the ankle. The ankle also was painful with more than 30 degrees of internal and external rotation, as well as flexion and extension. He diagnosed a lumbosacral strain and a sprained ankle. She was placed on light duty restrictions to perform sit down only work. She came back to Dr. Hoffman on July 25, and reported that she was unable to work due to her pain. His exam showed the same findings, and the doctor took her off work and ordered physical therapy. The Petitioner returned to Dr. Hoffman on August 1, with complaints of increased pain in the foot and ankle. It was noted she was now using a cane. Dr. Hoffman gave her a light duty restriction and limited her to four hours of work per day. He also referred her to Dr. Rhode for her ankle. A week later, Dr. Hoffman made a referral to Dr. Kube for treatment of the lower back. (PX 18)

The Petitioner saw Dr. Rhode, an orthopedist, on August 8, 2012. Again she gave a history of accident consistent with her earlier descriptions. She also told the doctor that she had injured her right ankle back in 2007, but that she had recovered from those injuries. Dr. Rhode's exam showed edema of the lateral malleolus with pain of that area and at the talofibular ligament. He diagnosed calcaneotibial ligament pain related to an inversion injury at work. He recommended modified sedentary work. The Petitioner received conservative treatment consisting of physical therapy and injections, without much relief reported. On December 18, 2012, Dr. Rhode performed surgery of the lateral right ankle. His findings showed tendinopathy along with a 3 cm. split of the peroneus longus tendon, which was repaired. More physical therapy followed the surgery. She was on an off work status until March, 17, 2013, when the doctor released her to light to medium work for four hours a day. On April 14, 2013, Dr. Rhode said that the restrictions were permanent and declared her to be at maximum medical improvement. His examination on the day showed pain and edema of the lateral malleolus area, loss of some dorsiflexion and strength at 5-/5. He did an AMA rating at that visit which revealed

a 6 % impairment of the right ankle. Dr.Rhode has seen the Petitioner periodically since that time. On September 29, 2014, she complained of left knee pain which she felt was due to an altered gait occasioned by her ankle. (PX 7)

The Petitioner saw Dr. Kube, an orthopedist, on August 7, 2012 for her lower back. She gave a similar history of accident and also reported that she had no prior lower back pain. His examination revealed pain to palpation, reduced flexion and extension and an inability to perform toe and heel raises which he attributed to her right ankle condition. He diagnosed lumbago and sprain/ strain injuries to the low back. He ordered physical therapy and placed the Petitioner on sedentary work restrictions with a four hour a day limitation. The Petitioner has physical therapy and trigger point injections through May 6, 2013. On March 25, 2013, Dr. Kube had her spinal cord stimulator removed because it was not working and it impeded his ability to have an MRI done on the Petitioner's lower back. Subsequently, an MRI and EMG were performed. Dr. Kube reviewed them on April 9, 2013. He said that he did not see a specific pain generator for the Petitioner's ongoing complaints, and referred her to his partner, Dr. Cummings, for consideration of facet block injections. Those injections were performed, and Dr. Cummings declared the Petitioner to be at MMI on May 9, 2013. He noted that she had a degree of chronic pain and may need future care. The Petitioner was seen for what was described as a flare up of her lower back on July 16, 2013, and again on May 21, 2014 for an exacerbation while she was stretching in bed. More physical therapy followed. She last was seen by Dr. Kube's group in April 2015 when she was treated for pain in the cervical spine and shoulder following a motor vehicle accident. (PX 19)

Although the Petitioner was released to light duty work on August 1, 2012, she never returned to work. Carrie Weller of the Respondent testified that while the Petitioner called in and was told to report to work on August 6, 2012, she never reported to work. Petitioner testified that her supervisor told her there was no work; but said that this occurred prior to Dr. Hoffman's light duty release on August 1 and prior to her conversation with Carrie Weller when she was told to report to work on August 6. Petitioner's supervisor denied telling the Petitioner that there was no light duty work. The evidence further establishes that the Petitioner never returned to work at Vonachen after August 6, 2012.

The Respondent had the Petitioner examined by Dr. Kolb (Resp Ex #3) on January 29, 2013 (and again on September 24). He also had the opportunity to review medical records from the Petitioner's prior ankle injury (Resp. Ex#3. P. 19) He diagnosed the Petitioner with suffering a sprain to her right ankle and a strain to her lower back. He testified that the Petitioner's ankle sprain would have resolved in 6 weeks and that her remaining symptoms were related to her prior ankle injury. He noted that the Petitioner's initial treatment after the July accident failed to show any evidence of pain to the peroneal tendon. He testified that if the July accident had injured the peroneal tendon he would expect there to be immediate symptoms (Resp. Ex #3, P.16). He testified that with the symptomology not starting until roughly four months later, he could not link the peroneal injury to this work accident. (Resp. Ex. #3, p. 16) He also testified that the peroneal tendon is not in the same area of the ankle as where the Petitioner initially

complained of pain (Resp. Ex. #3, p.17). He opined that the Petitioner needed no further treatment for the ankle sprain at the time that he first saw her and that the peroneal injury was not related to this work accident and that he would place no restrictions on the (Resp. Ex#3, p. 17-18).

Dr. Kolb's examination of 1-29-13 showed a normal range of motion of the ankle. He also found symptom magnification by the Petitioner. Records of treatment by her physical therapist on January 17, 2013 showed the Petitioner with stiffness, weakness, swelling and pain. On February 1 she was noted to have joint line edema of the lateral malleolus area. Dr. Rhode noted lateral ankle pain to palpation on February 20; edema and swelling on March 17 and the positive findings previously noted on April 14, 2013. (PX 7)

Dr. Rhode explained during his deposition how the accident was causally related to the Petitioner's peroneal tendon injury. He said it was stretched by the inversion injury she suffered when she slipped and fell. (PX 13 at 22-29) He also opined that the Petitioner could work more than four hours a day if her job were sedentary, but was limited to those hours if her job required to her be an her feet constantly. (PX 13 at 40, 41)

As noted previously, the petitioner has essentially not worked for the Respondent since her accident. She did work at her Lutheran services job until August 19, 2014. At that time the job was changed to full time, and the petitioner said that she could not work on that basis. Around that time, she began a self directed job search. Her job logs show many contacts made through April 20, 2015. They also show that she told her respective employers that she was only able to work part time. (PX 23;See Carmike Cinemas 1-15-15; CMX 1-13-15; UPS 1-12-15; HCS 1-7-15 state Farm 1-6-15) Bob Hammond, a vocational expert hired by the Petitioner, testified that the Petitioner had no skills which could transfer to part time work, and that an unskilled part time job would earn her $9.00 an hour for up to 30 hours per week. (PX 31 at 44, 57, 59)

CONCLUSIONS OF LAW:

The Petitioner has proven a causal relationship between her accident and her lower back injury. Other than a comment during work hardening for her ankle in 2010 that her back was "beat up," there was no evidence to show any prior back injuries or complaints. She had immediate back symptoms after her accident and evidence of an acute injury in the emergency room, with a finding of muscle spasm and, three days later to Dr. Hoffman, who noted ongoing tenderness. Her symptoms continued through her treatment with Dr. Kube, referenced above, and upon her release by Dr. Cummings in May 2013, she was found to have a degree of chronic pain.

The Petitioner also has proven a causal relationship between her accident and her right ankle injuries, including the peroneal tendon tear which was repaired in surgery. Dr. Rhode persuasively testified as to how an inversion ankle injury could stretch the tendon, and the Petitioner consistently had findings of lateral ankle pain and edema in the areas

near that tendon. On September 23, 2012, Dr. Rhode noted pain over the calcaneofibular ligament, which anatomically in very close proximity to the injured tendon. This finding contradicts Dr. Kolb's opinion that the records in the case do not show any peroneal pain until November 2012. Additionally, Dr. Kolb on cross-exam agreed that a finding made of pain by Dr. Rhode on October 3, 2012 was in an area close to the tendon. (RX 3 at 30) He also agreed that an inversion injury could cause a peroneal problem. (Id at 35) A review of Dr. Rhode's notes between August 8, 2012 and the date of surgery, along with the therapy notes of treatment for the same time period, support Dr. Rhode's opinion on causation. The Arbitrator adopts said opinion.

On the other hand, the Arbitrator does not believe the Petitioner has proven a causal relationship between the accident and the permanent work restrictions, including the limit for four hour days, prescribed by Dr. Rhode. First of all, the evidence shows that the Petitioner had, despite her testimony to the contrary, an ongoing injury to her right ankle prior to her accident at work. She told the doctor at the Ruskusky Clinic in late November 2010 that she could only work four hours a day due to pain and swelling. Her exam findings at that time showed numbness on the lateral aspect of the ankle along with decreased muscle strength. The findings were very similar to those of Dr. Rhode on May 14, 2013, which were the basis for his restrictions. While Dr. Rhode related the accident to the need for his restrictions, he was working under the assumption that the Petitioner had completely recovered from her earlier accident, an assumption which was not valid given the Ruskusky records. The Arbitrator finds that the Petitioner sustained an inversion injury to her right ankle causally related to a peroneal tendon tear, but not causally related to the need for restrictions. Without ruling on the need for those restrictions, the Arbitrator finds that they were present and seen in medical reports in early 2011. As such, they are not causally related to the accident of July 19, 2012.

On the issue of TTD, the Arbitrator finds the Petitioner entitled to benefits from July 20, 2012 through May 9, 2013, the date when Dr. Cummings declared her to be at MMI. The Respondent is not responsible for the one day when the Petitioner worked light duty which, based upon the payroll records, appears to have been during the July 22-August 4 pay period. (PX 3) The Petitioner was advised to stay off work completely by Dr. Hoffman, from July 25 through August 6, 2012; Dr. Rhode, from August 15 through September 19, 2012 and again from December 26, 2012 through March 17, 2013; and Dr. Kube, from February 8, 2013 through April 30, 2013. The remainder of the time the Petitioner was on light duty restrictions. Respondent argues that it had light duty available which was offered to the Petitioner which she declined to accept. Petitioner says she presented her restrictions to the Respondent on a regular basis and was not offere3d work. The Arbitrator finds the Petitioner more credible on the issue. Respondent's human resource generalist, Carrie Weller, testified that light duty was made available to the Petitioner. She also said that the Petitioner performed the light duty for one day, which she said consisted of sitting in a chair cleaning out garbage cans. Dr. Hoffman's note of July 25, 2012, indicated that the Petitioner reported trying to work light duty for a day, but stopping due to increased low back and right ankle pay. Dr. Hoffman then took the Petitioner off work. No testimony was offered to show that Ms. Weller offered a different job to the Petitioner after her next release for light duty on August 6. At that time,

according to objective findings from both Dr. Kube and Dr. Rhode, the Petitioner had clear signs of injury to both areas. It would make no sense for the petitioner to try and do the same job which caused her pain to increase when tried less than two weeks earlier. Also, the testimony of Petitioner's supervisor, Patty Showens, causes the Arbitrator to question whether a light duty job was offered at all. She said that in the nine plus years she has worked in management for the Respondent, she did not recall anyone working with light duty accommodations. In summary, the Petitioner was not at MMI until May 2013. She had objective findings of injury from her accident date until her date of MMI. She tried the one job offered, and her doctor took her off work completely after one day on that job. Under those facts, she is entitled to benefits.

Petitioner testified that she did work at Lutheran Services during her period when she was entitled to benefits. She said that she earned $231.06 per week. She did not present any evidence indicating she lost any time from the Lutheran Services job, and the Arbitrator is unable to ascertain any such evidence from the payroll records submitted as PX 5. Accordingly, she would be only entitled to temporary partial disability benefits from July 20, 2012 through May 9, 2013 in the amount of $263.04 per week.

With respect to medical bills, PX 29 summarizes all of the Petitioner's treatment. Consistent with the earlier findings, the Arbitrator awards the Petitioner the bills through May 9, 2013, pursuant to the fee schedule. It is clear from the bills that some of the treatment was paid by Respondent's workers compensation carrier. Obviously, respondent is only liable to the extent of non payment.

The Arbitrator further denies the Petitioner's request for penalties. The Respondent paid more in TTD benefits than this award provides, and its failure to pay medical bills related to the Petitioner's tendon injury is supported by the opinions of Dr. Kolb. With respect to the lumbar treatment, it is clear that some of the bills were paid to both Dr. Hoffman and Dr. Kube. Under such circumstances, the Arbitrator does not believe penalties under Section 19 (k) are warranted.

Finally, with respect to nature and extent, the Arbitrator notes that an AMA rating was submitted on the foot and ankle injury only, and Dr. Rhode determined a 6% impairment of the right ankle existed. The Petitioner worked as a housekeeper, which is a job wherein she will be required to be on her feet throughout the work day. She was a younger individual, age 36, on the date of her accident. The Arbitrator does not feel her future wage earning capacity has been adversely affected by this accident. While she had some positive findings by both Drs. Kube and Rhode when she was deemed at MMI, they were not significantly different that her findings involving the ankle seen at the Ruskusky Clinic in early 2011. With those findings, the Petitioner was able to perform her job for the short time she worked for the Respondent prior to her injury. The Arbitrator is not convinced that she would not be able to perform that job at the present time. Finally, as a result of her foot and ankle injury, the Petitioner has positive findings outlined in Dr. Rhode's report of 4-14-2013 consisting of a minor loss of dorsiflexion and strength. The

Arbitrator feels has sustained an additional loss of use of the right foot to the extent of 15 %, taking into account her earlier loss from the 2007 accident. Dr. Cummings note, referenced above, shows ongoing chronic low back pain. She is awarded 5 % Person as a Whole for those injuries.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Amy Price,
Petitioner,

vs. NO: 13 WC 13898

City of Peoria,
Respondent.

17IWCC0095

DECISION AND OPINION ON REVIEW

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

The underlying facts of this claim were laid out in the Arbitrator's Decision, which is incorporated by reference herein. The claimant, 55 years old on the asserted date of loss of January 21, 2013, is a clerical staffer for the City of Peoria. Her job duties involved a significant amount of typing, preparing files, pulling files apart, copying, faxing, using hole punches, and doing payroll work and answering phones.

The claimant testified that she has suffered from carpal tunnel syndrome since at least 2002. To alleviate her symptoms, she used wrist splints intermittently for approximately ten years prior to the asserted manifestation date of January 21, 2013. During those ten years, she was also diagnosed with and treated for a variety of orthopedic and rheumatologic conditions not related to her employment, including cervical and shoulder issues and fibromyalgia; her treatment regimen during this period included multiple trigger point, epidural and facet joint injections, as well as physical therapy, medications, acupuncture and chiropractic care. The petitioner also lost time from work for these unrelated concerns; her manager, Ms. Nicole Frederick, testified that the petitioner's attendance was "sporadic" and RX10 is a history of the claimant's lost time from 2010 through 2015; it confirms the claimant was absent from work for a significant percentage of that period. The petitioner also testified to a history of smoking.

Regarding the carpal tunnel diagnosis, the petitioner testified, and the records confirm, that she had reported carpal tunnel symptoms to doctors at least as early as 2008. In October 2011, she saw Dr. Li and had an EMG performed, after which time Dr. Li advised her that she had bilateral carpal tunnel syndrome (see PX2). The claimant had an injection to her right wrist in November 2011 for carpal tunnel syndrome. The petitioner presented for a surgical evaluation by Dr. Lomax in October 2012; following a repeat EMG study, the claimant sought a second opinion with Dr. Garst, who ultimately performed the carpal tunnel release surgeries on June 5, 2013, and December 4, 2013. The petitioner was released to work by Dr. Garst in February of 2014; however, following 2014, she left her employment for reasons not related to the carpal tunnel syndrome.

The Arbitrator reviewed and weighed the causal opinions provided by Dr. Garst as well as Dr. Hoepfner, the respondent's Section 12 examiner. The Arbitrator found Dr. Garst more persuasive than Dr. Hoepfner and concluded that the claimant's employment was a causal factor in the worsening of her medical condition. The Commission finds that Dr. Hoepfner's conclusions are not unreasonable – the claimant did have idiopathic medical conditions which are linked to the development of carpal tunnel syndrome, and was a long-time smoker, which could also cause this condition. However, we are persuaded that the claimant's repetitive job duties, which included a number of duties beyond keyboarding, did play a causal role in the development of her present state of ill-being.

The determination of an accident date, or manifestation date, is somewhat less clear. The petitioner asserts a manifestation date of January 21, 2013. The determination of an accident date for purposes of repetitive trauma is somewhat flexible but is not completely fluid. In this case, the claimant was clearly aware of her medical condition long before January of 2013: she had been formally diagnosed with carpal tunnel syndrome by her medical provider years before that, and undergone active treatment for it. She had even provided notice to her employer before that date, showing a subjective understanding of its relationship to her workplace. However, the claimant does identify a rational basis for the selection of January 21, 2013 as a manifestation date, specifically her beginning treatment with Dr. Garst that day. While somewhat more tenuous than a date in 2008 or 2011, when she received active intervention for this condition, the Commission is persuaded that January 21, 2013 is not an irrational selection of a manifestation date within the parameters of *Durand v. Industrial Commission*, 224 Ill.2d 53 (2006).

With regard to the nature and extent of the injury, the Arbitrator accurately noted that neither party presented an AMA impairment rating for review, and that the claimant had ceased work due to unrelated health issues, and nothing suggested any limitation on either functioning or earning capacity being related to this claim. The Commission reviews and weighs the facts somewhat differently than did the Arbitrator regarding the ultimate extent of her disability, and finds that in light of all evidence presented in this matter, an award of permanent partial disability of 10% loss to the petitioner's right hand and 7.5% loss to the petitioner's left hand is more in line with the extent of the injuries sustained, and modifies the Arbitrator's award accordingly. The Arbitrator's awards of temporary total disability from June 5, 2013 through July 22, 2013 and from December 4, 2013 through February 8, 2014 (from the dates of each surgery through Dr. Garst's regular duty releases) are affirmed, though the Commission notes this is a total of 16 & 3/7 weeks, rather than 25 as originally noted in the Arbitrator's decision. All other findings of the Arbitrator are affirmed, including the award of medical costs.

17IWCC0095

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the sum of $604.52/week for 16 & 3/7 weeks, commencing June 5, 2013 through July 22, 2013 and December 4, 2013 through February 8, 2014, those being the periods of temporary total incapacity from work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION Petitioner is entitled to have and receive from Respondent the sum of $544.62 per week for a further period of 33.25 weeks, as provided in §8(e)9 of the Act, because the injuries sustained caused the loss of use of Petitioner's right hand to the extent of 10 % thereof and the loss of use of Petitioner's left hand to the extent of 7.5 % thereof.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner's outstanding medical bills as listed in Petitioner's exhibit No. 9, pursuant to the Fee Schedule. Respondent shall additionally hold Petitioner harmless with regard to payments made by her health insurance pursuant to Petitioner's Exhibit No. 9. Respondent is entitled to a credit under §8(j) of the Act, as requested on the request for hearing.

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: FEB 14 2017

Joshua D. Luskin

o-01/31/17
jdl/jl
68

Ruth W. White

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PRICE, AMY
Employee/Petitioner

Case# **13WC013898**

CITY OF PEORIA
Employer/Respondent

17IWCC0095

On 9/11/2015, 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 0.27% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0192 CUSACK GILFILLAN & O'DAY
DANIEL P CUSACK
415 HAMILTON BLVD
PEORIA, IL 61602

0980 HASSELBERG GREBE SNODGRASS
KEVIN D DAY
401 MAIN ST SUITE 1400
PEORIA, IL 61602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

AMY PRICE
Employee/Petitioner

v.

CITY OF PEORIA
Employer/Respondent

Case # **13** WC **13898**

Consolidated cases: _____

17IWCC0095

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Peoria**, on **July 23, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0095

FINDINGS

On January 21, 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 $**47,200.40**; the average weekly wage was $**907.70**.

On the date of accident, Petitioner was **55** years of age, ***single*** with 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 $ for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

Respondent is entitled to a credit of $10,403.34 under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $604.52/week for 25 weeks, commencing June 5, 2013 through July 22, 2013 and December 4, 2013 through February 18, 2014, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner's outstanding medical bills as listed in Petitioner's Exhibit No. 9, pursuant to the Fee Schedule. Respondent shall additionally hold Petitioner harmless with regard to payments made by her health insurance pursuant to Petitioner's Exhibit No. 9. Respondent is entitled to credit under Section 8 (j) as requested on the request for hearing.

Respondent shall pay Petitioner permanent partial disability benefits of $544.62/week for 47.5 weeks, because the injuries sustained caused the 15% loss of the right hand and 10 % loss of the left hand, as provided in Section 8(e) of the Act.

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

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

D. Dyla McCarthy
Signature of Arbitrator

Sept. 8, 2015
Date

SEP 11 2015

17IWCC0095

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

FACTS:

For approximately fifteen years, Amy Sue Price ("Petitioner") worked for the City of Peoria ("Respondent") as Administrative Specialist 2, Administrative Specialist 1 and Fiscal Tech 2. Petitioner has been a Fiscal Tech 2 since 2006. Petitioner testified that the job description entered into evidence as Petitioner's Exhibit No. 10 and Respondent's Exhibit 1 is an accurate description of her job duties. Petitioner's job duties included data entry, preparing files, copying papers, using standard office equipment such as 3 hole punch and 2 hole punch. While working in the Grant Department, the Petitioner managed the HUD system, performed data entry, prepared reports, and monitored funds used for grants. In addition, she would obtain purchase orders, prepare invoices, secure lien waivers from contractors, prepare e-mails, and utilize a variety of computer systems to obtain information for various projects. She testified that she spent approximately 90% of her day using her hands.

Nicole Frederick testified on behalf of Respondent. Ms. Frederick testified that she has worked for Respondent since April of 2005. She testified that she worked with Petitioner beginning in February 2008. She testified that Petitioner worked as support staff wherein she would set up projects, prepare financial documents, pull data and do reports on a daily basis. She testified that she would occasionally take meeting minutes and answer phones. She estimated that the Petitioner would spend 30 % of her work day typing and 10 to 15 % of the day filing. She did not explain how the Petitioner spent the remainder of her work day, nor comment about the Petitioner's estimate that she used her hands 90 % of the time.

During the course of her employment, the Petitioner acknowledged missing work for a variety of reasons, including other medical conditions referenced below, along with personal reasons and vacations. She was never subject to any discipline concerning her absences. Ms. Fredrick testified that it was common knowledge that the Petitioner did not work a full work week, and that her absences caused other workers to frequently perform her job duties. Her work attendance records from 2010 and early 2015 were admitted into evidence. (RX 10)

Petitioner has a rather extensive health history. She testified that in 2002 she was referred by her primary care physician to Dr. Demaceo Howard a pain specialist for cervical pain. She also testified that since 2003, she has had symptoms to varying degree in her hands and wrists. She said that she treated those symptoms on her own using splints. The first medical entry referencing carpal tunnel was in Dr. Howard's note of February 26, 2008. At that time she was seen in follow up from a cervical injection. The doctor's note indicates she was complaining of bilateral carpal tunnel pain. He offered to set her up with an orthopedist, but no follow up treatment was obtained. The Petitioner kept working. She testified that she believed at that time that her hand symptoms were related to her job. She testified that she still sees Dr. Howard on an as needed basis.

Additionally, Petitioner has seen Dr. Hanna, a rheumatologist, for fibromyalgia. She testified that due to insurance coverage, she stopped treating with Dr. Howard and switched to Dr. Yibing Li as her pain specialist. She testified that in October 2011, she told Dr. Li that her neck pain had began radiating down into her arms and hands and that she had tingling and numbness in her hands. Dr. Li performed an EMG. Petitioner testified that Dr. Li told her that the EMG revealed she had bilateral carpal tunnel, moderate on the right hand and mild on the left hand. The test results confirmed her testimony. On November 7, 2011,

Dr. Li injected her right carpal tunnel, and on December 8, 2011, the Petitioner reported that her right hand symptoms had improved.

She testified that her numbness and tingling continued to worsen and that she sought treatment on October 3, 2012 with Dr. Lomax with Soderstrom Dermatology. At that time, she was symptomatic with positive Tinel's and Phalen's signs, with bilateral loss of sensation in the fingers associated with the median nerve. He said that she clearly had carpal tunnel symptoms, and recommended another nerve conduction test. It was performed on November 1, 2012, and it showed moderate carpal tunnel on the left and mild to moderate on the right. Dr. Lomax's follow up exam of November 8, 2012 indicates the diagnosis and that he recommended the Petitioner have bilateral surgery to the more symptomatic left wrist, followed by the right. At the follow up appointment on January 15, 2013, Dr. Lomax noted a new cyst had developed on the left wrist, and ordered an MRI prior to performing any surgery.

Petitioner testified that sometime in January, she told her supervisor, Mr. Black, that she had carpal tunnel as well as the cyst. She decided she would like a second opinion and scheduled an appointment with Dr. Jeffrey Garst. She stated she first saw Dr. Garst January 21, 2013. She testified that she discussed with Dr. Garst whether or not her carpal tunnel might be related to her work. Dr. Garst told her he believed that doing secretarial work for 13 years would certainly be a contributing factor. She testified that after seeing Dr. Garst she went to the Respondent's company physician, Dr. Braun, at OSF Occupational Health, for an initial workers' compensation visit in an attempt to have the surgery under workers' compensation.

Petitioner testified that she had a left hand carpal tunnel release on June 5, 2013, by Dr. Garst. She stated that she was off work from June 5, 2013 until July 22, 2013. She had a right hand carpal tunnel release on December 4, 2013, and was off work from December 4, 2013, through February 2, 2014.

Petitioner testified in detail regarding the difference in pain from fibromyalgia versus the pain from carpal tunnel. The carpal tunnel pain caused congestion and numbness in her hands. The fibromyalgia is pain throughout her entire body but did not produce tingling or numbness.

Jeffrey Garst, a board certified orthopedic surgeon, testified by way of evidence deposition on behalf of Petitioner. Dr. Garst first saw Petitioner on January 21, 2013, and at that time her chief complaint was bilateral hand pain with numbness and tingling. Since she had already failed conservative measures, he performed a left sided carpal tunnel release, a left wrist volar ganglion excision, and a left wrist DeQuervain's release. About a week later, Petitioner had her stiches removed and was started on physical therapy. He then performed a right carpal tunnel release on the Petitioner on December 4, 2013. She had a little longer recovery time on the left side and was sent back to work full duty on February 8, 2014. With regard to any ongoing problems, Dr. Garst noted that:

> A: Most patients with that surgery will have some tenderness around the scar. They might get a bit of weakness to grip, but, compared to prior to the problem coming up.

(Petitioner's Exhibit No. 1, page 12).

With regard to causation, Dr. Garst concluded as early as January 21, 2013, that the carpal tunnels were connected to her work.

He also stated that although he didn't have a job description for her, his impression at that time was that her job was strenuous. At his deposition, he was asked the following hypothetical:

Q: Let me ask you to assume that she will testify to these things: That she performed many general administrative duties, such as typing, filing, answering phones, greeting and assisting customers, data entry, developing and preparing reports, forms and documents utilizing a variety of computer programs, mass mailings, operating general office machines, such as copiers and fax machines, setting up files, three hole punching, sorting, stapling and unstapling papers.

Is that what you're talking about when you say repetitive?

A: That is part of it, yes.

(Petitioner's Exhibit 1, page 17, 18)

With regard to the ganglion cyst and the DeQuervain's, he stated as follows:

A: A Ganglion cyst is a fluid-filled cavity. It looks like a little balloon or a little cyst, but it's small. You are talking 5-6 millimeters usually. And then the tendinitis I was talking about, the DeQuervain's, that was not on my first note but on a subsequent note. That's a very common tendintis in the wrist, which was right near where her cyst was, and I would think both are related.

(Petitioner's Exhibit No. 1, page 16, 17).

He also stated that his general impression of her job after talking with her is that it was strenuous on her hands and agreed the right carpal tunnel, left carpal tunnel, ganglion cyst and the DeQuervain's are contributing factors. (Id at 17)

Dr. Peter Hoepfner testified on behalf of Respondent. Dr. Hoepfner performed a records review and as a result did not examine Petitioner. The doctor, like Dr. Garst, had very little information about the time spent on specific tasks. (RX 2 at 65, 66) However, that information was really not important to Dr. Hoepfner. He testified that even if the Petitioner worked every day, her work would not be a causative factor in the development of her injuries. He said it did not matter how much keyboarding she did, as keyboarding was not causative of carpal tunnel. (Id at 65) He opined that only individuals who engage in sustained, forceful use of the hands with full wrist flexion and extension as well as sustained forceful squeezing and gripping are at risk. (Id at 53) He further wrote in his report that DeQuervain's tenosynovitis would be caused by vigorous housework, yard work or cleaning, and that the ganglion cyst had no known etiology. (Id, Dep. X 2)

The evidence supports the Petitioner's claim that she had a hand intensive job as a Fiscal Tech worker for the Respondent. She described in detail the various job functions she performed, and the written job description submitted by both parties corroborates her testimony. The Respondent's witness, Ms. Fredrick, confirmed that the Petitioner spent 30 % of her work day keyboarding, while spending another 10 to 15 % of each day filing. She offered no testimony as to what the Petitioner did for the rest of her normal day, but in no way provided any rebuttal to the Petitioner's claim that 90 % of her work involved using her hands.

Dr. Garst, an orthopedic hand surgeon, listened to the Petitioner describe her job and opined that it was rather repetitive and strenuous on her hands and wrists. Even though her duties varied, the doctor said that if she did them for a number of years on a full time basis, it supported his opinion.

In order to find his opinions persuasive, the Arbitrator must now consider the Respondent's contention that the Petitioner's absences from work undermine the doctor's assumptions, referenced above. The relevant wage records would be those prior to November 1, 2012, which is when the most recent nerve studies revealing the carpal tunnel for which she received surgery were taken. RX 10 shows that between January 2012, the month after the Petitioner reported to Dr. Li that her right hand symptoms had improved with an injection, and November 2012, a period of ten months, the Petitioner was off work for illness, absences, vacation and holiday approximately 20 % of the time. While that does seem significant, the Arbitrator notes that it was not until October that any of the lost time was not paid, indicating that the Petitioner was truthful when she said that she had not been disciplined for excessive absences. Considering the above time off and the hand intensive nature of the job, along with our law which requires that the work be a contributing factor and not the sole or even primary factor in the development of the conditions off ill being, the Arbitrator does not find that the work absences provide the Respondent a defense to the claim.

The other doctor providing opinions on causation, Dr. Hoepfner, was not persuasive. He basically testified that no amount of keyboarding could be a causative factor in the development of any of the Petitioner's conditions. The Arbitrator believes that the Petitioner's work was repetitive, contrary to the doctor's opinions. (RX 2 at 70) The Petitioner and Ms. Fredrick's testimony, along with the job description establish the repetitive nature of the work. The Arbitrator agrees with Dr. Garst that it could be a causative factor.

The Respondent further argues that the condition manifest itself at least by 2008 and, as such the claim should be barred by the statute of limitations and a lack of notice. The Arbitrator believes the case of Durand v. The Industrial Commission is instructive on those issues. 224 Ill. 2d 53 (2006) In Durand, as in the instant case, a petitioner testified that she knew she had carpal tunnel related to her job more than three years prior to filing her claim. The Supreme Court, citing earlier Appellate Court opinions in Oscar Meyer and Three D Discount, said that the rule as to when a repetitive injury manifest itself should not be inflexible. Petitioners should not be punished by continuing to try and perform their jobs without immediately making a claim for benefits. The Court recognized that repetitive injuries are often progressive in nature. In Durand, as in this case, the evidence showed that the conditions of ill being, while being apparent, did progress as the Petitioner continued to perform their repetitive jobs. Ms. Price knew she had carpal tunnel in 2008 but she did not get treatment. She treated in late 2011 with an injection, but testified without rebuttal that her condition worsened over the course of 2012. It wasn't until she saw Dr. Garst on January 21, 2013 that learned from a physician that her condition was related to her job.

The Arbitrator believes that January 21, 2013 is the proper manifestation date for the repetitive accident. The Respondent had received proper notice six days earlier on January 15. The claim filed on April 26, 2013 was timely.

Upon review of the medical exhibits and the testimony, the Arbitrator finds that the medical services were reasonable and necessary to treat Petitioner's bilateral carpal tunnel and left sided ganglion cyst and DeQuervain's release. Respondent shall pay the outstanding medical bills as listed in Petitioner's Exhibit No. 9, or pursuant to the medical fee schedule. Additionally, Respondent shall hold Petitioner harmless with regard to payments made by Petitioner's health insurance carrier, as it is entitled to the 8 (j) credit claimed.

The Arbitrator finds that Petitioner is due TTD benefits from June 5, 2013 thru July 22, 2013, and again from December 4, 2013 through February 8, 2014, representing 25 weeks at a rate of $604.52 per week. The medical evidence reflects that Dr. Garst took Petitioner off work following her surgeries.

With respect to permanency and the factors listed in Section 8.1b of the Act, the Arbitrator first notes that no AMA report was submitted. The Petitioner was 55 years old when the accident occurred, and was not working on the date of arbitration due to an unrelated condition. Accordingly, there is no evidence from which the Arbitrator can infer a future wage loss or heightened disability due to the nature of the job. The Petitioner testified that when she briefly returned to work in August 2014, her hands were doing wonderfully. Dr. Garst noted in his final treatment note of May 13, 2014 that the Petitioner was still complaining of pain in the right wrist. He opined that it could be the result of thick scarring related to her carpal tunnel repair. (PX 6)

Based upon the above, the Arbitrator awards 15 % loss of the right hand and 10 % loss of the left for the injuries sustained.

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

Robert Weiss,
Petitioner,

vs. NO: 11 WC 25314

Village of Schaumburg,
Respondent.

17IWCC0096

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

The underlying facts of this claim were well laid out in the Arbitrator's Decision, which is incorporated herein, and the Arbitrator's findings of fact are adopted. The Commission further affirms the Arbitrator's findings regarding occupational exposure and the causal relationship between the occupational exposure and the petitioner's coronary artery disease, for which the claimant underwent cardiac stenting.

With regard to the nature and extent of the injury, however, the Commission reviews and weighs the facts somewhat differently than did the Arbitrator. Specifically, the Commission takes note of the fact that the claimant testified to some increased fatigue, but continues to do cardiovascular exercise and weightlifting in his retirement to maintain physical fitness. Furthermore, claims involving "loss of trade" are often assessed higher disability value than claims involving similar injuries where a claimant is able to return to his or her pre-injury occupation precisely because of the potential for financial distress such an injury could cause an injured worker. However, in this matter, the claimant applied for, was granted, and is presently receiving a firefighter's disability pension for this condition (see Joint Exhibits B and C), which mitigates any financial distress the petitioner's state of ill-being might otherwise cause.

17IWCC0096

In light of the above, the Commission finds an award of permanent partial disability of 30% loss to the whole person to be more in line with the extent of the injuries sustained, and modifies the Arbitrator's award accordingly. The Arbitrator's other findings are affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $669.64 per week for a period of 150 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused 30% loss of use of the person as a whole.

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

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

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

DATED: FEB 14 2017

Joshua D. Luskin

o-01/18/17
jdl/jl
68

Ruth W. White

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WEISS, ROBERT
Employee/Petitioner

Case# **11WC025314**

VILLAGE OF SCHAUMBURG
Employer/Respondent

17IWCC0096

On 8/7/2015, 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 0.16% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0147 CULLEN HASKINS NICHOLSON ET AL
CHARLES G HASKINS
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT B ULRICH
105 W ADAMS ST SUITE 2200
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Robert Weiss
Employee/Petitioner

Case # **11WC025314**

17IWCC0096

v.

Village of Schaumburg
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 **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **July 16, 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 Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an occupational exposure 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 occupational exposure?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

17IWCC0096

FINDINGS

On **07/23/2010**, 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 occupational exposure that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$93,600.00**; the average weekly wage was **$1,800.00**.

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 through Group Plan provided in part by Respondent.

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $669.64/week for 250 weeks, because the injuries sustained caused the 50% 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.

David A. Kane
Signature of Arbitrator

August 7, 2015
Date

AUG 7 – 2015

++++++++++++++++++ATTACHMENT TO ARBITRATION DECISION

Robert Weiss, Petitioner,	)	
vs.	)	Case No. 11WC025314
Village of Schaumburg, Respondent.	)	17IWCC0096

FINDINGS OF FACT

Robert Weiss began employment with the Village of Schaumburg on June 2, 1980 as a Firefighter. In July of 2014 he was promoted to Lieutenant.

Petitioner presently suffers from coronary artery disease and last worked a shift at the Village of Schaumburg on July 23, 2010.

When initially hired as a Firefighter, Petitioner underwent a pre-employment physical which included cardiovascular testing at a medical facility selected by the Respondent. Upon commencing employment he had no restrictions with reference to his cardiovascular or pulmonary systems.

Petitioner has never smoked cigarettes and when he began his employment his weight was approximately 155 lbs. At the time of Arbitration he weighed 178 lbs. During the period of 1980 through 2010 his weight was within those ranges. When Petitioner began employment he was on no type of medication for control of either his cholesterol or

hypertension. Petitioner exercises on a daily basis performing cardiovascular training and weight lifting.

Petitioner's family history regarding cardiac problems is as follows:

1) Petitioner's father passed away at age 63 due to cardiac issues. He was a heavy smoker and obese.
2) Petitioner had one brother who passed away at the age of 40 due to a cardiac condition. Petitioner's brother was a smoker and borderline obese.
3) Petitioner's mother is alive at the present time and is 87 years old. She does not have any cardiac conditions.
4) Petitioner has one sister who is alive and 58 years old. She has no cardiac conditions.

As his father and brother were obese and had cardiac issues, Petitioner ate healthy foods involving fish, chicken, vegetables and salads.

Petitioner's exhibit #1 consists of essential job function testing for the Firefighter position. The test is designed to confirm a firefighter's ability to perform functions likely to be encountered by firefighters. Personal protective equipment (PPE) encapsulates the firefighter. Self-contained breathing apparatus (SCBA) consists of face covering and air tank to provide breathing air. The combined weight of the PPE and SCBA is 70 lbs at the lightest. The SCBA weighs approximately 25 lbs. When fighting a fire or performing the testing firefighters deal with weights up to 100 lbs. The full body drag utilizes a 145 lbs mannequin.

Petitioner's exhibit #2 is the job description for the position of Fire Lieutenant. A Fire Lieutenant is required to perform all of the job functions of a firefighter. Additionally, a lieutenant is required to supervise all activities for the direct command of an assigned fire company and station on a shift, including ensuring fires are fought in the correct way, making decisions on what has to be done and how it is accomplished, laying out hose lines, opening portions of the burning building, etc. Petitioner summarized that the job of lieutenant was to make sure that all under his command would return home safely.

Beginning in 2005, Petitioner underwent annual physicals which were mandated by Respondent. Prior to 2005, he would undergo physical examinations even though they were not mandated.

In 1993 after his brother died, Petitioner went to St. Francis Hospital in Evanston and underwent a stress test. The testing was inconclusive and he underwent an angiogram. He was prophylactically prescribed medication for both cholesterol and hypertension. There were no further recommendations for treatment and he was not placed on any type of restrictions at that time.

For approximately the first five years of his career as a firefighter, SCBA equipment was not utilized. Over the course of his career he would fight approximately 10 fires per year. An "overhaul" is the removal of debris after

the fire has been extinguished. Typically SCBA is not utilized during an overhaul. During an overhaul there are still embers, particulate matter and carbon monoxide.

In the first five years there were two notable fires that he recalls. The first was a shoe store in the Woodfield Mall. There was a small back room where the shoes were stored. That was the center of the fire and there was intense heat and very intense smoke. Hand pumps were utilized to extinguish the fire and Petitioner and the firefighters were present for a significant period of time and Petitioner inhaled a lot of smoke. The materials fueling the fire were mostly synthetics, plastic and rubber. By the time the overhaul was completed they were on the scene for a couple of hours. Petitioner noticed difficulty breathing, his eyes were burning and his throat was irritated. Every time he would blow his nose black soot would come out.

The next memorable fire, was a barn fire. In front of the barn was a lean to, hanging off of the roof with side walls. The fire was intense and the firefighters were ordered to get animals out. There was intense smoke and heat. They were at the scene for approximately six to eight hours. Petitioner noticed that his eyes were irritated. He had difficulty breathing. When he returned from the fire and removed his protective clothing the side of his body was red from the heat. His nose, throat and chest were extremely irritated. He felt like there was a lump in his chest that would just not go away.

At all the fires Petitioner fought prior to 2005 he noticed similar types of symptoms, including irritation of the eyes and throat, the heat and difficulty breathing.

Petitioner underwent coronary artery scan at the University of Illinois Department of Cardiology on September 18, 2003. That test was interpreted as highly likely showing evidence of non-obstructive coronary stenosis. (PX5, pg. 3, RX1). Petitioner came under the care of Dr. Rosenberg of the Advocate Medical Group and had an evaluation on October 13, 2003. (PX5, pp5-7, RX2). Myocardial rest stress perfusion study was interpreted as normal. Cardiac stress test showed good exercise tolerance, normal heart rate and blood pressure. Response to exercise was negative for exercise-induced ischemic symptoms/changes (PX5, pp11-13, RX3&4).

In 2005 Petitioner returned to Dr. Rosenberg and came under the care of Dr. Parag. Testing included catheterization and angiography and ultimately he underwent placement of two stents (PX5, pp 20-21, see also RX5-8). In 2006 there was stenosis in one of the stents and he underwent replacement (PX5, pp 34-35).

Petitioner lost a total of approximately three months following those procedures and returned to regular unrestricted work. Petitioner underwent stress testing thereafter and was never placed on restrictions. Between 2005 and 2010 Petitioner continued his lieutenant and firefighter duties, fighting other fires. He would experience fatigue quickly as well as difficulty

breathing every time he went to a fire. He would be out of breath very quickly.

Petitioner continued his duties as a Fire Lieutenant, including fighting fires. There was a notable fire occurring in December 19, 2009. It was a fire in a multilevel house that started in the garage. The fire had proceeded into a room behind the garage and also through the side wall of the house going up the stairs, burning through a pull down stairway. The bedroom on top of the garage was full of flames and the fire extended into the attic. Petitioner identified as Petitioner's exhibit #3 the Post Incident Critique form from the fire. Attached thereto were photos of the house and fire.

Petitioner participated in fighting the fire and the overhaul. There was an extreme amount of heat and smoke during the fire. The Petitioner and his crew tried to go up the stairs and could only make it approximately three quarters of the way up. It was reported there was heavy fire and smoke in the room under the stairs and Petitioner backed his company down. They continued to fight the fire until they ran out of air. The smoke was intense and the fire was significant. Petitioner was wearing his SCBA apparatus. Petitioner went through two air packs (each bottle would hold approximately 20 minutes of air).

At the scene Petitioner noticed extreme exhaustion and was unable to catch his breath. He had a hard time concentrating and had to sit for extended periods to catch his breath. Attached to Petitioner's exhibit #3 is a picture of Petitioner sitting in the front yard with some of his equipment off.

Petitioner's last scheduled day of work with Respondent was July 23, 2010.

On July 30, 2010 he was taken to Lutheran General Hospital in the morning after experiencing chest pain. He was admitted under the care of Dr. Parag Patel. Petitioner underwent angiography with stent placements (PX4, pg. 6-7). Petitioner was discharged the next day, July 31, 2010 and Dr. Patel stated in the angiogram report that the occupation of firefighter is clearly contributing to the vascular disease progression and the doctor indicated he would recommend retirement since ongoing stress and exposure to smoke would potentiate his atherosclerosis (PX4, pg. 47).

Dr. Patel completed Certificate of Disability on September 10, 2010 in conjunction with Petitioner's application for disability pension. Dr. Patel stated that the progression of Petitioner's cardiovascular condition is most likely linked to the occupational responsibilities as a firefighter and that Petitioner is not able to continue his occupational duties. (PX6, Exhibit B and Joint Exhibit C).

Dr. Patel reiterated in letter of June 23, 2014 that he continued to maintain Petitioner's exposure to carbon monoxide as a firefighter contributes to the progression of the atherosclerosis (PX5, pg. 151).

Dr. Patel's evidence deposition took place on April 1, 2015. Dr. Patel is board certified in cardiology and interventional cardiology. He is the director of the cardiac intensive care unit and one of the directors of the Advocate

Medical Group at Lutheran General Hospital (PX6, pg. 5). Dr. Patel's diagnosis is coronary artery disease, hypertension and hyperlipidemia. Atherosclerosis contributes over time to ischemia or lack of oxygen to the heart (PX6, pp 6-7). The doctor stated that in temporal order that Petitioner's risk factors for development of coronary disease where family history, hypertension, hyperlipidemia and exposure to his occupation (PX6, pg. 8). The doctor indicated that during his period of treatment the hypertension and the lipid issues were reasonably controlled. The doctor stated that the basis of his opinion that the Petitioner's occupational responsibilities as a firefighter and lieutenant contributed to the condition of ill-being is that a catecholamine surge occurs when a firefighter is exposed to smoke, by-products of smoke and rapid changes in the environment, impacting blood pressure and heart rate which contributes to the development of vascular disease (PX6, pp 9-10, 22). Also, stress can cause a release of adrenaline or norepinephrine which vasoconstricts the arteries and increases heart rate and blood pressure. (PX6, pp 9-10). The doctor continued that the occupation of firefighter contributes to coronary artery disease based upon the stress of going to a fire as well as the exposure to smoke and its byproducts, particularly carbon monoxide. (PX6, pp 17-18). The doctor indicated that hypertension, coronary artery disease and atherosclerosis are contributed to by the occupational component (PX6, pp 17-18, 22).

Dr. Patel indicated that Petitioner was not fit to resume work as a firefighter (PX6, pg. 11).

Dr. Patel reviewed the articles relied on by Dr. Fintel who evaluated at Respondent's request. The articles relied on by Dr. Fintel did not address the long-term atherosclerotic risk that a firefighter experiences. (PX6, pg. 11-12).

Petitioner was evaluated at his request by Dr. Jeffrey Coe on June 12, 2012. Dr. Coe issued a report which is contained as Petitioner's Deposition Exhibit B within the transcript of his deposition (PX7). Dr. Coe also issued an addendum dated July 12, 2012 which is attached as Deposition Exhibit C (PX7). Lastly, Dr. Coe issued a report dated July 29, 2013 (Deposition Exhibit D, PX7), which consists of a review of Dr. Fintel's report.

On October 14, 2014 Dr. Coe testified that Mr. Weiss has coronary artery disease which is also described as atherosclerotic cardiovascular disease. The doctor stated that Petitioner's work as a firefighter was a factor in his development of multi-vessel coronary artery disease. By conditions of employment the doctor talked about exposure to carbon monoxide and pyrolysis products (combustion products) as well as the physical and psychological stress of the work. These were all factors in causing the development of multi-vessel coronary artery disease (PX7, pp 21-22). Dr. Coe stated carbon monoxide and pyrolysis exposure are risk factors to development of coronary artery disease. Dr. Coe made reference to standard teaching text in occupational medicine (attached to PX7 as Deposition Exhibit E is page 336 of the Lang Occupational Environmental Medicine text book which indicates that firefighters are at high risk for carbon monoxide exposure).

Dr. Coe continued that psychological stress increases blood pressure and therefore increases demand on the heart. Dr. Coe indicated that firefighters' work environment is a classically psychologically stressful condition (PX7, pp 26-27). Dr. Coe indicated that his opinions are based upon the chronic exposure due to Mr. Weiss' years of service as a firefighter (PX7, pg. 28).

Dan Fintel, MD testified on December 11, 2014 by vehicle of evidence deposition (RX 20) that he performed a record review in this matter. The report generated is attached as exhibit 2 to Respondent's exhibit 20.

Dr. Fintel diagnosed the Petitioner with coronary artery disease and felt that a positive family history, hyperlipidemia and hypertension were the factors that promoted the inexorable progression of Lieutenant Weiss' coronary artery disease (PX20, pp 19-20). The doctor stated that there was no relationship, direct or otherwise, between the events requiring fire suppression and the progression of the coronary artery disease (RX20, pp 20-21). The doctor stated that in Petitioner's admissions to the hospital there was no evidence of fighting a fire either that day or the day before (RX20, pp 20-21).

As Dr. Fintel did not examine Petitioner, the doctor had no opinion on Petitioner's fitness for duty with Respondent (RX20, pg 36).

Dr. Fintel cited in his report an editorial from the New England Journal of Medicine in 2007 (contained as exhibit 3 to Respondent's exhibit # 20). This editorial commented on an article in the same issue of the New England Journal of Medicine regarding "Emergency Duties and Deaths from Heart Disease among Firefighters in the United States". The first listed author was Stefanos N. Kales, M.D., M.P.H. This article was attached to Respondent's exhibit 20 as exhibit #4.

The article (RX20, exhibit 4) and the editorial (RX20, exhibit 3) both deal with death from heart disease among firefighters. Dr. Fintel admitted that both addressed sudden cardiac events. Dr. Fintel indicated that the articles were talking about the likelihood of sudden cardiac events during work as a cause for death. (RX20, pg 33).

Petitioner offered as Petitioner's exhibit 8 an article written in part by Stefanos N. Kales in 2013 for BioMed Central. In that article the authors indicate that physical exertion, emotional stress and environmental pollutants are encountered by firefighters on a regular basis during fire suppression activities and therefore it is likely that these multiple stressors may function independently or work in concert to precipitate cardiovascular disease in firefighters (PX8, pg 4).

Dr. Fintel admitted that Petitioner's weight is not a risk factor and that his statins were being appropriately used to lower Petitioner's cholesterol. Additionally, Petitioner's hypertension was controlled and therefore would

be a decreased risk factor (RX20, pp 26-28). Dr. Fintel agreed that firefighting is strenuous work (RX20, pg 35).

Dr. Fintel stated that whether carbon monoxide inhalation is a risk factor for the development of coronary artery disease is controversial in the medical literature with non-uniform conclusions. He admitted that there are articles that support the contention that chronic carbon monoxide exposure can accelerate coronary artery disease (RX20, pg 37). Dr. Fintel admitted pyrolysis is a risk factor in the development of coronary artery disease (RX20, pg 38).

The doctor stated that the literature goes both ways as to whether work related stress aggravates coronary artery disease but admitted that in certain individuals it probably is a factor (RX20, pp 41-42).

Dr. Fintel admitted that, when inhaled, carbon monoxide disrupts the blood's transport of an intercellular use of oxygen and that the resulting hypoxia can cause myocardial injury. The doctor admitted that long-term repeated exposure to elevated concentrations of particulate matter has been associated with the initiation/progression of atherosclerosis (RX20, pp 46-47). Lastly Dr. Fintel admitted that not every individual who has the risk factors of family history of coronary artery disease, increased cholesterol, increased hypertension and is male of the approximate age of 50 is guaranteed develop of coronary artery disease (RX20, pg 48).

Petitioner was awarded a Line of Duty Occupational Disability Pension by the Board of Trustees of the Pension Fund. The medical submitted as part of the Pension Hearing was received as joint exhibits in this case.

Joint exhibit A is the report and certificate of Dr. Joseph Mitton. The doctor indicated that Petitioner's coronary artery disease is not related to fire service but directly related to the risk factors of family history, hypercholesterolemia and hypertension. The doctor stated that Petitioner is unable to perform duties as a firefighter (Joint Exhibit A).

Petitioner was also evaluated by Dr. Timothy McDonough. Dr. McDonough opined that Petitioner was unable to perform duties as a firefighter and stated that the heart disease may be caused by exposure to heat, radiation or carcinogen but stated disability did not result from service as a firefighter. In the doctor's report he incorporated the editorial contained as exhibit 3 in the deposition of Dr. Fintel (RX20). The doctor stated that the condition of coronary artery disease is not primarily a result of the fire service (Joint Exhibit B).

The Certificate of Disability of Dr. Patel was received as Joint Exhibit C.

At the outset of hearing Petitioner specifically made election to seek benefits under Section 8(d)2 of the Workers' Compensation Act.

CONCLUSIONS OF LAW

Section 1(d) of the Occupational Disease Act defines Occupational Disease as follows:

> In this Act the term "Occupational Disease" means a disease arising out of and in the course of the employment or which has become aggravated and rendered disabling as a result of the exposure of the employment. Such aggravation shall arise out of a risk peculiar to or increased by the employment and not common to the general public.
>
> A disease shall be deemed to arise out of the employment if there is apparent to the rational mind, upon consideration of all the circumstances, a causal connection between the conditions under which the work is performed and the occupational disease. The disease need not to have been foreseen or expected but after its contraction it must appear to have had its origin or aggravation in a risk connected with the employment and to have flowed from that source as a rational consequence. (820ILCS310/1(d)).

Section 1(d) of the Occupational Disease Act continues:

> Any condition or impairment of health of an employee employed as a firefighter, emergency medical technician

(EMT), or paramedic which results directly or indirectly from any.....heart or vascular disease or condition, hypertension.....resulting in any disability (temporary, permanent, total, or partial) to the employee shall be rebuttably presumed to arise out of and in the course of the employee's firefighting, EMT, or paramedic employment and, further, shall be rebuttably presumed to be causally connected to the hazards or exposures of the employment..... (820ILCS310/1(d)).

* * * *

Disputed Issue C – Did an accidental exposure occur that arose out of and in the course of employment?

The threshold issue is whether an occupational exposure occurred to Robert Weiss that arose out of and in the course of his employment by the Village of Schaumburg.

It is clear that the Legislature has created a rebuttable presumption, above cited, that when a firefighter who sustains a heart or vascular disease or condition or hypertension, that such condition shall be rebuttably presumed to arise out of and in the course of such employment and rebuttably presumed to be causally connected to the hazards or exposures of the employment.

Petitioner gave detailed testimony as to the various exposures to smoke and pyrolysis products during the course of his 30 year career. It is clear that even after SCBA equipment was available that it would not always be used potentially during an overhaul. Petitioner also detailed the temperature extremes to which he was exposed as well as the psychological stresses of both fighting fires and supervising and being responsible for personnel under his command.

The editorial relied on by Dr. Fintel (RX20, Exhibit 3) acknowledges that firefighting is a higher hazard job and sometimes extremely physically demanding. The article acknowledges that exposure to carbon monoxide and particular matter is routine.

The occupational medicine text relied on by Dr. Coe acknowledges that firefighters are at high risk for carbon monoxide exposure (RX7, Exhibit E).

There was no evidence submitted which would in any way rebut or contradict Petitioner's 30 year exposure to carbon monoxide and pyrolysis, temperature extremes and psychological stress. Petitioner worked as a Firefighter/Lieutenant through July 23, 2010 which would be the last exposure date.

Accordingly the Arbitrator concludes that Petitioner was last exposed to an occupational exposure that arose out of and in the course of his employment on July 23, 2010.

* * * *

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

The issue in this case is whether the presumption of exposure is overcome by Petitioner's family history of cardiac problems as to his father and his brother. Unlike his father and his brother, Petitioner never smoked and was not obese. Petitioner exercised regularly and ate in a reasonably healthy fashion. His blood pressure and lipids were well controlled.

Doctors Patel and Coe are of the opinion that Petitioner's firefighter duties contributed, accelerated and aggravated to the condition of coronary artery disease.

Dr. Fintel felt that Petitioner's condition of ill-being was directly related to the personal risk factors. However, Dr. Fintel's cited article deals with sudden cardiac death. There is no such claim in this case. Additionally, Dr. Fintel admitted that Petitioner's weight was not a risk factor and that his cholesterol and hypertension were appropriately controlled which would decrease them as risk factors. Dr. Fintel admitted that the medical community has non-uniform conclusions on whether carbon monoxide is a risk factor in the development of coronary artery disease and he did admit that pyrolysis is a risk factor

in the development of coronary artery disease. The doctor admitted that work related stress can be a factor in aggravation of coronary artery disease.

Dr. McDonough stated that Petitioner's coronary artery disease is not primarily the result of fire continuing that there are no specific precipitating events for the incenses of angina requiring stent implantation.

It is clear that the editorial underlying the opinions of both Dr. Fintel and Dr. McDonough (Pension Board examiner) addresses sudden cardiac death. The arbitrator concludes that the same has no basis here.

Dr. Mitton (second Pension Board examiner) indicated that Petitioner's coronary artery disease is not related to fire service. Dr. Mitton states that the coronary artery disease is related to family history with hypertension and high cholesterol being major risk factors. The doctor continued that the brothers' history of myocardial infarction at an early age was very significant. However, as above indicated Petitioner's hypertension and lipids were well controlled and Petitioner's health was significantly different than that of his brother or his father (no smoking, well controlled weight, regular exercise, etc.).

The Illinois Supreme Court has clearly indicated that when an occupational activity aggravates or accelerates an underlying

condition that a causal connection exists. *Sisbro, Inc. v. Industrial Commission, (2003) 207 Ill. 2d 193, 797 N.E. 2d 278; Twice Over Clean, Inc. v. Industrial Commission, (2005) 214 Ill. 2d 403, 827 N.E. 2d 409.*

The Supreme Court in *Sisbro*, supra, stated as follows:

> It is axiomatic that employers take their employees as they find them. (Citation omitted). "When workers' physical structures, diseased or not, give way under stress of their usual tasks, the law views it as an accident arising out of and in the course of employment". (Citations omitted). Thus, even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. (Citations omitted). *Sisbro, 207 Ill. 2d at 205.*

In this case it is clear that the overwhelming weight of the evidence indicates that Petitioner's thirty year career as a Firefighter/Lieutenant aggravated and accelerated any underlying coronary artery disease condition. When the presumption of causation is applied the only conclusion that can be reached is that a causal connection exists.

The Arbitrator concludes that Petitioner's coronary artery disease is causally related to the occupational exposure of thirty years of service as a Firefighter/Lieutenant.

* * * *

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

All physicians with the exception of Dr. Fintel agree that Robert Weiss is physically unable to continue his employment with the Village of Schaumburg. Dr. Fintel did not render an opinion concerning work capability. Dr. Fintel's lack of opinion is based upon the fact that he only performed a record review and never actually examined the Petitioner.

In this case Petitioner required invasive stenting and is left with the residuals of extreme fatigue. Lieutenant Weiss does not engage in any outside employment. He clearly has suffered a loss of career.

Robert Weiss presently is tired and fatigued all the time. He indicates he experiences difficulty in performing day to day tasks.

In *Collingnon v. Village of Arlington Heights*, 08 IWCC 1437, the Commission adopted and affirmed and award of 50% loss of use of the person to a 63 year old firefighter/paramedic who was forced to retire from his position as a result of coronary artery disease found to

be occupationally related. The Petitioner in *Collingnon* was working at the time of Arbitration, performing water treatment maintenance calls.

Based upon the above the Arbitrator concludes that the Petitioner has sustained permanent partial disability pursuant to Section 8(d)2 of the Act to the extent of 50% loss of use of a person.

STATE OF ILLINOIS)
) SS.
COUNTY OF LA SALLE)

☐ 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

Donald Barnes,
Petitioner,

vs. No. 12 WC 44202

Parsec,
Respondent.

17IWCC0097

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of benefits rates, wage calculation, causal connection, medical expenses, prospective medical care, and temporary total 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).*

Donald Barnes, 51, testified that in October 2012 he was employed by Respondent Parsec as a groundsman. He testified that on that date he was also employed part-time at NRJM, Inc., an owner of a Domino's Pizza franchise (hereinafter, "Domino's"), working in the store and delivering pizzas. Petitioner testified he informed his supervisors at Respondent about his other job at Domino's, on his employment application and at his pre-employment interview. He worked 20 hours/week at Domino's for four months. At Respondent Parsec, he worked a 40 hour week, earning $13.50/hour. His duties as a groundsman included constant climbing, bending, and walking up and down the railway tracks to lock and unlock "IBC" (inner box connection) pins.

On October 14, 2012, after unlocking a railcar pin, Petitioner slipped and fell backwards 5' to 6' from the ladder he was descending onto the concrete pavement striking his back, shoulders, elbow and head. That evening, he sought treatment at Provena St. Joseph. He continued working for another month with pain in his legs, shoulders and elbows, until Dr. Singh authorized him off work. He was referred to and treated by Drs. Templin and Fuentes. Petitioner received work restrictions from Dr. Templin, which Respondent never accommodated.

Petitioner continued receiving treatment including physical therapy, occupational therapy and a lumbar steroid injection by Dr. Sharma. Petitioner underwent a lumbar discogram and an FCE. Dr. Templin referred Petitioner to Dr. Urbanosky, who gave Petitioner a right shoulder injection. Although Dr. Templin released Petitioner with back restrictions, Petitioner continued to treat with Dr. Urbanosky for upper extremity symptoms. In February 2014, Dr. Urbanosky administered injections to Petitioner's right shoulder, and recommended right shoulder surgery.

Dr. Urbanosky permitted Petitioner to work with a 30 lb. lifting restriction but no overhead lifting. On April 16, 2014, Petitioner returned to work for a different employer. He now drives an 18-wheel tractor-trailer truck and does spotting work for Crown Services, earning $24.00 per hour. Prior to working at Respondent, he had worked as an independent truck driver for 18 years. Petitioner continues to see pain doctor, Dr. Sharma; he now wishes to undergo lumbar spine surgery, right shoulder surgery, and right elbow injections.

Dr. Leah Urbanosky testified she first treated Petitioner on August 26, 2013 for his ***bilateral shoulder and elbow pain***. She diagnosed him with work-related right shoulder bursitis and/or impingement syndrome, and right elbow lateral epicondylitis. Throughout 2014, Petitioner's right shoulder complaints continued and he had positive impingement signs.

In September 2014, Dr. Urbanosky diagnosed Petitioner with ***right shoulder*** subacromial bursitis, supraspinatus tendinosis and AC arthrosis. Based on Petitioner's ongoing pain and his failure to respond to conservative care, she recommended arthroscopic surgery. Her diagnosis regarding Petitioner's ***right elbow*** was work-related lateral epicondylitis. Dr. Urbanosky recommended a right elbow injection of platelet rich plasma and restrictions of 30 lbs. lifting with no overhead reaching or lifting.

Dr. Cary Templin testified he first treated Petitioner in December 2012 for ***spine*** pain. Dr. Templin found Petitioner had degenerative changes at L4-5 and L5-S1, with mild disc protrusions possibly consistent with aging. Petitioner's spinal nerve roots were not compressed. Dr. Templin's diagnosis of Petitioner's spine was degenerative disc disease and discogenic low back pain, the latter of which was caused by his accident.

On February 1, 2013, Dr. Templin referred Petitioner to a pain management specialist, who administered spinal injections and performed a discogram which showed concordant L4-5 and L5-S1 pain. On 7/19/13, Dr. Templin recommended spine surgery because of Petitioner's positive discogram and continuing pain. Because Petitioner did not then want surgery, Dr. Templin ordered an FCE, which Petitioner underwent on August 8, 2013. The FCE placed Petitioner at a light to medium physical demand level. Dr. Templin opined Petitioner would be able to perform all of his usual and customary job duties. On September 13, 2013, Dr. Templin

again offered Petitioner surgery as an option, but not as a recommendation. He placed Petitioner on permanent restrictions and gave him a home exercise program. He last saw Petitioner on March 31, 2014, at which time Petitioner still complained of low back pain and reportedly was "interested in considering" spine surgery.

On behalf of Respondent, **Dr. Troy Karlsson** conducted three Section 12 examinations of Petitioner's ***upper extremities***, the first being on January 14, 2013. Dr. Karlsson testified that Petitioner gave a history of bilateral shoulder surgeries 20 years earlier. He tore his right biceps muscle and required reattachment of the tendons near his shoulder. Petitioner complained to Dr. Karlsson of pain in both elbows, shoulders, and his left knee. Bilateral shoulder and elbow MRI's taken on October 14, 2012 were unremarkable. Dr. Karlsson's diagnoses following his first exam included ***right elbow*** lateral epicondylitis, and ***right shoulder*** rotator cuff syndrome. Dr. Karlsson found Petitioner's right elbow and right shoulder issues related to his work accident. Dr. Karlsson recommended a right elbow injection and a right shoulder MRI. Dr. Karlsson recommended Petitioner not do any above-the-shoulder work on his right, although Petitioner could still work as a groundsman.

At his 2nd IME on April 29, 2013, Dr. Karlsson diagnosed Petitioner with right shoulder rotator cuff tendonitis, AC joint arthropathy, and right elbow lateral epicondylitis. He recommended an injection to the elbow and shoulder. He did not rule out shoulder surgery, depending on results of the shoulder injection. At Dr. Karlsson's 3rd IME on January 16, 2014, Petitioner reported that the injections provided no pain relief. Dr. Karlsson diagnosed work-related right shoulder rotator cuff tendonitis and right elbow lateral epicondylitis. Because Dr. Karlsson believed Petitioner failed to respond to right shoulder injections, he opined Petitioner would be a poor surgical candidate with little chance of improvement. Dr. Karlsson recommended a home exercise program instead. Dr. Karlsson opined that Petitioner did not require any further right elbow treatment. He agreed that all of Petitioner's shoulder and elbow treatment through January 2014 was reasonable.

Dr. Gunnar Andersson was Respondent's Section 12 ***spine*** expert. At his initial exam of Petitioner on January 8, 2013, Petitioner complained of mid and low back pain; bilateral shoulder and elbow pain, and left knee pain. Dr. Andersson noted Petitioner's lumbar MRI showed a flattening of the spinal cord, but no fractures, dislocations, herniations, stenosis, or structural damage to his back caused by his fall. Dr. Andersson diagnosed Petitioner with neck and back contusions from his fall.

Dr. Andersson performed a 2nd IME on April 1, 2014, and also reviewed additional medical records and reports. Petitioner reported he no longer had mid or upper back or neck symptoms and his low back symptoms were localized and not radiating. Dr. Andersson believed Petitioner's lumbar MRI showed degenerative changes and small central L4-5 and L5-S1 annular tears, but no disc herniations at any level. Petitioner told Dr. Andersson that he did not want to undergo surgery.[1] Dr. Andersson provided these opinions: Petitioner had normal degenerative changes at L4-5 consistent with his age and unrelated to his fall. Petitioner's work accident only

[1] This is the opposite of what Dr. Templin reported Petitioner told him just one day earlier: that Petitioner *was* interested in considering spine surgery (PX19, p. 18).

caused spine contusions. Discography is not a particularly accurate test. Petitioner's accident did not cause his degenerative spine condition to become symptomatic because Petitioner's films showed no evidence of herniation or any other structural changes or fractures. Petitioner did not require spine surgery to relieve symptoms from his work injury. He had no findings that showed surgery to be necessary. He reached MMI for his back in February 2013. He was capable of returning to his job as a groundsman.

Concurrent Employment

The Arbitrator found Petitioner proved Domino's was a concurrent employer under the Act, and included his earnings from that job in Petitioner's average weekly wage calculation.

The only evidence purporting to show Respondent had knowledge of Petitioner's concurrent employment prior to his injury was Petitioner's testimony. He testified he listed Domino's as an employer on his job application, and he mentioned that fact to Respondent at his pre-employment interview. The Commission finds this testimony vague and insufficient. No details of his conversation were offered. Petitioner did not testify he informed Respondent during his interview that he planned to continue working for Domino's if he were hired. He did not testify he informed Respondent that he was still working for Domino's once he began working for Respondent. Without such evidence, it would be speculative for the Commission to presume Respondent had actual knowledge, once Petitioner began working for Respondent, that he continued working for a prior employer. Moreover, because Respondent hired Petitioner to work full-time and not part-time, the Commission finds it less likely Respondent would expect Petitioner to have other outside employment. Consequently, the Commission finds Petitioner did not prove Respondent had knowledge of Petitioner's concurrent employment prior to his injury, and reverses that finding of the Arbitrator.

Average Weekly Wage ("AWW")

After finding Domino's to be a concurrent employer, the Arbitrator included Petitioner's Domino's earnings in her calculation of Petitioner's average weekly wage, which the Arbitrator found to be $651.07. Because the Commission finds Petitioner did not proved Respondent had knowledge of Petitioner's employment with Domino's, the Commission reverses that finding, and excludes Petitioner's Domino's earnings from its calculation of Petitioner's average weekly wage.

Petitioner began working for Respondent on September 30, 2012. His accident occurred on October 14, 2012. Petitioner testified he was paid $13.50/hour. In this case the earnings used to calculate his AWW would be those listed on his pay details from Respondent for two pay periods: those ending on September 30, 2012 and on October 7, 2012 (PX9). For the week ending September 30, 2012, Petitioner worked 4 hours and earned $54.00. For the week ending October 7, 2012, he earned $540.00 for working 40 straight time hours with no overtime. Using these earnings, the Commission calculates Petitioner's correct AWW to be $540.00.

Causal Connection

The Arbitrator found Petitioner sustained injuries to his: neck, left knee, left elbow, low back, right shoulder and right elbow. The Arbitrator found Petitioner's neck injury to be minimal, and noted that Petitioner was not seeking further treatment for his neck, left knee or left elbow. The Arbitrator deferred until final resolution of this case a finding of permanent partial disability as to those body parts (Arbitration decision, pp. 14-15). That leaves, for this Review, the issue of causal connection of Petitioner's injuries to his low back, right shoulder and right elbow. The Arbitrator found each of those injuries causally related to his work accident.

Low Back

The Arbitrator found persuasive Dr. Templin's opinion that Petitioner needs a lumbar fusion due to his ongoing pain, positive discogram, and failed conservative care. The Arbitrator awarded him prospective lumbar spine surgery.

The Commission finds Dr. Andersson's opinions more persuasive: that Petitioner attained maximum medical improvement ("MMI") for his spine condition in February 2013, and that any need for treatment after that time is unrelated to his work injury. Dr. Andersson has more experience than Dr. Templin. He opined that that discograms are unreliable, giving many false negatives and false positives. He noted that Petitioner's lumbar MRI showed no disc herniations at any level. He testified that Petitioner's degenerative L4-5 changes were related to his age, not his fall. Dr. Andersson opined that, relative to Petitioner's spine, Petitioner sustained only contusions as a result of his work accident. There was nothing in Petitioner's films or in his physical exam to suggest anything else. Dr. Andersson opined that Petitioner did not require spine surgery and he was capable of returning to his job as a groundsman.

Dr. Templin's opinion, that Petitioner requires lumbar fusion surgery due to his accident, is less persuasive. Dr. Templin found no compression of Petitioner's spinal nerve roots, and he acknowledged that Petitioner's pain above his low back is only musculoskeletal pain, without any neurological basis. He admitted that Petitioner was neurologically intact at each of his clinical examinations. He conceded that Petitioner's mild disc protrusions seen on his MRI could be consistent with aging. His opinion that Petitioner's fall aggravated his pre-existing condition was qualified: Dr. Templin testified that Petitioner's accident could have *potentially* aggravated his annulus.

The Commission finds that Petitioner attained maximum medical improvement for his lumbar spine as of February 28, 2013. The Commission reverses the Arbitrator's finding that Petitioner's low back condition of ill-being after that date is causally related to his work accident, and reverses the Arbitrator's award of medical bills and prospective treatment relating to his low back, after that date.

Right Shoulder

The Arbitrator found Dr. Leah Urbanosky's opinions regarding Petitioner's right shoulder condition and need for arthroscopic surgery, more persuasive that Dr. Troy Karlsson's.

Dr. Urbanosky believed Petitioner's right shoulder MRI showed least a partial thickness rotator cuff tear. Based on Petitioner's failure to respond to conservative management, she recommended right shoulder arthroscopic surgery. Dr. Urbanosky and Dr. Karlsson had opposite opinions on Petitioner's need for right shoulder surgery, based on their interpretations of whether Petitioner's condition improved following Dr. Urbanosky's injections. Both doctors believed surgery would be inappropriate, if the injections provided no temporary improvement. Dr. Karlsson relied on Petitioner's subjective report that the injections provided no decrease in pain. Dr. Urbanosky agreed Petitioner reported no subjective reduction of pain, but testified he did have *objective or clinical improvement* – he had a greater range of motion and less pain during those range of motion movements. Therefore, Dr. Urbanosky believed arthroscopic surgery would benefit Petitioner's right shoulder symptoms.

The Commission affirms and adopts the Arbitrator's finding that Dr. Urbanosky's opinions are more persuasive than Dr. Karlsson's, with regard to Petitioner's current right shoulder condition of ill-being, and his need for arthroscopic surgery.

Right Elbow

The Arbitrator found Dr. Urbanosky's opinions regarding Petitioner's right elbow condition and need for plasma rich platelet (PRP) injections, more persuasive that Dr. Karlsson's opinions. Both Dr. Urbanosky and Karlsson diagnosed Petitioner with right elbow lateral epicondylitis related to his October 14, 2012 work accident. Petitioner has treated for this condition with Dr. Urbanosky since August 2013. A right elbow MRI on December 5, 2013 confirmed the presence of joint effusion and common extensor tendinosis, likely traumatic in origin. At least since February 2014, Dr. Urbanosky has recommended plasma rich platelet injections to alleviate Petitioner's right elbow pain. She continued to recommend this treatment at her subsequent visits. In April 2015, she noted that Petitioner was still using splints and medications for his right elbow pain, which made it "tolerable." The Commission finds the recommended right elbow PRP injections reasonable, necessary and causally related, and affirms and adopts the Arbitrator's findings and awards on this issue.

Medical Expenses, Prospective Medical Treatment

Except for Petitioner's low back treatment, the Commission affirms and adopts the Arbitrator's award of Petitioner's unpaid medical bills pursuant to the fee schedule, and affirms the award of prospective right shoulder arthroscopic surgery and prospective right elbow platelet rich plasma injections. All of Petitioner's prior treatment and medications for his neck, left knee, left elbow, right shoulder and right elbow were reasonable, necessary and causally related to his work injury.

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Regarding Petitioner's lumbar spine, the Commission denies prospective lumbar surgery which it finds is not reasonable or necessary per Dr. Andersson's opinions. The Commission finds Petitioner's low back treatment received only through February 28, 2013 to be reasonable, necessary and causally related. The Commission reverses the Arbitrator's award of prospective lumbar surgery and past medical related to Petitioner's low back incurred after February 28, 2013.

Temporary Total Disability

The Commission affirms and adopts the *dates* of Arbitrator's award of TTD – 73-6/7 weeks from November 15, 2012 through April 15, 2014 – based on the Arbitrator's reasoning. The Commission does, however, modify the TTD *rate* to be $360.00, based on the AWW of $540.00.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 26, 2015, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's average weekly wage is modified to be $540.00.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of temporary total disability benefits is modified, and that Respondent pay Petitioner the sum of $360.00 per week, commencing November 15, 2012 through April 15, 2014, totaling 73-6/7 weeks, that being the period of temporary total incapacity from work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of medical benefits is modified, and with regard to Petitioner's low back injuries, Respondent shall pay Petitioner only the reasonable and necessary medical expenses through his date of MMI, February 28, 2013, pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of prospective medical treatment is modified. Respondent shall only pay for prospective care of right shoulder arthroscopic surgery and right elbow PRP injections, as recommended by Dr. Urbanosky. The award of low back surgery recommended by Dr. Templin is reversed.

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

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

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

Bond for 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: FEB 14 2017

o-12/14/16
jdl/mcp
68

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

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

BARNES, DONALD
Employee/Petitioner

Case# **12WC044202**

PARSEC
Employer/Respondent

17IWCC0097

On 10/26/2015, 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 0.11% 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:

0274 HORWITZ HORWITZ & ASSOC
TYLER BERBERICH
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT T NEWMAN
105 W ADAMS ST SUITE 2200
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF LaSALLE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b) & 8(a)

Donald Barnes
Employee/Petitioner

v.

Parsec
Employer/Respondent

Case # 12 WC 44202

Consolidated cases: N/A

17IWCC0097

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Ottawa** on **July 27, 2015** and in the city of **Kankakee** 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. ☐ 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, October 14, 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 as explained *infra*.

In the year preceding the injury, Petitioner earned $33,855.12; the average weekly wage was $651.07 as explained *infra*.

On the date of accident, Petitioner was 51 years of age, *married* with 1 dependent child.

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

Respondent shall be given a credit of $10,505.04 for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $10,505.04. *See* AX1.

Respondent is entitled to a credit of $0 under Section 8(j) of the Act. *See* AX1.

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $434.05/week for 73 & 6/7th weeks, commencing November 15, 2012 through April 15, 2014, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from October 14, 2012 through July 27, 2015, and shall pay the remainder of the award, if any, in weekly payments.

As stipulated by the parties, Respondent shall receive credit of $10,505.04 for temporary total disability benefits paid. *See* AX1.

Medical Benefits

Respondent shall pay reasonable and necessary medical services as reflected in Petitioner's Exhibits that remain unpaid pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive a credit, if any, as agreed by the parties.

Prospective Medical Treatment

As explained in the Arbitration Decision Addendum, the Arbitrator awards the prospective medical care in the form of a right shoulder surgery right elbow injections as prescribed by Dr. Urbanowsky and a low back surgery as prescribed by Dr. Templin pursuant to Section 8(a) of the Act.

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

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

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

Signature of Arbitrator

October 21, 2015
Date

ICArbDec19(b) p.3

OCT 26 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*
19(b) & 8(a)

Donald Barnes
Employee/Petitioner

v.

Parsec
Employer/Respondent

Case # **12** WC **44202**

Consolidated cases: **N/A**

17IWCC0097

FINDINGS OF FACT

The issues in dispute include causal connection, Respondent's liability for certain unpaid medical bills, Petitioner's entitlement[1] to temporary total disability benefits from June 8, 2013 through April 15, 2014, and whether he is entitled to prospective medical care in the form of a low back surgery as ordered by Dr. Templin as well as a right shoulder surgery and right elbow injections as ordered by Dr. Urbanowsky. Arbitrator's Exhibit[2] ("AX") 1. The Arbitrator notes that while Petitioner underwent treatment for injuries to various body parts as addressed herein, the focus of the parties' disputes relate to the low back, right shoulder, and right elbow.

Employment & Background

Prior to his employment with Respondent, Petitioner testified that he worked as a truck driver for 18 years or so from 1995 to 2012. He performed mostly local, but also some interstate, driving. Petitioner testified that he engaged in a lot of equipment handling, which he does not do now as a truck driver. He explained that he was not placed on any work restrictions by any physician during this period of time.

Petitioner testified that he was employed by Respondent on October 14, 2012 as a ground man. He was also employed by a franchisee of Domino's Pizza as a delivery driver for about four (4) months. In this position, he would perform clean-up duties in the store as well as make deliveries. Petitioner testified that he worked about 20 hours per week earning minimum wage plus tips. He received paychecks from Domino's Pizza and was paid $4.95 per hour while making deliveries and $8.25 per hour while working in the store. *See* PX10. On cross examination, Petitioner testified that the checks he received were for work performed before his accident at work with the exception of the last week of pay.

Petitioner testified that he never had low back, right elbow, or left elbow injuries or treatment prior to October 14, 2012. He did have an injury to his right shoulder in the late 1980's and underwent surgery with medical treatment spanning three years or more. He testified that, however, that he had no other injuries to his right shoulder or work restrictions after completing this treatment. Also, in June of 2012, Petitioner did complain of pain to the left knee and underwent x-rays, but testified that he was not placed on any work restrictions and he continued to work full duty. Petitioner is right hand dominant. *See generally* PX2.

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[1] Respondent stipulated that Petitioner is entitled to temporary total disability benefits commencing on November 16, 2012 through June 7, 2013. AX1.

[2] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party. Exhibits attached to depositions will be further denominated with "(Dep. Exh. _)."

Petitioner testified that he interviewed with Respondent about two-to-three days before he was hired and worked for Respondent from October 1, 2012 until June 30, 2013. Petitioner testified that he informed Respondent on his application about his other job as well as during his interview with Mr. Barnes.

While working for Respondent, Petitioner testified that he worked eight hours per day, sometimes up to 12 hours per day, five days per week. He was paid $13.50 per hour up to eight hours and he received "time and a half" for time worked over eight hours. Petitioner explained that he was required to work that overtime and the supervisor would let him know at the end of his shift whether he was going to work overtime. Petitioner submitted into evidence copies of his paychecks from Respondent. PX9.

Petitioner testified that his job duties as a ground man required him to walk up and down tracks, bend, climb steel ladders, pick up "ICB" pins that keep container boxes from falling off of the train cars, and locking and unlocking pins weighing about 15 pounds each. He was on his feet about seven hours per day and testified that he would have to lock and unlock about 25-30 cars per hour. Petitioner explained that locking and unlocking pins entailed climbing on the carts, which sometimes required him to use his hard hat to make the pins come loose, and then replacing the pins. Petitioner reviewed Respondent's Exhibit 3, which is the ground man job description. RX3. He noted that it includes a high "pace rating," which requires "[h]ands or body in rapid, steady motion. Opportunities for temporary pauses are few and worker may occasionally fall behind." *Id.*

October 14, 2012

On October 14, 2012 Petitioner was working as a ground man. Petitioner testified that it was raining and cold outside and he was unlocking pins off railcars. When he was unlocking the last pin on the railcar he fell backwards off the ladder onto the concrete pavement. Petitioner testified that his back, shoulders, hands, and head with a hard hat on hit the pavement.

Medical Treatment

On October 14, 2012, Petitioner went to Provena St. Joseph Medical Center for emergency care. PX3 at 26-27. He reported that he fell off of a ladder at work onto concrete and fell on his back. *Id.* He reported pain in the low, mid, and upper back and in both elbows. *Id.* He underwent x-rays of both shoulders, both elbows, and the entire spine. PX3 at 19-25. The emergency room physician diagnosed a fall with multiple contusions, provided pain medication, and discharged Petitioner with instructions to follow up with his primary care physician. PX3 at 26-27.

Petitioner testified that he continued working for Respondent after October 14, 2012, but he was in a lot of pain and could not keep up with the pace of his work. He explained that he had difficulty engaging in the physical activities of the job and experienced a lot of pain in his shoulders, elbows and low back climbing up ladders.

Petitioner then went to the office of his primary care physician, Jitinder Singh, D.O. ("Dr. Singh") at CR Medical Group on October 22, 2012. PX1 at 2-3. He reported an injury at work on October 14, 2012 involving his back, elbows, back of neck, shoulders, and left knee. *Id.* Petitioner was diagnosed with lumbago, thoracolumbar back pain, and a neck sprain and strain. *Id.*

As ordered by Dr. Singh, Petitioner underwent a thoracic MRI on November 8, 2012. PX1 at 4-6. The interpreting radiologist noted no acute compression deformity or subluxation, some endplate changes at multiple levels that appeared chronic, a Schmorl's node within the inferior endplate of T11, some disc space narrowing,

and small disc bulges throughout the thoracic spine most notable at T3-T4 and T4-T5 along with flattening of the cord at those levels. *Id.* Petitioner also underwent a lumbar MRI. *Id.* The interpreting radiologist noted disc protrusions at L4-L5 and L5-S1 with some encroachment upon the descending S1 nerve roots. *Id.*

On November 15, 2012, Dr. Singh noted Petitioner's report that he had continued to work since his injury, but in severe pain. PX1 at 8-9. He also reported continued pain in the back, shoulders, knee and both elbows, and low back pain radiating down the left leg. *Id.* Dr. Singh noted tenderness to palpation along the midline lumbo-sacral spine and paraspinal musculature, limited range of motion secondary to pain, lumbar paraspinals spasms, and a positive straight leg raise test on the left. *Id.* He diagnosed a disc bulge at L4-L5, nerve root compression, and left knee pain. *Id.* Dr. Singh ordered narcotic pain medications, and referred Petitioner to Dr. Henry Fuentes for a surgical evaluation. *Id.* Petitioner continued to see Dr. Singh while receiving medical treatment from orthopedic specialists through December 18, 2014. PX1.

On December 6, 2012, Petitioner saw Henry Fuentes, M.D. ("Dr. Fuentes") at Parkview Orthopedic Group. PX4 at 2-4; RX6 at 9. He reported pain over the posterior aspect of both elbows and pain over the medial aspect of the left knee. *Id.* After an examination, Dr. Fuentes diagnosed Petitioner with bilateral elbow contusions with lateral epicondylitis of the right elbow and medial epicondylitis of the left elbow status post his injury at work. *Id.* Dr. Fuentes also ordered a left knee MRI to rule of a medial meniscal tear as well as physical therapy for both elbows and the left knee. *Id.*

On December 7, 2012, Petitioner saw Cary Templin, M.D. ("Dr. Templin") at Hinsdale Orthopaedics for the first time. PX2 at 5-8. He reported an injury at work on October 14, 2012 when he fell off a ladder on a rail car landing flat on his buttock, loading on his back. *Id.* Petitioner also reported continued pain at a level of 9/10 extending across the lower back in the lumbosacral region with some pain extending into the posterior thighs and up to the thoracolumbar junction. *Id.* In addition, Petitioner reported some shoulder and elbow pain. *Id.*

Dr. Templin examined Petitioner and reviewed his MRIs noting that lumbar MRI showed very mild disc protrusions at L4-5 and L5-S1 with degenerative changes and no nerve root compression, although there was some abutment of the nerve traversing near the L5-S1 level. *Id.* With regard to the thoracic spine, Dr. Templin noted that the MRI showed mild flattening of the cord at T3-4 and T4-5 due to small disk bulges and kyphosis, but no disc herniations or cord impingement. *Id.* Dr. Templin diagnosed status post work injury with an axial load to the spine and continued lower back pain. *Id.* He recommended physical therapy followed by a possible pain management referral, and imposed work restrictions. *Id.* Petitioner testified that he provided these restrictions to Respondent's nurse via facsimile and that he spoke with her by phone when he first received the off work note and restrictions. Petitioner testified that he was not offered light duty by Respondent.

On December 20, 2012, Dr. Fuentes noted his review of Petitioner's left knee MRI, which showed Grade II-III patellofemoral chondromalacia most pronounced along the medial facet, a small joint effusion, and medial and lateral tibial-femoral joint space narrowing with osteophyte formation and Grade III chondromalacia. PX4 at 12-13; RX6 at 8. Dr. Fuentes administered a cortisone injection into the left knee, recommended continued physical therapy for the knee and elbows, and kept Petitioner restricted to light duty work. *Id.*

First Section 12 Examination – Dr. Andersson

On January 8, 2013, Petitioner saw Gunnar Andersson, M.D. ("Dr. Andersson") at Respondent's request. RX2 (Dep. Exh. 2). Dr. Andersson's report reflects that he took a history from Petitioner, examined him, reviewed

various treating medical records, and rendered opinions regarding his physical condition. *Id.* At the time of this evaluation, Petitioner reported pain in the back, neck, elbows and shoulders. *Id.*

Dr. Andersson diagnosed Petitioner with contusions to the neck and back as related to the accident at work. *Id.* He recommended an additional four weeks of physical therapy at which point Petitioner would reach maximum medical improvement. *Id.* Dr. Andersson noted that Petitioner's thoracic MRI was essentially normal and that the lumbar MRI showed mild degenerative changes "felt to be normal by Dr. Templin." *Id.* Dr. Andersson opined that Petitioner's lumbar condition was degenerative and neither caused nor aggravated by the accident at work on October 14, 2012. *Id.* He also opined that there were no objective findings precluding Petitioner from working full time and that he was not in need of any narcotic pain medication for his neck or back conditions. *Id.*

Second Section 12 Examination – Dr. Karlsson

On January 16, 2013, Petitioner submitted to a medical evaluation with Troy Karlsson, M.D. ("Dr. Karlsson") at Respondent's request. RX1 (Group Dep. Exh. 3). Dr. Karlsson's report reflects that he took a history from Petitioner, examined him, reviewed various treating medical records, and rendered opinions regarding his physical condition in the bilateral shoulders, bilateral elbows, and left knee. *Id.*

Specifically, Dr. Karlsson noted Petitioner's report that he fell at work on October 14, 2012 from a railcar landing on his back. *Id.* Petitioner reported pain in the right shoulder when trying to lift the arm and pain in the anterior and lateral aspects of the shoulder. *Id.* He also reported right elbow pain over the outer aspect of the elbow as well as pain with lifting and pain that sometimes awakened him at night. *Id.* With regard to the left shoulder, Petitioner reported pain if he moved it a lot. *Id.* With regard to the left elbow, Petitioner reported sometimes feeling as though a shockwave was going down his arm toward the hand which he localized posteriomedially. *Id.* With regard to the left knee, Petitioner reported pain primarily over the front of the knee, which worsened with ladders, driving or walking. *Id.*

After an examination, Dr. Karlsson diagnosed Petitioner with chondromalacia and osteoarthritis of the left knee unrelated to work, lateral epicondylitis of the left elbow, and rotator cuff syndrome of the right shoulder. *Id.* Dr. Karlsson found no objective abnormalities in the left upper extremity. *Id.*

Dr. Karlsson opined that Petitioner's left knee condition was completely unrelated to the accident at work. *Id.* He also opined that Petitioner's right elbow and right shoulder conditions as well as the need for further medical treatment were causally related to the accident at work. *Id.* Dr. Karlsson restricted Petitioner from overhead work with the right arm, indicated that he could perform the reaching activities of his job with his left arm, and indicated that narcotic pain medications were not appropriate. *Id.*

Continued Medical Treatment

On January 17, 2013, Petitioner saw Dr. Fuentes reported only two days of relief with the cortisone injection into the left knee and continued bilateral elbow pain, worse on the left, with a shooting pain down the left forearm to the hand. PX4 at 14-17; RX6 at 7. Dr. Fuentes ordered a left upper extremity EMG to rule out left ulnar neuropathy. *Id.*

On January 28, 2013, Petitioner underwent the recommended right shoulder MRI. PX2 at 19-20; RX5. The interpreting radiologist noted mild supraspinatus tendinopathy without evidence for full thickness rotator cuff

tear, moderate arthrosis of the AC joint with associate edema, inflammatory changes and narrowing of the supraspinatus outlet (recommending clinical correlation to rule out impingement syndrome), anchoring or the right biceps relating to previous surgery, and no significant joint effusion. *Id.*

On February 1, 2013, Petitioner returned to Dr. Templin reporting continued pain in the back, neck, arms, and legs with most of the pain localized to the lower back. PX2 at 21-23. He also reported completing physical therapy, which provided no benefit and continued pain at a level of 8/10. *Id.* Dr. Templin noted that, given Petitioner's widespread pain, a referral to a pain management physician was appropriate. *Id.* Petitioner remained on work restrictions. *Id.*

On February 7, 2013, Petitioner saw Dr. Fuentes reporting "right shoulder pain secondary to the fall in October of 2012, this while he was at work." PX4 at 19-20; RX6 at 5. Petitioner had pain on shoulder abduction beyond 90 degrees and positive Kennedy's and Neer's impingement signs. *Id.* Dr. Fuentes diagnosed right shoulder impingement, degenerative joint disease of the left knee with patellofemoral pain, and status post contusions of both elbows, rule out left-sided ulnar neuropathy. *Id.* He ordered continued physical therapy to include the right shoulder and administered a cortisone injection into the right shoulder. *Id.*

Petitioner testified that he then saw Samir Sharma, M.D. ("Dr. Sharma") as referred by Dr. Templin. The medical records reflect an initial visit with Dr. Sharma on February 11, 2013. PX5 at 6-16. Petitioner reported neck and back pain after his fall at work. *Id.* Dr. Sharma diagnosed Petitioner with neck pain, cervical myositis, low back pain, a lumbar strain, and lumbosacral radiculitis. *Id.* He recommended a transforaminal epidural steroid injection for the low back pain and radiculopathy. *Id.*

Petitioner returned to Dr. Sharma on February 18, 2013 reporting neck and back pain. PX2 at 24-26; PX5 at 17-20. Dr. Sharma recommended and administered a lumbar epidural steroid injection. *Id.* Petitioner then returned to Dr. Templin on March 8, 2013 at which time he reported continued pain mostly in the lower back extending into the right leg as well as somewhat into the left leg. PX2 at 27-28. Dr. Templin kept Petitioner on light duty work restrictions while undergoing treatment with Dr. Sharma. *Id.*

On March 7, 2013, Petitioner returned to Dr. Fuentes reporting left knee pain, right shoulder pain and pain in both shoulders. PX4 at 21-24. Dr. Fuentes continued to recommend a left upper extremity EMG. *Id.*

On March 20, 2013, Petitioner saw Dr. Sharma reporting continued neck and lower back pain. PX2 at 35-37; PX5 at 24-27. Dr. Sharma recommended and administered a lumbar intra-articular facet joint injection of the L4-L5 and L5-S1 joints. *Id.* Petitioner returned to Dr. Templin on April 16, 2013. PX2 at 38-45; PX5 at 31. Dr. Templin noted that Petitioner had failed conservative treatment in the form of physical therapy and injections. *Id.* He recommended rehabilitation through additional physical therapy and work conditioning, which he had yet been unable to do given his pain, or a discogram to determine whether Petitioner was a surgical candidate. *Id.* Dr. Templin kept Petitioner on light duty work restrictions. *Id.*

As of April 4, 2013, Dr. Fuentes believed that Petitioner may have left cubital tunnel syndrome, and continued to recommend a left upper extremity EMG. PX4 at 25-26; RX6 at 3. On May 1, 2013, Petitioner underwent the EMG/NCV of the left arm after falling at work onto his left elbow with ongoing radiating pain, numbness and tingling. PX2 at 46-47. The results were normal. *Id.*

Third Section 12 Examination – Dr. Karlsson

On May 1, 2013, Petitioner underwent a second medical evaluation at Respondent's request with Dr. Karlsson. RX1 (Group Dep. Exh. 3). Dr. Karlsson's report reflects that he took additional history from Petitioner, examined him, reviewed various interim treating medical records, and rendered opinions regarding his physical condition in the right shoulder and right elbow. *Id.*

Dr. Karlsson diagnosed Petitioner with right rotator cuff tendinitis and AC arthropathy as well as lateral epicondylitis of the right elbow. *Id.* He opined that Petitioner's rotator cuff tendinitis could be related to his injury at work, but that the AC arthritis was solely a pre-existing and degenerative condition. *Id.* Dr. Karlsson indicated that Petitioner was a candidate for further treatment to the right shoulder including an injection, if needed, followed by surgery and post-operative physical therapy as well as an injection to the right elbow. *Id.* He indicated that "[b]oth the injection of the elbow and the surgery or injection to the shoulder, if it has not already been given, would be related to the October 14, 2012 injury." *Id.* Dr. Karlsson maintained that Petitioner could perform his full duty work and indicated that narcotic pain medications were not necessary. *Id.*

Continued Medical Treatment

Petitioner returned to Dr. Fuentes on May 2, 2013 and was released back to full duty work. PX4 at 27-28. Also on May 2, 2013, Petitioner saw Dr. Sharma who refilled his prescription pain medications and instructed him to follow up after his discogram. PX5 at 32-34.

On June 7, 2013, Petitioner underwent the lumbar discogram, which was performed by Dr. Sharma as ordered by Dr. Templin. PX2 at 49-51; PX5 at 35-38, 50-52, 55-57. Dr. Sharma noted concordant pain at L4-L5 and L5-S1. *Id.* Petitioner's post-discogram CT scan showed a small focal contained central protrusion at L4-L5 and a diffuse contained protrusion at L5-S1. PX2 at 48.

Petitioner returned to Dr. Fuentes on June 27, 2013 and was again discharged from care and released to full duty work. PX4 at 29; RX6 at 1.

On July 19, 2013, Petitioner returned to Dr. Templin. PX2 at 52-61. Noting the results of the discogram, Dr. Templin recommended a two-level fusion surgery. *Id.* However, Petitioner declined surgery at that point indicating that he wished to return to work. *Id.* On cross examination, Petitioner testified that he did not recall telling Dr. Templin that he did not want surgery. The medical records reflect that Dr. Templin ordered a functional capacity evaluation and follow up visit after a return to work to determine how to proceed. *Id.*

Petitioner underwent the recommended functional capacity evaluation on August 8, 2013. PX2 at 64-70; PX8; RX7. The evaluating physical therapist found the test results to be valid and representative of Petitioner's ability to work at the light-to-medium demand level. *Id.* Petitioner's job duties as a truck driver/groundsman were considered to be at the medium physical demand level. *Id.*

On August 26, 2013, Petitioner saw Leah Urbanowsky, M.D. ("Dr. Urbanowsky") at Hinsdale Orthopaedics as referred by her colleague, Dr. Templin. PX2 at 74-78. Petitioner reported bilateral shoulder and elbow pain when raising his arms and lifting as well as other symptoms radiating into the fingers. *Id.* However, Petitioner's complaints were worst in the right shoulder. *Id.* On examination, Petitioner had tenderness in the right elbow and decreased flexion and extension in the right shoulder as well as positive impingement and Yergason's tests. *Id.* Dr. Urbanowsky diagnosed right shoulder impingement syndrome, secondary bursitis, and

right elbow lateral epicondylitis. *Id.* She administered a right shoulder subacromial bursa injection, ordered physical therapy, prescribed medications, fitted Petitioner for a right wrist cock up splint, and placed Petitioner off work. *Id.*

On September 13, 2013, Petitioner returned to Dr. Templin. PX2 at 85-88. Dr. Templin cleared Petitioner to work within the restrictions outlined by the functional capacity evaluation and noted that he had as of that visit continued to decline surgery. *Id.* He was to return as needed. *Id.*

Petitioner continued in physical therapy for the right shoulder and right elbow and returned to Dr. Urbanowsky on September 30, 2013. PX2 at 95-100. He reported pain in the right posterior shoulder, lateral elbow, and ulnar wrist as well as pain in the left elbow. *Id.* After an examination, Dr. Urbanowsky diagnosed Petitioner with right lateral epicondylitis, bilateral carpal tunnel syndrome, neck pain, and right shoulder pain unresponsive to therapy and injections. *Id.* She discontinued physical therapy, as it was not helpful, maintained the work restrictions imposed by Dr. Templin, and ordered a bilateral EMG. *Id.*

Petitioner continued to see Dr. Sharma for follow up and medication refills due to his low back pain through October 14, 2013. PX5 at 64-76. On this date, Dr. Sharma ordered an updated lumbar MRI. PX5 at 74-76.

On November 22, 2013, Dr. Urbanowsky noted that Petitioner's bilateral EMG was negative. PX2 at 101-105. She maintained Petitioner's diagnoses noting that the bilateral carpal tunnel syndrome was a clinical diagnosis, and administered a second subacromial bursa injection for diagnostic purposes. *Id.* Dr. Urbanowsky ordered a right elbow MRI and recommended a right shoulder arthroscopy with inspection of the bicep tendon and rotator cuff, acromioplasty, distal clavicle resection, and debridement as necessary. *Id.*

On December 5, 2013, Petitioner underwent the right elbow MRI. PX2 at 111-112. He reported that he fell and injured his right elbow. *Id.* The interpreting radiologist noted to show elbow joint effusion, common extensor tendinosis that was likely post-traumatic, and no other abnormality. *Id.*

Narrative Report – Dr. Templin

On December 6, 2013, Dr. Templin authored a narrative report regarding his treatment of Petitioner's neck, mid back, and low back as a result of his accident at work. RX19 (Dep. Exh. 2). Dr. Templin noted his review of Petitioner's medical records from other treating physicians. *Id.* He diagnosed Petitioner with lumbar degenerative disease, discogenic low back pain, cervical and thoracic strains, and cervical and thoracic spondylosis. *Id.* Dr. Templin also rendered various opinions about Petitioner's condition of ill-being and relation, if any, to his accident at work. *Id.*

Specifically, Dr. Templin opined that Petitioner's injury at work on October 14, 2012, more likely than not, caused Petitioner's current condition of ill-being. RX19 (Dep. Exh. 2). He explained that Petitioner had a pre-existing condition in the spine, which was "aggravated by the axial load imparted to his spine when falling approximately 5 feet and landing on his buttocks loading the spine." *Id.* Dr. Templin noted that Petitioner had continued pain since his accident and that it was probable that his injury at work contributed to his current condition. *Id.* With regard to future medical treatment, Dr. Templin noted that Petitioner had declined the surgery he recommended. *Id.* Thus, he recommended pain management treatment as well as a home exercise program. *Id.* Dr. Templin also indicated that Petitioner should be restricted to light-to-medium physical demand level work consistent with the results of the functional capacity evaluation. *Id.*

Continued Medical Treatment

On December 23, 2013, Dr. Urbanowsky noted Petitioner's report of numbness down his entire right arm, pain in the elbow, and anterior and posterior shoulder pain that worsened with movement. PX2 at 113-119. She kept Petitioner off work and continued to recommend right shoulder surgery. *Id.*

Fourth Section 12 Examination – Dr. Karlsson

On January 16, 2014, Petitioner saw Dr. Karlsson a third time at Respondent's request. RX1 (Group Dep. Exh. 3). Dr. Karlsson's report reflects that he took additional history from Petitioner, examined him, reviewed various interim treating medical records, and rendered opinions regarding his physical condition in the right shoulder and right elbow. *Id.*

Dr. Karlsson diagnosed Petitioner with right shoulder rotator cuff tendinitis and lateral epicondylitis of the right elbow, which were related to his injury at work on October 14, 2012. *Id.* However, Dr. Karlsson opined that Petitioner did not need surgery to the right shoulder at this time. *Id.* In so concluding, he noted that Petitioner had injections to the right shoulder with absolutely no relief and no evidence of a tear in the shoulder. *Id.* Thus, Dr. Karlsson recommended a home exercise program only. *Id.* With regard to the right elbow, Dr. Karlsson also found that no further medical treatment was necessary. *Id.* In reaching this conclusion, he noted that Petitioner had "complaints of tenderness diffusely around the elbow, though greater on the lateral epicondyle. Yet, he has no pain with resisted wrist extension. I do not feel he is a candidate for further treatment of the elbow either." *Id.*

Dr. Karlsson maintained that Petitioner could work his full duty job as outlined in the job description of July 8, 2008, no narcotic medications were necessary, and he concluded that Petitioner had reached maximum medical improvement with regard to his injury at work. *Id.*

Continued Medical Treatment

Petitioner returned to Dr. Urbanowsky on February 10, 2014. PX2 at 121-126. She continued to recommend right shoulder surgery and also recommended a right elbow lateral epicondylar PRP injection. *Id.* Petitioner remained off work per Dr. Urbanowsky's orders. *Id.*

On March 21, 2014, Petitioner underwent the recommended right elbow injection with Dr. Urbanowsky and remained on work restrictions. PX2 at 133-136.

On March 31, 2014, Petitioner returned to see Dr. Templin about his ongoing low back pain. PX2 at 137-138. Dr. Templin noted that Petitioner wished to proceed with surgery. *Id.*

Fifth Section 12 Examination & AMA Guides Rating – Dr. Andersson

On April 1, 2014, Petitioner returned to Dr. Andersson a second time at Respondent's request. RX2 (Dep. Exh. 3). Dr. Andersson's report reflects that he took additional history from Petitioner, examined him, reviewed various interim treating medical records, and rendered opinions regarding his physical condition. *Id.*

Dr. Andersson stated that it was "difficult to understand how a patient from a fall can develop degenerative changes requiring surgery without having any evidence of a herniation or vertebral fracture. Clearly the degenerative changes have no relationship to the alleged accident. I also think that the surgical indication is in question particularly since this patient underwent a functional capacity evaluation which would allow him to return to his previous job without restrictions. ... I think this patient has reach maximum medical improvement and that he is capable of performing his job as a ground man without any restrictions. I do not believe that the patient requires surgery as a result of the occupational injury." *Id.*

With regard to Petitioner's cervical condition, Dr. Andersson maintained that Petitioner sustained a contusion and possible sprain with only occasional complaints of neck pain and no objective findings. *Id.* Dr. Andersson also determined that Petitioner had an impairment of class 1, grade B with impairment of 1% of the whole person. *Id.*

Continued Medical Treatment

On May 7, 2014, Petitioner returned to Dr. Urbanowsky and saw her certified physician's assistant, Matthew Schneider, PA-C. PX2 at 139-142. Mr. Schneider maintained Petitioner's diagnoses as assessed by Dr. Urbanowsky and recommended a series of three injections for the right lateral epicondylitis. *Id.* Petitioner remained on light duty work restrictions. *Id.*

Deposition Testimony – Dr. Templin

Petitioner called Dr. Templin as a witness and he provided testimony at an evidence deposition on May 23, 2014. RX19. Dr. Templin testified that he is a board certified orthopedic surgeon. RX19 at 4-5; RX19 (Dep. Exh. 1). Dr. Templin testified consistent with the information contained in his narrative report. *See generally* RX19. He also explained his opinions. *Id.*

Dr. Templin maintained that Petitioner's condition in the spine was causally related to his accident at work because he sustained an axial load injury to the spine, which disrupted the disc and aggravated his pain. RX19 at 14-15. He explained that an axial load injury occurs when a disc is compressed. RX19 at 15. A degenerative disc does not have the ability to manage such stress and the annulus of the disc can tear and aggravate pain. *Id.* Dr. Templin testified that none of his opinions regarding Petitioner's diagnoses or causal connection have changed since December 6, 2013. RX19 at 18-19. He understood that Petitioner had no treatment to the low back and was asymptomatic prior to his accident at work, but acknowledged that he did not have any treating medical records related to the back other than those of Dr. Fuentes related to Petitioner's extremities. RX19 at 32-33.

On cross examination, Dr. Templin testified that regarding certain abilities noted by the evaluating physical therapist at the time of Petitioner's functional capacity evaluation on August 8, 2013. RX19 at 21-22. Dr. Templin acknowledged that the physical therapist did not have Petitioner's job description as a ground man available to him at the time of the functional capacity evaluation. *Id.* He also acknowledged that the functional capacity evaluation showed that Petitioner was able to occasionally lift 41.2 pounds from chair to floor, 39 pounds from desk to chair, and 28 pounds to the shoulders. *Id.* Dr. Templin agreed that, if all that Petitioner's job for Respondent required him to carry was inner box connector locks weighing 14 pounds up to 52 feet, then Petitioner could do this with pain if he decided to do so. RX19 at 22-23.

On cross examination Dr. Templin also testified that that at the time he initially examined Petitioner, he noted an intact neurological examination and negative straight leg raise test. RX19 at 23-24. Dr. Templin acknowledged that Petitioner was 51 years old at the time of his initial treatment and the MRI findings of mild disc protrusion at L4-L5 and L5-S1 could be consistent with degeneration due to aging. RX19 at 25. He explained that Petitioner's pain was musculoskeletal or discogenic, and that Petitioner's MRI showed no compression such that Petitioner's complaints of pain extending upward were not radicular caused by nerve root compression. RX19 at 25-26. He testified that Petitioner's problems were not radicular in nature. RX19 at 30-31.

Deposition Testimony – Dr. Karlsson

Respondent called Dr. Karlsson as a witness and he provided testimony at an evidence deposition on June 2, 2014. RX1. Dr. Karlsson testified that he is a board certified orthopedic surgeon. RX1 at 5-8; RX1 (Dep. Exh. 1). Dr. Karlsson testified consistent with the information and opinions contained in his Section 12 examination reports. *See generally* RX1. He also testified consistent with the opinions rendered in his various reports. *Id.*

Ultimately, Dr. Karlsson opined that Petitioner had right shoulder rotator cuff tendonitis and right elbow lateral epicondylitis that were causally related to his injury at work as well as AC joint arthritis that was unrelated to his injury at work. RX1 at 43, 62. He maintained that Petitioner did not require any surgery for the right shoulder because he did not have at least a temporary response to any of the injections he had to the shoulder and no evidence of a tear or structural damage in his MRI. RX1 at 43-45. Dr. Karlsson also maintained that Petitioner was not a candidate for any elbow surgery because of his diffuse complaints of tenderness around the elbow, not localized to the lateral epicondyle, and his and Dr. Urbanowsky's inability to reproduce pain with resisted use of the muscles attached to the lateral epicondyle. RX1 at 45-46. Dr. Karlsson further testified that Petitioner could perform all of the duties of a ground man when he compared the job description given to him to Petitioner's functional capacity evaluation results. RX1 at 41-42, 46, 47, 49.

On cross examination, Dr. Karlsson testified that he performs approximately 150 medical examinations per year virtually all requested by respondents. RX1 at 51-52. He acknowledged that Petitioner had no prior condition in either elbow and no shoulder problems in either shoulder for approximately 20 years. RX1 at 52. Dr. Karlsson also acknowledged that as of Petitioner's first and second evaluations, he recommended further diagnostic tests and treatment for the right shoulder and right elbow. RX1 at 53-58.

On re-direct examination, Dr. Karlsson testified that Petitioner's physical presentation changed between the second and third evaluations. RX1 at 63-64. He testified that he was able to reproduce elbow pain with resisted wrist extension and Petitioner pointed to the area that he would expect to hurt with epicondylitis; this was not the case at Petitioner's third evaluation with Dr. Karlsson. RX1 at 63-64. Dr. Karlsson testified that he wondered if Petitioner's elbow condition had improved with treatment or time after his second evaluation. *Id.*

Continued Medical Treatment

On June 4, 2014, Dr. Urbanowsky continued to recommend right shoulder surgery and a series of injections for the right elbow. PX2 at 144-149. She also kept Petitioner restricted to light duty work. *Id.* On July 9, 2014,

Dr. Urbanowsky administered a third right shoulder subacromial bursa injection and maintained her treatment recommendations for the right shoulder and right elbow. PX2 at 150-154.

Deposition Testimony – Dr. Andersson

Respondent called Dr. Andersson as a witness and he provided testimony at an evidence deposition on October 8, 2014. RX2. Dr. Andersson testified that he is a board certified orthopedic surgeon. RX2 at 4-7; RX2 (Dep. Exh. 1). Dr. Andersson testified consistent with the information and opinions contained in his Section 12 examination reports. *See generally* RX2.

Specifically, Dr. Andersson testified that as of his first evaluation he believed that Petitioner contused his back and neck as a result of his accident at work and that his MRIs showed no evidence of structural damage caused by his accident. RX2 at 12-13. He believed that Petitioner would benefit from four additional weeks of physical therapy and that he did not require narcotic pain medication. RX2 at 13-14.

As of Petitioner's second evaluation, Dr. Andersson noted that Petitioner had no further complaints in the upper back or neck, and he found that Petitioner's low back MRI showed degenerative changes at L4-5 and L5-S1 with small central annular tears, no evidence of spinal stenosis, and mild protrusions at both levels evidenced by Petitioner's post-discography CT scan. RX2 at 18-19. Dr. Andersson maintained that Petitioner sustained contusions and that his ongoing symptoms were related to his degenerative condition in the back only. RX2 at 20-21. He indicated that Petitioner did not need any surgery. RX2 at 22-23.

Finally, Dr. Andersson explained how he reached the conclusion pursuant to the AMA Guides Sixth Edition that Petitioner had a zero impairment rating with regard to the neck and a 1% impairment rating with regard to the low back. RX2 at 23-25.

On cross examination, Dr. Andersson testified that a fall of the type sustained by Petitioner could cause an asymptomatic condition in the lumbar spine to become symptomatic. RX2 at 33.

Continued Medical Treatment & Narrative Report (Dr. Urbanowsky)

Petitioner returned to Dr. Urbanowsky on several occasions beginning August 22, 2014 through April 27, 2015. PX2 at 157-186. She continued to recommend a right shoulder arthroscopy with inspection of the bicep tendon and rotator cuff, acromioplasty, distal clavicle resection, and debridement as necessary as well as right lateral PRP injections for the right elbow. *Id.* Dr. Urbanowsky also kept Petitioner on light duty work restrictions throughout this period of time. *Id.* Petitioner testified that he continues to be on work restrictions.

In the interim, Dr. Urbanowsky issued a narrative report in September of 2014 at Petitioner's counsel's request. RX18 at 9; RX18 (Dep. Exh. 2). She reviewed her own medical records relating to Petitioner's treatment, medical records from Petitioner's other treating physicians, as well as the reports of Dr. Karlsson. RX18 at 9-26; RX18 (Dep. Exh. 2).

In her report, Dr. Urbanowsky diagnosed Petitioner with (1) right shoulder subacromial bursitis, supraspinatus tendinosis, and AC arthrosis all contributing to secondary impingement temporarily responsive to injection, nonresponsive to medication, therapy and rest; and (2) right elbow lateral epicondylitis, minimally responsive to medication, splinting, rest, and therapy with 40% transient pain relief with local anesthetic present post-injection. RX18 (Dep. Exh. 2). She opined that these conditions were causally related to Petitioner's accident

at work. *Id.* In so concluding, Dr. Urbanowsky noted that Petitioner reported these symptoms at the emergency room on the date of injury and throughout his medical care with herself and his other physicians and therapists. *Id.*

Dr. Urbanowsky noted that the mechanism of injury reported by Petitioner to her and throughout his medical records are consistent regarding a fall from a railcar backwards onto concrete and that "[b]asic instinct would be to reach back with the arms to break the fall, which would explain both the right shoulder and right elbow pains. Regardless of prior history of shoulder surgery as well as presence of acromioclavicular arthritis, this mechanism of injury does explain perpetuation of his symptoms." RX18 (Dep. Exh. 2). She opined that Petitioner's right shoulder pain including subacromial bursitis/impingement resulted from his accident at work and that his pre-existing osteoarthritis was asymptomatic and aggravated by the accident. *Id.* Dr. Urbanowsky also opined that Petitioner's right elbow pain resulted from the fall at work noting that he had no prior complaints in the right elbow. *Id.*

Dr. Urbanowsky disagreed with the opinions of Dr. Karlsson. RX18 (Dep. Exh. 2). She noted that Petitioner did show improvement after his injections into the shoulder and elbow, although the relief was only temporary, showing that his response made him a good surgical candidate. *Id.* Dr. Urbanowsky recommended right shoulder surgery and a right elbow PRP injection with work restrictions including no lifting over 30 pounds or overhead reaching or lifting. *Id.*

Deposition Testimony – Dr. Urbanowsky

Petitioner called Dr. Urbanowsky as a witness and she provided testimony at an evidence deposition on February 18, 2015. RX18. Dr. Urbanowsky testified that she is a board certified orthopedic surgeon specializing in upper extremity, including the elbow and shoulder, as well as microvascular surgery in addition to a certificate for added qualification in surgery of the hand. RX18 at 4-5; RX18 (Dep. Exh. 1). Dr. Urbanowsky testified consistent with the information contained in her medical records. *See generally* RX18.

Specifically, Dr. Urbanowsky testified consistent with the opinions in her report that Petitioner's right shoulder and right elbow conditions were causally related to the accident at work, noting that he was asymptomatic in the shoulder and elbow prior to his accident. RX18 at 27-29. She recommended a right shoulder arthroscopy with subacromial decompression to include acromioplasty as necessary, distal clavicle resection, extensive bursectomy and smoothing of any partial thickness rotator cuff tears and assessing the biceps for any needed tenodesis. RX18 at 29. She also testified that Petitioner was not at maximum medical improvement without surgery and that his work restrictions were necessary as a result of Petitioner's condition after his accident at work. RX18 at 32-33.

Timothy Sullivan

Respondent called Timothy Sullivan ("Mr. Sullivan") as a witness. He testified that he is an Assistant Terminal Manager and has been employed by Respondent since November of 2005. Mr. Sullivan testified that Respondent loads and unloads trains for other companies. He works at the Elwood Logistics Park Chicago ("LPC"). Mr. Sullivan testified that he is in charge of anyone that is on the Respondent's property at any given time, including ground men. Mr. Sullivan reviewed Respondent's Exhibit 3, the ground man job description.

Mr. Sullivan explained that there are some duties at the Elwood LPC that a ground man does not have to perform. Mr. Sullivan testified that ground men are trained to direct cranes using hand signals, load and unload

trains, lock and unlock interlock connectors (a.k.a. "IBCs") which keep containers attached to the railcars, climb up and down ladders, and warn operators of obstacles on the tracks. Mr. Sullivan explained that an IBC has two-cone shaped pieces and an 8" handle to spin cones together to lock or unlock them. He also testified that a pedestal is on a flat car where you would seat the container for that car style. He explained that it is used to lock the car, but pedestals are not used at the Elwood LBC because they do not receive that type of car at the facility.

Mr. Sullivan testified that a ground man can do his job at the LPC without lifting over 30 pounds. He explained that the IBCs have to be lifted, but weigh only 14-15 pounds and, when standing on the platform, the IBCs are at chest/face level. Mr. Sullivan also testified that anything relating to a trailer is not required at the Elwood LPC and that the duties listed in numbers 4, 13, 14 &15 are not performed at the Elwood LPC.

Additional Information

Beginning on April 16, 2014, Petitioner testified that he worked for another employer, Crown Services, a temporary staffing company as a truck driver and doing spotting work. Petitioner testified that he has to bag up grain underneath, open doors and take trailers out to the parking lot area and drop trailers there. He would also let down the landing gear using a crank and he would wind the dolly legs down to the ground, which he explained requires very little force. Petitioner testified that he is not expected to lift anything at all and he is on his feet very little (i.e., 3 hours at the most throughout the day), he does not climb ladders, and the pace of work is slow, without rush.

While performing his job for Crown, he testified that his back hurt really badly when he sat for long periods of time. He experienced shooting pain, stiffness, radiating symptoms down his legs and pain in the lower back and into the buttocks. With regard to his right shoulder, Petitioner testified that he experienced pain when pulling pins and "dollying" down the trailer legs and operating the truck steering wheel. Petitioner also testified that he had a lot of pain in his right elbow when lowering the trailer legs.

On cross examination, Petitioner also testified that he worked for Crown Services driving a spotter truck in Joliet for Midwest Bulk. He explained that he did the grain filling work for about one month from April 15, 2014 until sometime in May of 2014, and he did not work there in 2013. *See* RX9 (Petitioner's 2014 W-2 wage and tax statements). Petitioner could not recall an employer named "MI" for which he worked in 2014 and earned $728. *Id.*

On cross examination, Petitioner further testified that he began working for CCS Trucking on May 29, 2014 and that he remains a current employee. He drives an 18-wheeler tractor trailer and performs mostly local driving as well as some interstate driving. Petitioner testified that he has to connect the tractor to the trailer using the fifth wheel. With regard to the physical responsibilities of the job, Petitioner testified that he hooks electrical components and air-lines, and cranks dolly legs up or down depending on whether he is hitching or dropping the trailer. Petitioner testified that he does not unload the contents of the trailers; that work is done by dock workers at the destination sites. He also testified that this work is within Dr. Templin and Dr. Urbanowsky's restrictions. Petitioner testified that he earned $24.00 per hour for CCS Trucking in 2015 and $23.50 per hour in 2014. *See* RX9 (Petitioner's 2014 W-2 wage and tax statements).

On cross examination, Petitioner also testified that he could not perform his job for Respondent with the job restrictions imposed by Dr. Urbanowsky. Petitioner testified that he wants to undergo the recommended surgeries to the low back, right shoulder and right elbow injection. Petitioner testified that he has not had any

new injuries. He also testified that he stays within the work restrictions given to him by Dr. Templin and Dr. Urbanowsky while working.

Petitioner also acknowledged that he has filed prior workers' compensation claims. He had a settlement for $140,000 against Newberg Construction working on a Commonwealth Edison nuclear plant as a laborer after an accident on April 3, 1989. He testified that he saw doctors for his right shoulder and torn biceps tendon and underwent surgery. Petitioner testified that he could not go back to work as a construction laborer per his doctors' orders. Petitioner also had an injury in the left arm in 1996 at Argonne National Laboratory. RX4.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows:

In support of the Arbitrator's decision relating to Issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

To recover in a preexisting condition case, a claimant need only establish a causal connection between his work-related injury and claimed current condition of ill-being by showing that his injury aggravated or accelerated the preexisting disease. *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193, 204-206, (2003) (*citing Caterpillar Tractor Co. v. Industrial Commission*, 92 Ill. 2d 30, 36-37 (1982) (an accidental injury will be deemed compensable if it can be shown that the employment was also a causative factor)). It has long been held that an employer takes its employees as it finds them. *Sisbro*, 207 Ill. 2d at 205 (*citing Baggett v. Industrial Commission*, 201 Ill.2d 187, 199 (2003)). As in this case, even where an employee has a pre-existing condition that renders him more vulnerable to an injury, "recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor." *See Sisbro*, 207 Ill. 2d at 205 (*citing Caterpillar Tractor Co. v. Industrial Commission*, 92 Ill. 2d at 36; *Williams v. Industrial Commission*, 85 Ill. 2d 117, 122 (1981); *County of Cook v. Industrial Commission*, 69 Ill. 2d 10, 18 (1977)).

Petitioner claims injury to various body parts as a result of his undisputed accident. Specifically, he asserts injury to the low back, right shoulder, right elbow, left elbow, and left knee. Petitioner also received some medical treatment to the neck, which appears to have been minimal. In light of the record as a whole, the Arbitrator finds that Petitioner has established a causal connection between his current condition of ill-being and his accident at work. In so concluding, the Arbitrator first addresses the several body parts for which no further medical treatment is being requested.

With regard to the cervical spine, the Arbitrator notes that Petitioner initially complained of pain and symptoms in the neck when he received emergency care. Thereafter, he sought medical treatment with Drs. Singh, Templin, Sharma, and Urbanowsky. Petitioner reported neck pain to all of these physicians as well as to Respondent's Section 12 examiner, Dr. Andersson. However, the medical records reflect very limited treatment to the neck. Indeed, Petitioner had no focused treatment to the cervical spine despite ongoing complaints of neck pain. He was diagnosed with a cervical strain by his primary care physician, Dr. Singh, and subjectively reported ongoing neck pain which his other physicians diagnosed. Petitioner was evaluated by Dr. Andersson on two occasions regarding the neck at Respondent's request, and he opined that Petitioner sustained contusions to the neck only. Notably, no treatment has been recommended by Petitioner's treating physicians for the

cervical spine although he continues to report neck pain without any change in condition. Moreover, no physician has opined that Petitioner's ongoing symptoms in the neck are causally related to the accident at work. Thus, the Arbitrator finds that Petitioner has reached maximum medical improvement with regard to the cervical spine as opined by Dr. Andersson in his April 1, 2014 Section 12 report. A determination regarding permanent partial disability, if any, is deferred to final resolution of Petitioner's case.

With regard to the left knee, the record reflects that Petitioner reported left knee pain immediately after his accident at work. He then reported left knee pain to his primary care physician, Dr. Singh, who referred him to a specialist, Dr. Fuentes, for further care. Petitioner underwent a left knee MRI, a course of physical therapy, and a cortisone injection into the left knee as ordered by Dr. Fuentes. Dr. Fuentes diagnosed Petitioner with degenerative joint disease of the left knee with patellofemoral pain through May 2, 2013. On this date, Dr. Fuentes diagnosed status post left knee contusion and he released Petitioner back to full duty work with regard to his left knee. There is no evidence that Petitioner had any left knee injury or medical treatment before his accident at work, and his testimony at trial relating the left knee condition is corroborated by the medical records. Thus, the Arbitrator finds that Petitioner has established causal connection between his left knee condition and his accident at work. A determination regarding permanent partial disability, if any, is deferred to final resolution of Petitioner's case.

Petitioner also claims an ongoing condition in the left elbow. He immediately reported bilateral elbow pain in the emergency room and underwent follow up case with Dr. Singh and Dr. Fuentes thereafter. Dr. Fuentes diagnosed bilateral epicondylitis, status post contusion for which Petitioner underwent physical therapy. He released Petitioner from care and back to full duty work on May 2, 2013. Thereafter, Petitioner reported some transient left elbow pain to Dr. Urbanowsky, but that those complaints seemed to remit without the need for injection or further care. There is no evidence that Petitioner had any left elbow injury or medical treatment before his accident at work, and his testimony at trial relating the left elbow is corroborated by the medical records. Thus, the Arbitrator finds that Petitioner has established causal connection between his left elbow condition and his accident at work. A determination regarding permanent partial disability, if any, is deferred to final resolution of Petitioner's case.

The most readily disputed injuries relate to Petitioner's low back, right shoulder and right elbow. Petitioner seeks further medical treatment pursuant to Section 8(a) with regard to these body parts. In light of the record as a whole, the Arbitrator finds that Petitioner has established causal connection between his current condition of ill-being in the low back, right shoulder, and right elbow and his accident at work. In so concluding, several undisputed facts are significant.

Petitioner had no complaints or medical treatment relative to the low back or right elbow before his accident at work. He did have significant treatment to the right shoulder including a surgery, but this occurred in the late 1980's. In the decades that followed, Petitioner worked several different, full duty jobs. He did not receive any medical treatment to the right shoulder during those years until after his October 14, 2012 accident. While it is also clear that Petitioner had pre-existing degeneration in the lumbar spine and right shoulder at the time of his accident, he only became symptomatic immediately after his accident prompting emergency room care and, ultimately, a recommendation for a low back surgery, right shoulder surgery, and right elbow injections.

With regard to the low back, Petitioner reported symptoms beginning on the date of accident which were consistently reported to emergency room, treating, and evaluating physicians alike. He also reported low back pain to Dr. Andersson when he underwent the first evaluation of the low back at Respondent's request on January 8, 2013. Dr. Andersson diagnosed Petitioner with contusions to the back that were related to the

accident at work and which required an additional four weeks of physical therapy. As of his second evaluation of Petitioner, Dr. Andersson maintained that Petitioner only sustained contusions and opined that he needed no further treatment. He concluded that Petitioner's ongoing low back condition was degenerative and no longer causally related to the accident at work. However, Dr. Andersson only saw Petitioner on two occasions. He acknowledged that Petitioner was asymptomatic in the low back before his accident at work. He also acknowledged at his deposition that a fall of the type sustained by Petitioner could cause an asymptomatic condition in the lumbar spine to become symptomatic. Regardless, Dr. Andersson maintained that Petitioner's lumbar condition was wholly unrelated to the accident at work beyond a contusion despite the mechanism of injury.

In contrast, Petitioner's treating physician, Dr. Templin, opined that Petitioner's low back condition was causally related to the accident on October 14, 2012. He examined Petitioner every six weeks or so during treatment in 2013 and continued to see Petitioner regularly thereafter while he was in pain management with Dr. Sharma and receiving care for the right shoulder and right elbow with Dr. Urbanowsky. In his narrative report and deposition testimony, Dr. Templin opined that Petitioner's accident, more likely than not, caused his low back condition. In so concluding, he acknowledged that Petitioner had a pre-existing condition in the spine; an agreement with Respondent's examiner, Dr. Andersson. However, Dr. Templin explained that this pre-existing lumbar condition was "aggravated by the axial load imparted to his spine when falling approximately 5 feet and landing on his buttocks loading the spine." RX19 (Dep. Exh. 2). He also noted that Petitioner had continued pain since his accident, which was a plausible response to the mechanism of injury.

In light of the totality of the evidence, the Arbitrator finds the opinions of Petitioner's treating physician, Dr. Templin, to be persuasive. Dr. Templin plausibly reasoned that the mechanism of Petitioner's injury was competent to cause the type of pain and symptoms that he experienced and highlighted the lack of prior back injuries, pain, or medical treatment. Dr. Andersson's opinions are simply unpersuasive given these facts, as are the opinions of Dr. Karlsson.

With regard to the right shoulder and right elbow, Petitioner also reported pain when he presented in the emergency room on the date of accident. He then saw his primary care physician, Dr. Singh, on October 22, 2012 and received follow up care with Dr. Fuentes reporting pain in the right or both shoulders and in the right or both elbows. On February 7, 2013, Petitioner received a cortisone injection into the right shoulder and sought further care of the right shoulder with Dr. Urbanowsky.

On August 26, 2013, Petitioner saw Dr. Urbanowsky reporting pain and symptoms in the bilateral arms, but his complaints were worst in the right shoulder. Dr. Urbanowsky diagnosed right shoulder impingement syndrome, secondary bursitis, and right elbow lateral epicondylitis and administered a right shoulder subacromial bursa injection. As of November 22, 2013, Dr. Urbanowsky recommended a right shoulder arthroscopy with inspection of the bicep tendon and rotator cuff, acromioplasty, distal clavicle resection, and debridement as necessary. As of February 10, 2014, Dr. Urbanowsky continued to recommend right shoulder surgery and also recommended a right elbow lateral epicondylar PRP injection. As of June 4, 2014, Dr. Urbanowsky continued to recommend right shoulder surgery and a series of injections for the right elbow. On July 9, 2014, Dr. Urbanowsky administered a third right shoulder subacromial bursa injection.

Petitioner then saw Dr. Karlsson at Respondent's request on January 16, 2013. He initially opined that Petitioner's right elbow and right shoulder conditions were causally related to the accident at work. Dr. Karlsson also imposed work restrictions, but felt that Petitioner could perform the reaching activities of his job with his left arm, and indicated that narcotic pain medications were not appropriate. As of May 1, 2013, Dr.

Karlsson opined that Petitioner's rotator cuff tendinitis and lateral epicondylitis of the right elbow were related to his injury at work, but maintained that he could perform his job and that he did not need narcotic pain medication. By the time of Petitioner's third evaluation with Dr. Karlsson on January 16, 2014, Dr. Karlsson again diagnosed Petitioner with right shoulder rotator cuff tendinitis and lateral epicondylitis of the right elbow, which were related to his injury at work on October 14, 2012, but he maintained that Petitioner did not need surgery to the right shoulder or right elbow because he had "absolutely" no relief from diagnostic injections, diffuse pain around the elbow, and no pain with resisted wrist extension.

In her narrative report, Dr. Urbanowsky disagreed with the opinions of Dr. Karlsson. In so doing, she explained that Petitioner did show improvement after his injections into the shoulder and pain with wrist extension during physical examinations, which were necessary to determine whether he was a surgical candidate. Dr. Urbanowsky also identified Petitioner's reports of improvement in her medical records which conflicted with Petitioner's generalized statements to Dr. Karlsson that the injections to the shoulder did not help his conditions. She explained that, although the relief from the injections was only temporary, evidence of such a response made him a good surgical candidate. Dr. Urbanowsky maintained that Petitioner would benefit from right shoulder surgery and a right elbow PRP injection with work restrictions including no lifting over 30 pounds or overhead reaching or lifting.

In light of the totality of the evidence, the Arbitrator finds the opinions of Petitioner's treating physician, Dr. Urbanowsky, to be persuasive. Dr. Urbanowsky explained how Petitioner's physical responses to the diagnostic injection and on physical examination showed that he was a good candidate for shoulder surgery and elbow injection despite any generalized statements he may have made as a patient that the treatment thus far had not benefited him at all. It is notable that Dr. Karlsson performs medical evaluations almost exclusively for respondents, but found over his three evaluations of Petitioner that the right shoulder and right elbow conditions were causally related to the accident at work. Dr. Karlsson's ultimate departure in opinion from Dr. Urbanowsky about Petitioner's need for further medical treatment, the type of medical treatment, or the type of work Petitioner could perform, are simply unpersuasive given these facts.

Thus, given the totality of the medical evidence in this record the Arbitrator finds that Petitioner has established causal connection between his low back, right shoulder, and right elbow conditions and his accident at work on October 14, 2012.

In support of the Arbitrator's decision relating to Issue (G), what were Petitioner's earnings/average weekly wage, the Arbitrator finds the following:

Petitioner asserts that his average weekly wage should total $770.07 per week including earnings in the year preceding the injury of $40,043.64 from Respondent as well as from another employer, Domino's Pizza. *See* AX1. Respondent asserts that Petitioner is only entitled to an average weekly wage totaling $540.00 with annual earnings of $28,080.00. *Id.* Section 10 of the Act states in pertinent part:

> When the employee is working concurrently with two or more employers and the respondent employer has knowledge of such employment prior to the injury, his wages from all such employers shall be considered as earned from the employer liable for compensation.

820 ILCS 305/10 (LEXIS 2011). In cases where a claimant works less than a full year before his injury, there are several methods to calculate the claimant's average weekly wage.

In *Sylve r*, the Illinois Supreme Court explained:

> [S ection 10 provides four different methods for calculating average weekly wage. (1) By default, a erage weekly wage is 'actual earnings' during the 52 week period preceeding the date of injury, illness o disablement, divided by 52. (2) If the employee lost five or more calendar days during the 52 week p riod, 'whether or not in the same week,' then the employee's earnings are divided not by 52, but by 'the n mber of weeks and parts thereof remaining after the time so lost has been deducted.' (3) *If the e ployee's employment began during the 52 week period, the earnings during employment are divided l 'the number of weeks and parts thereof during which the employee actually earned wages.'* (4) Finally, i he employment has been of such short duration or the terms of the employment of such casual nature t t it is 'impractical' to use one of the three above methods to calculate average weekly wage, 'regard s ll be had to the average weekly amount which during the 52 weeks previous to the injury, illness or d sablement was being or would have been earned by a person in the same grade employed at the same v ork for each of such 52 weeks for the same number of hours per week by the same employer.'

Sylveste v. Industrial Comm'n, 197 Ill. 2d 225, 230-31 (2001) (citing 820 ILCS 305/10 (West 1992) (*emphasis* added)).

Petitione s testified that his first day of work with Parsec was October 1, 2012, but his pay stubs reflect four hours of ork during the pay period beginning September 24, 2012 through September 30, 2012. PX9. From Septeml 24. 2012 through October 7, 2012 Petitioner earned $510.79 for 86.25 hours of work over three weeks. While working for Respondent, Petitioner testified that he worked five days per week and eight hours pe day, sometimes up to 12 hours per day while working overtime.

Petitione also submitted into evidence paychecks from NRJM, Inc., which he referred to as Domino's Pizza, showing is earnings during one week of concurrent employment for days worked from September 24, 2012 to October , 2012. PX10. During these dates, Petitioner earned $338.09 for 33.37 hours worked. *Id.* However, Petitione testified that he began working for Respondent on October 1, 2012 and his pay stubs show that he worked f of one day (4 hours) before October 1, 2012. PX9.

Petitione further testified that he interviewed with Respondent several days before he was hired and worked for Respone nt from October 1, 2012 until June 30, 2013. He explained that Respondent was aware of his concurre t employment because he noted the work with Domino's on his application and informed Respondent during h s interview for the position. No evidence was submitted to the contrary.

In light of the evidence presented, the Arbitrator finds that Petitioner established earnings of $33,855.12 with an average eekly wage of $651.07. Petitioner actually earned $1,348.61 during the 52 week period before his accident hile working for Respondent. This amount is reached by adding Petitioner's gross earnings from his employ nt with Respondent plus half of his gross earnings for employment with Domino's Pizza[3] while working r Respondent ($1,179.56 + $169.05). Petitioner's actual earnings amount of $1,348.61 is then divided the weeks and parts thereof (14 ½ days) resulting in an average weekly wage of $651.07. The average eekly wage is then multiplied by 52 weeks resulting in a yearly earnings amount of $33,855.12.

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[3] While it unclear exactly how many hours Petitioner worked during the pay period from September 24, 2012 through October 7, 2012, it is so unclear on what day or days Petitioner worked four hours for Respondent during that overlapping period. *See* PX9 & PX10. Pe tioner's pay stubs for wor for Domino's Pizza (through NRJM, Inc.) show that in the prior two pay periods preceding this these over ing employment dates Petitioner earned $527.06 and $579.69) PX9. The Arbitrator finds it to be a reasonable inference that Petiti ned half of the $33 .09 total during the pay period from September 24, 2012 through October 7, 2012 while working for Respo ly 4 hours during the same two-week period.

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

"Under section 8(a) of the Act (820 ILCS 305/8(a) (West 2006)), a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of her employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury." *Absolute Painting/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill. App. 3d 463, 470 (4th Dist. 2011) (*citing University of Illinois v. Industrial Comm'n*, 232 Ill. App. 3d 154, 164 (1st Dist. 1992)). Whether a medical expense is either reasonable or necessary is a question of fact to be resolved by the Commission, and its determination will not be overturned on review unless it is against the manifest weight of the evidence. *F&B Manufacturing Co. v. Industrial Comm'n*, 325 Ill. App. 3d 527, 534 (1st Dist. 2001).

As explained more fully above, the Arbitrator finds that Petitioner's current conditions of ill-being are causally related to the accident at work relying on Petitioner's testimony which is corroborated by the medical records as well as the recommendations and opinions of his treating physicians. The medical bills submitted into evidence which Petitioner calculates to total $97,816.57 are for the reasonable and necessary medical treatment rendered to Petitioner to address these conditions.

According the Arbitrator finds that the medical bills submitted into evidence by Petitioner that remain unpaid are to be paid by Respondent as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive a credit, if any, as agreed by the parties.

In support of the Arbitrator's decision relating to Issue (K), Petitioner's entitlement to prospective medical care, the Arbitrator finds the following:

As explained above, the Arbitrator finds that Petitioner's current conditions of ill-being are causally related to his accident at work as claimed. Petitioner's low back, right shoulder and right elbow conditions have not improved since his accident at work.

In consideration of the record as a whole, the Arbitrator awards the recommended prospective medical care in the form of lumbar fusion surgery as prescribed by Dr. Templin as well as a right shoulder surgery and right elbow injections as recommended by Dr. Urbanowksy pursuant to Section 8(a) of the Act as these treatments are reasonable and necessary to alleviate Petitioner from the effects of his injuries at work.

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

In light of the causal connection analysis explained above, the Arbitrator addresses Petitioner's claim that he is entitled to temporary total disability benefits for the disputed period beginning June 8, 2013 through April 15, 2014.

"The period of temporary total disability encompasses the time from which the injury incapacitates the claimant until such time as the claimant has recovered as much as the character of the injury will permit, i.e., until the condition is stabilized." *Gallentine v. Industrial Comm'n*, 201 Ill. App. 3d 880, 886 (2nd Dist. 1990). The dispositive issue is whether the claimant's condition has stabilized, i.e., reached MMI. *Sunny Hill of Will County*

v. Ill. Wo *s' Comp. Comm'n*, 2014 IL App (3d) 130028WC at *28 (opinion filed June 26, 2014); *Mechanical Devices* *dustrial Comm'n*, 344 Ill. App. 3d 752, 760 (4th Dist. 2003).

In this ca he record reflects that Petitioner was undergoing active medical treatment and placed off work or on light restrictions by Drs. Singh, Fuentes, Sharma, Templin, and Urbanowsky as they related to his low back, rig oulder, right elbow, and left knee conditions during this period of time. Respondent disputes that Petitione s unable to work during this period of time based on the opinions of its evaluating physicians, Drs. Andersso d Karlsson, as well as on the job description for a ground man. While the weight limits noted in the job d ption may appear at first blush to be within the restrictions imposed during certain periods of the claimed t orary total disabi y period, Petitioner testified that the performance of his duties required continuo ork at a fast pace beyond that indicated in the job description. The functional capacity evaluation also indic that Petitioner was released to work at the light-to-medium demand level, while Petitioner's job duties as ound man were considered to be at the medium physical demand level. The opinions of Respond evaluating physicians that Petitioner could perform work for Respondent with one arm for example ithout use of narcotic pain medication is in conflict with the opinions of Petitioner's treating physicia ho have opined otherwise.

In light o foregoing, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits from as claime Respondent shall receive a credit as agreed by the parties. *See* AX1.

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

Edgar Bledsoe,
Petitioner,

17IWCC0098

vs.

NO: 11 WC 15181

The American Coal Company,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of occupational disease, permanent disability, statute of limitations, legal error, evidentiary error 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 13, 2015, is hereby affirmed and adopted.

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

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

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.

FEB 14 2017

DATED:
o1/31/17
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0098

BLEDSOE, EDGAR
Employee/Petitioner

Case# **11WC015181**

THE AMERICAN COAL COMPANY
Employer/Respondent

On 5/13/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

1662 CRAIG & CRAIG LLC
KENNETH F WERTS
PO BOX 1545
MT VERNON, IL 62864

17IWCC0098

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

EDGAR BLEDSOE
Employee/Petitioner

v.

THE AMERICAN COAL COMPANY
Employer/Respondent

Case # 11 WC 15181

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 **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Herrin**, on **March 12, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Was there an injurious practice under Section 19(d)?**

FINDINGS

On **11/14/10**, 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 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 $**71,518.20**; the average weekly wage was $**1,375.35**.

On the date of accident, Petitioner was **63** 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 $**N/A** 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

Petitioner failed to prove he sustained an occupational disease arising out of and in the course of his employment. Petitioner's claim for compensation is denied and no benefits are awarded.

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

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

Nancy Lindsay
Signature of Arbitrator

May 10, 2015
Date

MAY 13 2015

Edgar D. Bledsoe, Jr. v. The American Coal Company
11 WC 015181

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Medical records of Dr. Anad Salem were admitted into evidence. Petitioner's first office visit with Dr. Salem was on December 16, 1999, to establish himself as a patient. On that date Petitioner reported a non-productive cough. In the History and Physical which Petitioner completed, he related a positive history of shortness of breath and wrote in next to same "from working in mine." He had a negative smoking history. On that date his chest revealed same to be clear to auscultation. Dr. Salem's assessment was sinusitis. (Respondent's Exhibit No. 2, pp. 204, 206). Petitioner was seen by Dr. Salem on March 31, 2000, with complaints of right-sided chest pain. He told the doctor that when he worked he became short of breath and his arm started to get numb. He also had a cough. Physical examination of Petitioner's chest revealed inspiratory wheezes and musical notes in the right lower base when Petitioner took a deep breath. His lungs were clear to percussion bilaterally. The doctor performed spirometry on Petitioner in his office and charted that same revealed a mild obstruction. After four puffs of Albuterol the spirometry was repeated and it was charted that same was normal following bronchodilator. The assessment was reversible obstructive disease, unknown etiology, possibly asthma. (Respondent's Exhibit No. 5, pp. 6-7). A chest x-ray was performed on March 31, 2000. It was interpreted by Dr. F. Marmo as normal. (Respondent's Exhibit No. 5, p. 200).

Petitioner was seen on June 12, 2001, for head congestion, blurred vision, frontal headache, hoarseness and cough. On examination his lungs were clear to auscultation and percussion. The assessment was sinusitis. (Respondent's Exhibit No. 5, pp. 7-8).

Petitioner was seen by Dr. Salem on February 18, 2002. Petitioner related some mild shortness of breath with exertion. He also related some tightness in his chest. Physical examination of the chest revealed same to be clear to auscultation and percussion. The assessment was significant family history of heart disease. (Respondent's Exhibit No. 5, pp. 8-9). Petitioner underwent an exercise stress test at Memorial Hospital of Carbondale on March 4, 2002. Same was noted to borderline abnormal and he had a hypertensive response to a moderate workload. (Respondent's Exhibit No. 5, p. 195). Petitioner was seen on March 30, 2002. At that time he had no shortness of breath. Physical examination of Petitioner's chest revealed the lungs to be clear to auscultation and percussion. (Respondent's Exhibit No. 5, pp. 9-10).

Petitioner was seen by Dr. Brian McElhney on January 17, 2004, with complaints of a cough which was productive of green sputum present for the last couple of days. The diagnosis was bronchitis. (Respondent's Exhibit No. 5, p. 170). Petitioner was seen on April 22, 2004. Petitioner reported that when he was working at

the mine he developed chest pain and shortness of breath. On examination of his chest his lungs were found to be clear to auscultation and percussion. On that date a referral was made to a cardiologist for the chest pain. (Respondent's Exhibit No. 5, pp. 14-16). On April 30, 2004, Petitioner underwent spirometry testing. The reason for the testing was a three to four year history of dyspnea on exertion. The test was interpreted by Dr. Dave as revealing a mild obstruction. (Respondent's Exhibit No. 5, pp. 156-157). Petitioner saw Dr. Alan Spitler on June 9, 2004. Petitioner related that over the prior year he had experienced an increase in dyspnea on exertion. The assessment was that the doctor was very suspicious for coronary disease. (Respondent's Exhibit No. 5, p. 154). Petitioner underwent cardiac catheterization on June 15, 2004. Two stents were placed on that same date. (Respondent's Exhibit No. 5, pp. 152-153).

Petitioner was seen on June 14, 2005, with complaint of sore chest and cold. On examination the lungs were clear to percussion; however, there was expiratory wheeze with a prolonged expiratory phase. The assessment was bronchitis. (Respondent's Exhibit No. 5, p. 16). On February 1, 2006, Petitioner complained of cold symptoms. Physical examination of the lungs revealed same to be clear to auscultation. The assessment was sinusitis. (Respondent's Exhibit No. 5, p. 17). Petitioner was seen on June 29, 2006, for referral to a cardiologist and a pulmnologist. He was referred to Dr. Istanbouly. Examination of Petitioner's chest on that date revealed his lungs to be clear to auscultation and percussion. The assessment was chronic obstructive pulmonary disease or COPD. Dr. Salem noted that Petitioner had worked in an underground coal mine for nearly 30 years in dusty conditions and felt he probably had black lung as well. (Respondent's Exhibit No. 5, pp. 17-18).

Medical records of Southern Illinois Respiratory Disease Clinic were admitted into evidence. In a report dated September 6, 2006, Dr. Istanbouly noted that he was seeing Petitioner by way of referral from Dr. Salem for consultation for management of COPD. According to history provided to Dr. Istanbouly, Petitioner was diagnosed with COPD a few years prior based upon spirometry. Petitioner reported to Dr. Istanbouly that he had cough on a daily basis which was mild and mostly dry. His cough was triggered by inhaling dust and he had mild exertional dyspnea. The doctor also noted that Petitioner had confirmed coronary artery disease and angina. Physical examination of the chest revealed Petitioner's lungs to be clear to auscultation with no adventitious sounds. Dr. Istanbouly's assessment was chronic obstructive pulmonary disease mild in intensity based on clinical condition; rhinitis perennial, rather than seasonal; obstructive sleep apnea uncontrolled; and coronary artery disease. Dr. Istanbouly indicated that Petitioner's COPD could be related to his long history of coal mining. (Respondent's Exhibit No. 6, pp. 6-7). Petitioner was seen on November 9, 2006, for follow up regarding COPD, rhinitis, CPAP and coronary artery disease. Petitioner related exertional dyspnea and palpitations with light headedness. He related occasional cough but denied sputum production. He relayed to the doctor that he could walk long

distances if he walked slowly but he could not bend over presumably without shortness of breath. The assessment was again COPD, rhinitis controlled, obstructive sleep apnea, uncontrolled and coronary artery disease. (Respondent's Exhibit No. 6, p. 5).

Petitioner was seen by Dr. Salem on December 6, 2006. He denied any new shortness of breath. Physical examination revealed Petitioner's lungs to be clear to auscultation and percussion. The assessment included mild arrhythmia, COPD, ASHD and obstructive sleep apnea. (Respondent's Exhibit No. 5, p. 19)

Medical records from Prairie Cardiovascular Consultants were admitted into evidence. Petitioner was seen on January 15, 2007, to establish long term cardiac care. He gave a history of having two previous stent placements in 2002. He reported no recent chest pain, dyspnea, orthopnea, PND and pitting edema. His family history was positive for coronary artery disease. Review of systems respiratory was positive for snoring. On physical examination, the chest was clear to auscultation. His diagnoses included history of coronary artery disease, palpitations, history of hyperlipidemia and recent decrease in energy level. (Respondent's Exhibit No. 7, pp. 126-129). Petitioner was seen in the office on February 9, 2007. On that date he denied chronic cough. On examination the chest was clear to auscultation. (Respondent's Exhibit No. 7, pp. 114-117).

Petitioner underwent chest x-ray at Herrin Hospital on March 1, 2007. Dr. Jagan Ailinani interpreted same as showing small calcified granulomas in the right lung, otherwise normal chest. (Respondent's Exhibit No. 6, p. 4). Petitioner was seen on same date in Dr. Istanbouly's office. Petitioner related shortness of breath and cough although he indicated the cough was infrequent and without sputum. Physical examination of the chest revealed no lung abnormality. Petitioner also underwent spirometry on March 1, 2007. The diagnosis was COPD-very mild and obstructive sleep apnea untreated. (Respondent's Exhibit No. 6, p. 3). Dr. Istanbouly interpreted pulmonary function tests of March 1, 2007, as showing mild obstructive pattern with good response to bronchodilator treatment indicating hyperreactive airways. He noted Petitioner had normal gas diffusion capacity. (Respondent's Exhibit No. 4, p. 8).

Petitioner returned to Dr. Salem on March 19, 2007, complaining of upper respiratory symptoms. Petitioner related that he worked in a coal mine and was having a great deal of trouble with his sinuses. The assessment was upper respiratory infection. (Respondent's Exhibit No. 5, p. 20).

Petitioner was seen by Dr. Salem on October 29, 2007. At that time he denied shortness of breath or cough. Physical examination of the chest revealed the lungs to be clear to auscultation and percussion. (Respondent's Exhibit No. 5, p. 21).

Petitioner was seen again at Prairie Cardio on September 15, 2008, for reevaluation of coronary artery disease. He had no shortness of breath. Review of systems was negative except for calf pain and joint pain stiffness. On examination his chest was clear to auscultation. (Respondent's Exhibit No. 7, pp. 90-93).

Petitioner was diagnosed with influenza on February 29, 2008. On that date he denied chest pain or shortness of breath. (Respondent's Exhibit No. 5, p. 22).

Petitioner was seen at Prairie Cardio on April 8, 2009. He reported he had shortness of breath only if he overworked himself. Review of systems respiratory was positive for shortness of breath with activity. On examination his chest was clear to auscultation. (Respondent's Exhibit No. 7, pp. 49-51).

Petitioner was seen on February 24, 2010. He related that he continued to have cough, congestion and wheezing. He related that it hurt to take a deep breath. The assessment was sinusitis. A chest x-ray was carried out on that same date and interpreted by Dr. Hodge as revealing no acute cardiopulmonary process. The doctor did detect a calcified granuloma. (Respondent's Exhibit No. 5, pp. 23-24, 54).

Petitioner was again seen at Prairie Cardio on March 24, 2010, for chief complaint of palpitations, dyspnea on exertion and chest discomfort. His review of systems respiratory was positive for shortness of breath with activity. On examination the chest was clear to auscultation. (Respondent's Exhibit No. 7, pp. 25-28).

Petitioner's last day of work at Respondent's mine was on November 14, 2010.

Petitioner was examined by Dr. Salem on November 15, 2010, complaining of being weak and dizzy for the previous two days. Physical examination of his chest revealed his lungs to be clear to auscultation. The doctor's assessment was weakness and shortness of breath. Petitioner underwent a stress test on November 17, 2010, which was interpreted as normal. Petitioner also reviewed his blood work with Dr. Salem that day. He was noted to have a low blood count. (Respondent's Exhibit No. 5, pp. 24-26). Petitioner underwent a colonoscopy and esophagogastroduodenoscopy. The results from the procedures were suspicious of a gastric ulcer with incidental diverticulosis. (Respondent's Exhibit No. 5, p. 46). Petitioner returned to Dr. Salem on December 1, 2010, where he reported that he continued to be a little dizzy. He denied shortness of breath. Physical examination of Petitioner's chest revealed the lungs to be clear with auscultation. (Respondent's Exhibit No. 5, pp. 27-29). A note was generated dated December 7, 2010, indicating that Petitioner had to be off work as a result of a bleeding ulcer and anemia and that it would not be safe for him to return to work on the long wall machine. (Respondent's Exhibit No. 5, p. 29).

Petitioner was seen on February 23, 2011. He denied chest pain and shortness of breath. Physical examination of his chest revealed same to be clear to auscultation. It was noted that Petitioner's anemia had resolved. Petitioner was given a return to work slip without restriction as of February 24, 2011. (Respondent's Exhibit No. 5, pp. 30-31).

Petitioner testified that he formally retired in February of 2011 due to an ulcer and blood disorder.

The medical records from the Marion VA Clinic were admitted into evidence. Petitioner had a chest x-ray on February 26, 2011. Same was interpreted by Dr. Hisha T. Youssef as negative for pneumoconiosis or active cardiopulmonary disease. (Petitioner's Exhibit No. 4, p. 108).

Records from NIOSH were admitted into evidence. Petitioner underwent NIOSH x-ray screening on February 26, 2011. Said x-ray was interpreted by a NIOSH A-reader and B-reader as negative for pneumoconiosis. The B-reader noted a 5 x 3mm nodule in the right mid lung and recommended follow up. (Respondent's Exhibit No. 3).

Petitioner was seen at the VA on March 8, 2011, to establish care. At that time he denied shortness of breath or cough. On examination his lungs were clear to auscultation and percussion. (Petitioner's Exhibit No. 4, pp. 100-103).

On March 28, 2011 Dr. Henry K. Smith, board certified radiologist and NIOSH B-reader, interpreted Petitioner's chest x-ray taken on March 8, 2011 as positive for pneumoconiosis, profusion 1/0 with P/S opacities in all lung zones. (Petitioner's Exhibit No. 2).

Petitioner signed his Application for Adjustment of Claim in this matter on April 12, 2011 alleging shortness of breath and exercise intolerance as a result of inhaling coal mine dust in excess of 34 years. He alleged an accident date of February 28, 2011. (AX 2)

Petitioner was seen at the VA on August 12, 2011, with complaint of sore throat and that he had been coughing up black-yellow sputum mostly at night. Petitioner reported some shortness of breath and a history of working in the coal mines. On examination the lungs were clear to auscultation. Petitioner was prescribed an antibiotic. (Petitioner's Exhibit No. 4, pp. 89-90).

Petitioner was again seen at the VA on August 23, 2011. Under review of systems respiratory there was no shortness of breath or cough. Physical examination of

the lungs showed bilateral equal and fair air entry with no crackles or rhonchi. (Petitioner's Exhibit No. 4, pp. 83-88).

Petitioner returned to the VA on March 21, 2012, for a one year follow-up of medical problems. On review of systems respiratory he showed no shortness of breath, cough or phlegm. Physical examination of the lungs showed bilateral equal and fair air entry with no crackles or rhonchi. (Petitioner's Exhibit No. 4, pp. 77-83).

Petitioner was seen at the VA on April 4, 2012, for episode of loss of memory and a mild headache with numbness and tingling to the right hand. Review of systems respiratory showed no shortness of breath, cough or phlegm. Physical examination of the lungs showed that there was bilateral equal and fair air entry with no crackles or rhonchi. (Petitioner's Exhibit No. 4, pp. 72-76). On that same date he was seen in the emergency room at Good Samaritan Hospital. The assessment was TIA. (Petitioner's Exhibit No. 4, pp. 117-118).

Petitioner returned to the VA on June 4, 2012. He reported that he walked two miles a day and worked in his yard. The lungs were clear bilaterally. (Petitioner's Exhibit No. 4, pp. 57-63).

Petitioner was seen at the VA on December 5, 2012, for management of the active medical problems. He had no new complaints. On review of systems respiratory there was no shortness of breath, cough or phlegm. On physical examination of the lungs there was bilateral equal and fair air entry with no crackles or rhonchi. (Petitioner's Exhibit No. 4, pp. 20-26).

Petitioner saw Dr. Paul on January 15, 2013, at the request of Petitioner's counsel. (Petitioner's Exhibit No. 1, Deposition Exhibit No. 2).

On January 30, 2013, Dr. Michael Alexander, board certified radiologist and B-reader, interpreted chest x-ray dated March 8, 2011, as positive for pneumoconiosis, profusion 1/0 with P/P opacities in all lung zones. He also noted a 5mm granuloma in the right mid zone and recommended follow up evaluation. (Petitioner's Exhibit No. 3).

On June 15, 2013 Dr. Christopher A Meyer, board certified radiologist and B-reader, interpreted a chest x-ray taken on March 1, 2007, as negative for pneumoconiosis. He also noted a granuloma in the right mid zone over the anterior fourth rib. (RX 1) He also reviewed a February 24, 2010 chest x-ray as negative for pneumoconiosis. He also noted a calcified granuloma in the right mid zone. (RX 1)

Dr. Jeffrey W. Selby examined Petitioner at the request of Respondent's counsel on October 2, 2013. (Respondent's Exhibit 2, pp. 7-8). Dr. Selby is board certified in

internal medicine and pulmonology. He has been a B-reader since 1985. (Respondent's Exhibit No. 2, p. 3). Dr. Selby has a general pulmonology practice that entails both inpatient and outpatient. He does all manner of consultation work as far as chest, lungs or breathing disorders. His practice also includes occupational lung disease including individuals with coal workers' pneumoconiosis. (Respondent's Exhibit No. 2, pp. 4-5).

Petitioner told Dr. Selby that on his last day of work half way through his shift he had a spell. He had an ulcer and took off work for 289 days and then retired. (Respondent's Exhibit No. 2, p. 9). At the time of Dr. Selby's examination, Petitioner had no real complaint concerning his health. He stated that he had occasional shortness of breath. He was not sure when his shortness of breath started. Petitioner told Dr. Selby that "nothing bothered my breathing in the coal mines." (Respondent's Exhibit No. 2, p. 9). Petitioner told Dr. Selby that he felt he needed to take a deep breath. He had a non-productive cough at times. He walked two miles on level ground at his own pace two to three times per week. Petitioner told Dr. Selby that he "might be out of shape." Petitioner denied triggers for coughing, wheezing or shortness of breath. (Respondent's Exhibit No. 2, pp. 9-10). Petitioner has never smoked. (Respondent's Exhibit No. 2, p. 11).

Petitioner underwent pulmonary function testing. The overall interpretation was normal spirometry, normal lung volumes and normal diffusing capacity. (Respondent's Exhibit No. 2, p. 13). A methacholine challenge test was performed which showed a normal response to methacholine. (Respondent's Exhibit No. 2, pp. 13-14). Dr. Selby interpreted x-ray of October 2, 2013, as negative for pneumoconiosis. (Respondent's Exhibit No. 2, p. 13). Petitioner also underwent exercise testing. He completed 40 seconds of Stage IV, or 9 minutes and 40 seconds of total exercise time. His peak heart rate was 169 or 109% of his predicted maximum of 154. His oxygen saturation remained at 98% throughout the exercise test. (Respondent's Exhibit No. 2, p. 14).

The deposition of Dr. Christopher A. Meyer was taken on behalf of Respondent on July 16, 2014. (RX 1) Dr. Cristopher A. Meyer reviewed chest x-rays for Petitioner dated March 1, 2007, February 24, 2010, February 26, 2011, and March 8, 2011. Dr. Meyer testified that all of those films were quality I. He found no radiographic evidence of coal workers' pneumoconiosis. He noted that there was a calcified granuloma in the right mid zone and some degenerative changes of the spine. He testified that there was no change on serial exams he reviewed. (Respondent's Exhibit No. 1, p. 40). Dr. Meyer testified that he compared the February 26, 2011, film to the March 2007 and February 2010 films. He took the most recent examination and compared it to both of the older exams. He testified there was no change of significance from the earliest film to the oldest film. (Respondent's Exhibit No. 1, p. 41).

Dr. Meyer has been board certified in radiology since 1992. (Respondent's Exhibit No. 1, p. 7). Dr. Meyer has been a B-reader since 1999 (Respondent's Exhibit No. 1, p. 19). Dr. Meyer was asked to take the B-reading exam by Dr. Jerome Wiot (Respondent's Exhibit No. 1, pp. 19-20). Dr. Wiot was on the original committee that designed the training course which was called the B-reader program. (Respondent's Exhibit No. 1, pp. 21-22). Dr. Meyer has recently been asked to have a more active academic role with the B-reader course. (Respondent's Exhibit No. 1, p. 32). Dr. Meyer testified that radiologists have a 10% higher pass rate on the B-reading exam than other specialties. In Dr. Meyer's opinion radiologists have a better sense of what the variation of normal is. (Respondent's Exhibit No. 1, pp. 34-35).

Dr. Meyer testified that the B-reader looks at the films of the lung to decide whether there are any small nodular opacities or linear opacities and based on the size or appearance of the small opacities, they are given a letter score. (Respondent's Exhibit No. 1, p. 22). Dr. Meyer testified that specific occupational lung diseases are described by specific opacity types. Coal workers' pneumoconiosis is characteristically described by small round opacities. (Respondent's Exhibit No. 1, p. 28). The distribution of opacities is also described because different pneumoconioses are seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper zone predominant process. (Respondent's Exhibit No. 1, pp. 22-23). The last component in the lung involvement piece for the small opacities is the extent of the lung involvement or the so-called profusion. (Respondent's Exhibit No. 1, p. 23). Dr. Meyer testified that the profusion defines the density of the small opacities in the lung. (Respondent's Exhibit No. 1, p. 30).

The deposition of Dr. Glennon Paul was taken on Petitioner's behalf on December 1, 2014. (PX 1) Dr. Paul is board certified in internal medicine and asthma, allergy and immunology (Petitioner's Exhibit No. 1, pp. 9-10). Dr. Paul testified that when he did this fellowship in 1970 to 1972, there were not any pulmonary fellowships developed. (Petitioner's Exhibit No. 1, p. 10). Dr. Paul testified that he reads 100 chest x-rays a week and interprets the same number of pulmonary function tests. (Petitioner's Exhibit No. 1, pp. 7-8). Dr. Paul is not an A- or B-reader. (Petitioner's Exhibit No. 1, p. 42). Dr. Paul is not board certified in pulmonology. (Petitioner's Exhibit No. 1, p. 45).

Dr. Paul testified that based on all of the testing and data that he had available to him, he concluded that Petitioner had coal workers' pneumoconiosis, chronic bronchitis and a restrictive ventilatory defect. (Petitioner's Exhibit No. 1, pp. 14-15). Dr. Paul testified that in light of the diagnoses of pneumoconiosis, restrictive defect, obstructive ventilatory defect and chronic bronchitis, Petitioner could not have further exposure to the environment of a coal mine without endangering his health. (Petitioner's Exhibit No. 1, pp. 17-18). Dr. Paul testified that Petitioner's diffusion capacity was low, which

is present in someone with coal workers' pneumoconiosis. (PX No. 1, p. 16). Dr. Paul did not know what the inhalation time or hold time was for the tracer gas in regard to Petitioner's diffusion capacity testing. He did not know the exhalation time. He also did not record the exhalation volume for the tracer gas as compared to his largest vital capacity. (PX No. 1, pp. 44-45). Dr. Paul testified that Petitioner had physiologically significant pulmonary impairment as demonstrated on pulmonary function testing. He testified that same was caused by coal dust and the coal mine environment. He testified that Petitioner is totally disabled from working as a coal miner. (Petitioner's Exhibit No. 1, pp. 20-21). Dr. Paul testified that based on his clinical presentation and the testing, Petitioner could perform light manual labor. (Petitioner's Exhibit No. 1, p. 21).

Dr. Paul testified that by definition, if one has coal workers' pneumoconiosis, he has an impairment in the function of the lung at the site of the scar whether it can be measured by spirometry or not. (Petitioner's Exhibit No. 1, pp. 22-23). Dr. Paul testified that the scarring of pneumoconiosis can be both obstructive and restrictive. He testified that coal workers' pneumoconiosis is considered to be a progressive disease. (Petitioner's Exhibit No. 1, p. 26).

Dr. Paul saw Petitioner one time at the request of his counsel. He testified that in the past year he had seen 10 or 12 people at the request of Petitioner's counsel. Dr. Paul testified that dyspnea on exertion can be due to many different things but deconditioning and heart disease are not common causes. (Petitioner's Exhibit No. 1, pp. 39-40). Dr. Paul testified that Petitioner was not taking any breathing medications. Dr. Paul did not review any medical records. (Petitioner's Exhibit No. 1, p. 40). Petitioner did not tell Dr. Paul that he retired from coal mining at the time he did on the recommendation of a physician. Dr. Paul did not know if Petitioner left mining when he did due to an inability to perform his job. Dr. Paul did not remember if Petitioner told him he had any difficulties in performing the last job duties that he had. (Petitioner's Exhibit No. 1, p. 41).

Dr. Paul testified that simple coal workers' pneumoconiosis classically presents itself asymptomatically. It is more likely than not that simple pneumoconiosis will not progress once the exposure ceases. (Petitioner's Exhibit No. 1, p. 42). Dr. Paul testified that he believed it was more likely than not that Petitioner had black lung the last day he was at the mine. (Petitioner's Exhibit No. 1, pp. 42-43).

Dr. Selby was deposed on January 27, 2015. Dr. Selby reviewed medical records regarding Petitioner. Dr. Selby noted the stress test that was performed March 4, 2012, indicated a hypertensive response to moderate exercise. Dr. Selby testified that Petitioner suffered from coronary artery disease. He also testified that coronary artery disease and/or deconditioning are common causes of dyspnea on exertion. (Respondent's Exhibit No. 2, p. 15). Dr. Selby testified that to his knowledge there is

no such thing as radiographically apparent pulmonary impairment. (Respondent's Exhibit No. 2, p. 19).

Dr. Selby testified that the spirometry that he performed revealed no obstruction. He testified that lung volumes are the best test to determine whether a restriction is present. Petitioner's lung volumes were 107% which is normal. Dr. Selby testified that same completely ruled out restriction. He also testified that if an individual suffers a restriction due to dust exposure, that restriction will not go away with time. (Respondent's Exhibit No. 2, p. 19). Petitioner's diffusion capacity was 105% of predicted which is normal. That reveals there is no diffusion impairment. Dr. Selby testified for a diffusion capacity to be valid there must be inhalation to at least 85% of the largest previously measured vital capacity, a quick smooth inhalation within two seconds, breath holding from between 9 to 11 seconds and holding the breath without straining. If one does not have that information regarding the test and the test is below normal, it is not known whether it is a problem with the individual's diffusion capacity or a problem with the validity of the test. (Respondent's Exhibit No. 2, p. 20). Dr. Selby testified that if an individual suffers scarring due to a dust exposure that causes an impairment in diffusion capacity, it will not go away with time. Dr. Selby testified that one cannot fake a normal diffusion capacity. (Respondent's Exhibit No. 2, pp. 20-21).

Dr. Selby testified that exercise testing is the gold standard to determine cardiopulmonary ability (Respondent's Exhibit No. 2, p. 22). Dr. Selby testified that Petitioner's testing did not reveal a limit to exercise based upon a ventilatory impairment. Petitioner was quite capable of heavy manual labor from a pulmonary standpoint. (Respondent's Exhibit No. 2, p. 23). Dr. Selby concluded that Petitioner did not suffer from any respiratory or pulmonary abnormality as a result of coal mine dust inhalation or his coal mine employment. Petitioner does not have coal workers' pneumoconiosis and had a normal methacholine challenge test proving that he does not have asthma. (Respondent's Exhibit No. 2, pp. 24-25). Dr. Selby noted that Petitioner was out of shape or deconditioned. He also had coronary artery disease which could be the cause of shortness of breath. Dr. Selby testified that Petitioner had sleep apnea bad enough to need CPAP, but he could not tolerate the CPAP. Untreated sleep apnea was likely a cause of coronary artery disease and possible pulmonary artery hypertension. Dr. Selby testified that pulmonary hypertension is a known cause of shortness of breath. Petitioner was overweight which was another factor leading to shortness of breath. (Respondent's Exhibit No. 2, p. 25).

Dr. Selby testified that the board certification in pulmonary disease is a subspecialty of the American Board of Internal Medicine. He testified that the subspecialty of pulmonary disease was first given board certification in 1941. (Respondent's Exhibit No. 2, p. 28).

For a person to have coal workers' pneumoconiosis, in addition to having coal mine dust in the lungs, a tissue reaction is required. That tissue reaction is called scarring or fibrosis. (Respondent's Exhibit No. 2, p. 28). Dr. Selby testified that by definition if a person has pneumoconiosis, he would necessarily have an impairment in the function of his lung at the very site of the scarring whether that impairment could be measured by spirometry or not. (Respondent's Exhibit No. 2, p. 29). Dr. Selby testified that it is possible for a person to have radiographically significant coal workers' pneumoconiosis and have normal findings on physical exam of the chest, normal pulmonary function tests and normal arterial blood gas tests. (Respondent's Exhibit No. 2, pp. 34-35). Dr. Selby disagreed with the literature cited in the Federal Register of December 2000 concerning the incidence of obstructive lung disease for coal mine dust inhalation. He testified the global literature was being applied to a specific region of our country, and it was never intended for that. Dr. Selby testified that his experiences were from the tristate region where he sees nothing near the degree of obstruction purely from coal mine exposure as what is purported to occur in the literature from the international studies. (Respondent's Exhibit No. 2, pp. 38-39). Dr. Selby testified that in the course of treating hundreds or thousands of coal miners over the last 25 years, it is rare that someone has chronic obstructive pulmonary disease purely from coal mining. (Respondent's Exhibit No. 2, p. 40).

Dr. Selby did not label chronic sinusitis as a diagnosis. He testified that Petitioner had some evidence of it in his historical documents and based on the medical records it would have been a clear diagnosis to make. Dr. Selby was not sure it was still present. (Respondent's Exhibit No. 2, p. 49). Dr. Selby testified that any aggravation to Petitioner's sinusitis at work, assuming same occurred, would have been temporary. He testified that Petitioner had no evidence of a permanent functional impairment due to chronic sinusitis. (Respondent's Exhibit No. 2, pp. 61-62). Dr. Selby testified that Dr. Paul's methacholine challenge on Respondent revealed an 11% decline at the highest dilutional level in FEV1. This was virtually the same found by Dr. Selby. (Respondent's Exhibit No. 2, p. 62).

Petitioner lives in Sesser in Illinois and was 67 years old at the time of arbitration. Petitioner graduated from high school which was the extent of his education. Petitioner worked in the coal mine around 35 years with all of that time being underground. Petitioner testified that in addition to coal dust he was regularly exposed to and breathed silica dust. Petitioner also breathed roof bolting glue fumes and diesel fumes.

Petitioner's last day in the coal mine was November 14, 2010. He left on that date due to a medical condition although he did not actually retire until February 2011. He was working for Respondent at its Galatia mine. He as 62 years at that time. His classification was long wall operator. Petitioner testified he was exposed to coal dust on

that day. Petitioner testified that he retired in February 2011 due to an ulcer and blood disorder. Petitioner has not worked since leaving the mine.

Petitioner entered the military right out of high school. He served in the Army for two years in Vietnam. In the Army he was assigned to transportation. After his discharge he worked at a store in Olive Branch for two or three years. He then worked as a carpenter for about three years before going into the coal mine in 1974. The first mine was with Freeman Coal. He started roof bolting. He testified that when he installed pins in the top of the roof, he would get dust and everything out of the roof. He also worked as a timber man at Freeman. He worked at Freeman from 1974 to 1982. He was laid off for a while. In February 1985, he went to work at Kathleen Mine where he worked as a roof bolter for a little over a year. He began working for Respondent on September 2, 1986. At Respondent he worked as a roof bolter and long wall operator. As long wall operator, he ran the shear that went back and forth and cut the coal. He testified that there was a lot of dust in that job.

Petitioner testified that five or six years before he retired he could tell a difference in his breathing with the things he was doing. He testified that he was losing power and would get short of breath. He would have to stop to get his breath back. Petitioner testified that as of arbitration he could walk a couple of miles pretty easily with his wife. He was out of shape. He testified that he could probably climb a couple of flights of stairs before he would have to take it easy. Petitioner testified that from the time he first noticed breathing problems until the time he left the mine, the problems got worse. Petitioner testified that his problems have stayed the same since leaving the mine. Petitioner is not on any breathing medication. Petitioner testified that he gets out of breath doing anything but if he does anything strenuous like cutting firewood or shoveling snow he has to stop and get his breath back. He cannot mow his yard with a push mower.

Petitioner testified that he is currently treating at the VA. Prior to that he treated with Dr. Salem at Carbondale. He testified that he talked to the doctors about his breathing problems. Petitioner never smoked. He testified that he has stents in his heart. He takes medication for his heart.

Petitioner testified that several times over the years while employed as a coal miner he underwent chest x-rays by NIOSH for black lung. He testified that he thought he had one after he left his employment with Respondent. Petitioner testified that he had an ulcer and blood disorder which is what made him leave the mine. He testified that he might have had a TIA since leaving the mine. They were not sure if that was what it was. Petitioner testified that he likes to fish and spend time with his grandkids. He watches them play ball.

Edgar D. Bledsoe, Jr. v. The American Coal Company
11 WC 015181

The Arbitrator concludes:

1. Petitioner has failed to prove by a preponderance of the evidence that he sustained an occupational disease arising out of and in the course of his employment. The Arbitrator finds the B-readings by Drs. Meyer and Selby as well as the independent NIOSH B-readers to be more persuasive. In particular the Arbitrator finds the testimony of Dr. Meyer insightful, informative and persuasive. His background and experience in radiology, B reading, and CWP was impressive and beyond that of Petitioner's physician, Dr. Paul. He explained how difficult it is to determine who is "right" when 2 B readers reach different conclusions noting that it is important to make sure the individual interpreting the films has ample experience in reading them. (RX 1, pp. 48-49). Dr. Meyer has that experience. Dr. Paul, in contrast, is not a B reader.

2. Petitioner has failed to prove by a preponderance of the evidence that his current condition of ill-being is causally connected to his employment.

3. Petitioner has failed to prove by a preponderance of the evidence that he suffered a timely disablement under Section 1(f) of the Occupational Diseases Act.

4. Petitioner's claim for benefits is denied.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF ROCK ISLAND)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Janet L. Brown,
Petitioner,

17IWCC0099

vs.

NO: 11 WC 13623

John Deer Harvester,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 5, 2015, is hereby affirmed and adopted.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION Respondent shall pay the petitioner the sum of $944.38/week for life, commencing November 6, 2013, as provided in Section 8(f) of the Act, because the injury caused the permanent and total disability of the petitioner.

IT IS FURTHER ORDERED BY THE COMMISSION Commencing on the second July 15th after the entry of this award, the petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

17IWCC0099

Bond for 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: FEB 14 2017
o2/1/17
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0099

BROWN, JANET L
Employee/Petitioner

Case# **11WC013623**

JOHN DEERE HARVESTER
Employer/Respondent

On 11/5/2015, 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 0.28% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
221 N LASALLE ST SUITE 400
CHICAGO, IL 60601

2119 CALIFF & HARPER PC
STEVEN NELSON
506 15TH ST SUITE 600
MOLINE, IL 61266

17IWCC0099

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

Janet L. Brown
Employee/Petitioner
v.
John Deere Harvester
Employer/Respondent

Case # **11** WC **13623**

An *Application for Adjustment 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 **Rock Island**, on **September 9, 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 **Was petitioner exposed to the hazards of an occupational disease.**

FINDINGS

On **April 30, 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 $**73,661.99**; the average weekly wage was $**1,416.57**.

On the date of accident, Petitioner was **66** 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.

ORDER

Respondent shall pay reasonable and necessary medical services of $5,076.45, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent and total disability benefits of $**944.38**/week for life, commencing **11/06/13**, 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.

Arbitrator Anthony C. Erbacci

November 3, 2015
Date

FACTS:

On April 30, 2010 the Petitioner was a 36 year employee of the Respondent. The Petitioner testified that she began working for the Respondent on July 22, 1974 as an assembler, and that she worked five days per week, eight hours per day for the next 36 years. She testified that she worked as an assembler in the V Building for approximately one year, and that her work area was full of dust and smoke. She testified that she then started working as a material handler in the M Building and that her job duties included sweeping dirt, dust and cigarette butts from a road way on the Respondent's premises, hauling hoppers filled with slag (metal shavings and oil) three hours per day, cleaning out the basement, which was full of dust and dirt, every four to six months and painting stripes on the floor one time per year for about a week. The Petitioner testified that for two to three months in 1989 she worked as a welder in the M Building which she described as an environment filled with welding fumes, dust and smoke. She testified that for the next 20 years, she worked as an assembler in Department 982 in the VI Building which she described as dusty, dirty and full of fumes from forklifts operating in the building as well as second-hand smoke.

The Petitioner testified that she retired from her employment with the Respondent on April 30, 2010 and that that was the last day that she worked for the Respondent. The Petitioner testified that throughout the period of her employment with the Respondent, she was never provided with any type of respirator or breathing protection.

The Petitioner testified that in the early 1990s she began to notice she was having "breathing problems" and that, in the mid-1990s, she sought treatment for her complaints with Dr. Felipe Enriquez. The Petitioner testified that Dr. Enriquez sent her for a pulmonary function test and prescribed medications, a nebulizer, and oxygen. The Petitioner testified that she used the nebulizer at work two to three times per day and that her foreman, Craig Freebern, saw her using the nebulizer at work. The Petitioner also testified that sometime in 2005, a hopper caught fire inside the building and the building had to be evacuated. The Petitioner testified that, at that time, she told her foreman, Craig Freebern, that she had to go home because she could not breathe. The Petitioner testified that she has never smoked and that she has no family history of asthma.

The Petitioner testified that she currently notices difficulty breathing and shortness of breath three to four times per day. She testified that she uses oxygen at night and a nebulizer every three to four hours and that her current medications include Prednisone, Daliresp, Advair and Albuteral.

The records of Dr. Felipe Enriquez were admitted into the record as Petitioner's Exhibit 1 and Respondent's Exhibit 2. The records indicate that the Petitioner began seeing Dr. Enriquez on June 17, 1996 complaining of shortness of breath, dyspnea and wheezing. The Petitioner reported a history of asthma for the last five to six years and "this recent problem for the last eight weeks now." It was noted that the Petitioner also reported that "She works at John Deere, and according to her, there are a lot of people are smoking at work." She was diagnosed with asthma with rhinitis and post nasal drip. The post nasal drip was felt to be most likely allergic in nature.

The Petitioner returned to Dr. Enriquez on February 10, 2003 and was diagnosed with acute bronchitis and chronic obstructive pulmonary disease. Thereafter, the Petitioner continued to follow up with Dr. Enriquez on a fairly regular basis and continued to complain of coughing, wheezing and

difficulty breathing. Dr. Enriquez continued to diagnose the Petitioner as having chronic obstructive pulmonary disease and asthma. On April 6, 2008 the Petitioner reported that she was feeling good and not having any breathing problems. On May 4, 2009, it was noted that the Petitioner reported that "she is the only one in her family to have asthma, and she thinks she gets this from exposure to dust and fumes at work. She states that she is exposed to paint fumes at the plant and also has been exposed to welding fumes, dust and smoke in that her co-workers used to be able to smoke up until recently, at which time it was banned."

On September 12, 2011 the Petitioner saw Dr. Enriquez complaining of an increase in shortness of breath and coughing. It was noted that "She has been told that certainly some of her problem could be occupational given she is a non-smoker. She appears to have pulmonary functions which show an obstructive lung disease suggestive of chronic obstructive pulmonary disease, but we cannot exclude the possibility this could be occupationally related as well given that she was a welder." The Petitioner then underwent a pulmonary function test on October 7, 2011.

On December 15, 2011, Dr. Enriquez noted that the Petitioner's pulmonary function test showed moderate chronic obstructive pulmonary disease with hyperinflation consistent with emphysematous changes. Dr. Enriquez noted that the Petitioner's diffusing capacity was moderately reduced and there was worsening of lung function compared to a 2007 pulmonary function test. It was also noted that the Petitioner claimed that she was exposed to dust and fumes at work and that she "felt that the worsening of her breathing capacity has been contributed partly by her working in dust and exposure to fumes at the machine shop at John Deere."

On November 26, 2012 the Petitioner complained of chest congestion, and bronchospasm and frequent attacks of asthma flare up. Dr. Enriquez noted that "this is most likely related to her workplace." Dr. Enriquez also noted that "Most likely the work place has contributed somehow with worsening of her COPD." On March 18, 2003, Dr. Enriquez noted the Petitioner's description of her workplace as having a lot of dust and paint fumes and he opined; "Based on these exposure to the dust and fumes its most likely the cause of her asthma and COPD as she has no known history of smoking."

On November 6, 2013, Dr. Enriquez assessed the Petitioner as having acute bronchitis, exacerbation of COPD, moderate to severe persistent asthma and a history of atrial fibrillations and he indicated that "In view of the above findings, plus the presence of comorbidities including rheumatoid arthritis, plus her age of 70 and due to frequent exacerbation of her COPD and asthma, it is my opinion that the patient will not be able to go back to work anyplace."

The Respondent offered into evidence John Deere Medical Department record which show on October 15, 1980, Dr. J.F. Green wrote to Dr. Lewis Wok about the Petitioner's absence from work for an asthma allergy condition. Other records show a diagnosis of asthma in April of 1994, as do duty disposition reports dated December 6, 1999, December 8, 1999, February 15, 2002 (asthma with RAD resolving), February 18, 2002, (asthma improved) and February 19, 2003. On December 15, 1999, it is noted she is restricted to, "No exposure to welding fumes." Clinic progress notes reflect a virus affecting her asthma from February 28, 2005 to March 11, 2005. On February 22, 2010 she reported a vacation day because of breathing problems.

Craig Freeberg testified that he was the Petitioner's supervisor from March 2007 to September of 2009. He testified that in all that time, the Petitioner never complained to him about her breathing difficulties, and that he never saw her use a Nebulizer at work. Mr. Freeberg testified that had the Petitioner complained to him about difficulty breathing, he would have sent her to the Medical Department.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, and (O.), was Petitioner exposed to the hazards of an occupational disease, the Arbitrator finds and concludes as follows:

Pursuant to Section 1(d) of the Occupational Disease Act, "An employee shall be conclusively deemed to have been exposed to the hazards of an occupational disease when, for any length of time however short, he or she is employed in an occupation or process in which the hazard of the disease exists."

The Petitioner's unrebutted testimony indicates that during the term of her employment with the Respondent from July 22, 1974 through her last day of work on April 30, 2011, she was exposed to dirt, dust, paint fumes, slag fumes, welding fumes, forklift exhaust, and second hand smoke in the Respondent's plant. Her treating physician, Dr. Felipe Enriquez is of the opinion that her work exposure has caused or aggravated her chronic obstructive pulmonary disease and asthma.

The Petitioner's testimony further established that her last day of working in this environment was April 30, 2010.

The Respondent presented no evidence or testimony to rebut or contradict the Petitioner's testimony as to her work environment and, similarly, presented no medical evidence or opinion which questioned, contradicted, or rebutted the opinions of Dr. Enriquez.

Consequently, the Arbitrator finds that the Petitioner was exposed to the hazards of an occupational disease with the date of last exposure of April 30, 2010.

In Support of the Arbitrator's Decision relating to (E.), Was timely notice of the accident given to Respondent, the Arbitrator finds and concludes as follows:

Under Section 6(c) of the Occupational Disease Act, notice shall be given to the employer of the disablement, "as soon as practicable after the date of disablement." That section further states, "no defect or inaccuracy of such notice shall be bar to the maintenance of proceedings on arbitration or otherwise by the employee unless the employer proves that he or she is unduly prejudiced in such proceedings by such a defect or inaccuracy."

During the course of her employment with the Respondent the Respondent received notice that the Petitioner was experiencing breathing difficulties which constitute disablement on multiple occasions. On March 15, 2005, Dr. Enriquez's office notes indicate he checked with JDH (John Deere Harvester) and Petitioner was OK'd for coverage for a portable nebulizer. The records from the Respondent's medical department also demonstrate that the Petitioner reported breathing problems, asthma, or treatment with Dr. Enriquez on several occasions and that she missed time from work due to those complaints and was on restricted work from time to time as a result of those complaints.

The Act requires the employee to place the employer in possession of the known facts within the statutory period, but allows that a defect or an inaccuracy in the notice is not a bar unless the employer is unduly prejudiced by the inaccurate notice. Because the Respondent was aware of the Petitioner's job duties and environment and the fact that she was experiencing breathing problems and saw Dr. Enriquez during the term of her employment with the Respondent, it can be fairly said that the Respondent was in possession of the necessary known facts to put them on notice pursuant to Section 6(c) of the Occupational Disease Act. Furthermore there was no evidence of any undue prejudice to the Respondent.

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

According to Section 1(d) of the Occupational Disease Act, "A disease shall be deemed to arise out of the employment if it is apparent to the rational mind, upon consideration of all the circumstances, a causal connection between the conditions under which the work was performed and the occupational disease. The disease need not to have been foreseen or expected but after its contraction it must appear to have had its origin or aggravation in a risk connected with the employment and to have flowed from that source as a rational consequence."

The Petitioner's unrebutted testimony established that she has been a long time employee for the Respondent working in an environment which included dust, dirt, smoke, slag fumes, welding fumes, paint fumes, fork lift exhaust and second hand smoke from co-workers using cigarettes. It was during the term of the Petitioner's employment with the Respondent that she began developing difficulty breathing.

The Petitioner's primary treating physician has been Dr. Felipe Enriquez who is Board Certified in Internal Medicine and Pulmonary Disease. He diagnosed the Petitioner with chronic obstructive pulmonary disease and asthma. The medical records demonstrate that the Petitioner reported to Dr. Enriquez the fact that she was exposed to dust, dirt, smoke and fumes at work. On September 12, 2011, Dr. Enriquez commented that; "She has been told that certainly some of her problems could be occupational given she is a non-smoker. She appears to have pulmonary functions which are suggestive of chronic obstructive pulmonary disease, we cannot exclude the possibility this could be occupationally related as well given that she was a welder." On November 26, 2013, Dr. Enriquez commented that; "Her COPD is up a little bit after she has been retired compared to when she was working. Most likely the workplace has contributed somehow with worsening of COPD." On March 18, 2003, Dr. Enriquez again commented that; "Based on these (sic) exposure to dust and fumes it is

most likely the cause of her asthma and COPD as she has no known history of smoking. She also claimed that she had no family members at all with asthma."

The Respondent presented no evidence or testimony to rebut or contradict the Petitioner's testimony as to her work environment and, similarly, presented no medical evidence or opinion which questioned, contradicted, or rebutted the opinions of Dr. Enriquez.

Based upon the above, the Arbitrator concludes that the Petitioner's chronic obstructive pulmonary disease and asthma had its origin or aggravation in a risk connected with her employment and these conditions have flowed from that source as a rational consequence.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

The Respondent disputed their liability for the Petitioner's medical bills based upon defenses relating to causal connection, exposure to hazards of an occupational disease and notice. Having found for the Petitioner regarding these disputed matters, the Arbitrator finds the Respondent liable for the following medical expenses:

Petitioner's Exhibit #3	Apria Health Care	$5,049.47
Petitioner's Exhibit #4	Advanced Radiology	$26.98
	Total Medical Awarded	$5,076.45

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

The Petitioner testified that she worked for the Respondent from July 22, 1974 through April 30, 2010 when she retired. The Petitioner was not under any work restrictions when she retired and she testified that she has not worked at all since April 30, 2010. During the course of her employment with the Respondent the Petitioner began to notice breathing difficulties for which she sought medical treatment. The Petitioner continues to receive follow up medical treatment for her condition and she has been prescribed various medications including Prednisone, a nebulizer, Advair and oxygen to be used at night. The Petitioner testified that she has difficulty breathing and notices shortness of breath three to four times per day. Her primary treating physician has been Dr. Felipe Enriquez.

Dr. Enriquez' records demonstrate that the Petitioner has been under his care from June 17, 1996 through the present and that the Petitioner's diagnoses include chronic obstructive pulmonary disease and asthma. On November 6, 2013, Dr. Enriquez assessed the Petitioner as having acute bronchitis, exacerbation of COPD, moderate to severe persistent asthma and a history of atrial fibrillations and he indicated that "In view of the above findings, plus the presence of comorbidities

including rheumatoid arthritis, plus her age of 70 and due to frequent exacerbation of her COPD and asthma, it is my opinion that the patient will not be able to go back to work anyplace."

No evidence was offered into the record which questioned, contradicted, rebutted or discredited the opinions of Dr. Enriquez.

Based upon the above, the Arbitrator concludes that the Petitioner is permanently and totally disabled from November 6, 2013 through the present.

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

TIMOTHY GRUTZIUS,

Petitioner,

vs. NO: 11 WC 35317

VILLAGE OF ALSIP,

Respondent.

17IWCC0100

DECISION AND OPINION ON REVIEW

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

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner was a Lieutenant Paramedic for Respondent. He provided support for the ambulance company at the scenes of emergencies. He carried equipment and stretchers weighing up to 100 pounds. He also carried tools weighing up to 60 pounds. He usually handled 6 calls per shift. His gear included a turn-out coat, turn-out pant, boots, gloves, helmet and a self-contained breathing apparatus harnessed to his back. It weighed 70 pounds.

2. In 1998 Petitioner was treated for a double inguinal hernia. He did trainings on fire extinguisher use and had to lift a barrel full of water and topped with diesel fuel and gasoline into a truck after each training. This led to his hernias.

3. After the 1998 hernia, Petitioner was off work 6 weeks and returned to work with no restrictions. He has subsequently never had an issue passing his annual employment physicals.

4. On July 26, 2011 Petitioner felt fine when he began his 7a.m. shift. He performed only work related duties that day. During his calls that day, he had assistance from one co-worker lifting a patient on a stretcher weighing 226 pounds total, moving another patient to a cot and moved and carried a third patient on a stretcher. He was not wearing his turn-out gear for these calls, but did have to put on a bunker coat, pants and boots.

5. After his shift ended, Petitioner went home. Later that day he began noticing dull pain on the right side of his groin. After a day of this, he made an appointment with his primary care physician. During his next shift on July 29th, Petitioner informed the Chief and Deputy Chief of his pain and his doctor's appointment.

6. Petitioner underwent a herniorrhaphy on August 8th and worked until August 10, 2011. He scheduled a full hernia surgery for August 12, 2011. Petitioner drafted a memo regarding his injury and gave it to his Chief on August 10th. Petitioner acknowledged at trial, however, that he did not specifically state that his pain was work-related in his memo to the Chief.

7. After the surgery, Petitioner was cleared to return to work in late September 2011. He has returned to full duty and stated that for the most part, everything was fine with his health. He feels occasional pressure on the incision.

8. Dr. Coe examined Petitioner December 30, 2013 and reviewed medical records. Petitioner informed him of his work activities. Dr. Coe diagnosed Petitioner with an inguinal hernia. Petitioner was not obese and there was no evidence of a recurrent or residual herniation. Dr. Coe opined that there was a causal relationship between Petitioner's work duties and his hernia. His opinion was based on his knowledge of Petitioner's work duties, literature regarding hernias and the lack of mention of hernia in Petitioner's annual employment physicals.

9. Petitioner informed Dr. Coe that he was unable to recall any specific event that caused the mesh on his previous hernia repair to tear during the week of the accident in question.

10. Dr. Coe noted that Petitioner's gender, work duties and previous hernia were all risk factors for a recurrent hernia.

11. Dr. Palacci performed an Independent Medical Examination (IME) on Petitioner July 5, 2012. She reviewed prior medical records and noted that none of the records indicated Petitioner developed his hernia at work. Petitioner denied any excessive work activities on the accident date, or the previous day, and also denied any specific trauma.

The Commission affirms the Arbitrator's findings of accident, notice, causal connection, medical expenses, temporary total disability and permanent partial disability.

However, the Commission reverses the Arbitrator's finding with respect to penalties and fees. The Commission notes that no medical records indicate that the hernia suffered on the date in question was work-related. In fact, Petitioner himself stated, both in his medical records and at trial, that he was unaware of any specific lifting event that caused his pain. With the specific cause of the hernia being unknown to the Petitioner himself, the Commission finds no basis to award §19(L) penalties due to an unreasonable delay in paying benefits. Although §6(f) of the Act provides a rebuttable presumption of accident in the case at bar, Respondent provided a good faith rebuttal based on the opinion of Dr. Coe, who found no evidence of a recurrent hernia. Based on the above, the Commission reverses the Arbitrator's award for §19(L) penalties.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $933.33 per week for a period of 6-4/7 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 $695.78 per week for a period of 20 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused a 4% loss of use of Petitioner's person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is not liable for §19(L) penalties.

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 $7,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED:
O: 12/15/16
DLG/wde
45

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GRUTZIUS, TIMOTHY
Employee/Petitioner

Case# **11WC035317**

VILLAGE OF ALSIP
Employer/Respondent

17IWCC0100

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:

0728 LAW OFFICES OF THOMAS W DUDA
CRAIG MILLMAN
330 W COLFAX ST
PALATINE, IL 60067

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

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Timothy Grutzius
Employee/Petitioner

v.

Village of Alsip
Employer/Respondent

Case # 11 WC 35317

Consolidated cases: D/N/A

17IWCC0100

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **May 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. X Did Petitioner sustain an accident that arose out of and in the course of his employment by the 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 occupational exposure?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. 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. ☒ 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 27, 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 **$72,800.00**; the average weekly wage was **$1,400.00**.

On the date of accident, Petitioner was **47** years of age, **married** with **0** dependent children.

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

Respondent through group insurance ***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 Section 8(j) credit in the amount of **$22,603.90** for group insurance medical payments, in accordance with the parties' stipulation. Arb Exh 1.

ORDER

Temporary Total Disability

Respondent shall pay $933.33 per week for a period of 6 4/7 weeks to compensate Petitioner for being temporarily, totally disabled from work for the period 08-12-2011 through 09-26-2011. The parties agree Respondent paid no temporary total disability benefits prior to the hearing. Arb Exh 1.

Medical Payments

The Arbitrator awards Petitioner the medical expenses set forth in the itemized bills in PX 1. In accordance with the parties' stipulation, Respondent is entitled to credit under Section 8(j) in the amount of $22,603.90 for medical payments made by its group carrier, with Respondent holding Petitioner harmless against any claims made by said carrier.

Permanent Partial Disability

Respondent shall pay the amount of $695.78 per week for a period of 20 weeks because the injury sustained by Petitioner caused a permanent, partial disability to the body as a whole to the extent of 4% under Section 8(d)2 of the Act.

Assessment of Penalties/Fees

The Arbitrator finds Respondent liable for $10,000.00 in Section 19(l) penalties.

The basis for the Arbitrator's Decision is provided in the attached Memorandum of Decision.

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

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

Molly C Mason

Signature of Arbitrator

6/9/16
Date

JUN 9 - 2016

Timothy Grutzius v. Village of Alsip
11 WC 35317

Summary of Disputed Issues

Petitioner, a firefighter/paramedic lieutenant, claims he developed a hernia and ruptured a previous hernia repair due to physical activities performed during his 24-hour shift on July 26-27, 2011.

The disputed issues include accident, notice, causal connection, medical expenses, temporary total disability, nature and extent and penalties/fees. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner testified he began working as a firefighter/paramedic for Respondent in September 1994. In 1998, he was lifting a barrel onto a truck, in connection with a work-related safety demonstration, when he developed a double hernia. He underwent a double hernia repair at St. Francis Hospital after this incident. [Petitioner's counsel indicated Petitioner received benefits under the Act in connection with this incident but did not file a claim at the Commission.] He was off work for about six weeks after the repair and then resumed full duty. He did not require any follow-up care thereafter.

Petitioner testified that, during his tenure with Respondent, he underwent physical examinations every two years until he reached the age of 40, at which point he began undergoing these examinations each year. Until two years ago, Dr. Moisan performed these examinations. He passed all of the examinations.

Petitioner testified he became a lieutenant in July 2005. As a lieutenant, his main job is to evaluate emergency and fire suppression needs and provide support to ambulance and fire truck crews.

Petitioner testified his schedule consists of 24 hours "on" followed by 48 hours "off." During any 24-hour shift, he lives at the firehouse, leaving only when he has to respond to a call. He is not permitted to leave to attend to personal business.

Petitioner testified the number of EMS calls during any shift varies from a few to fifteen. As of the claimed accident, he typically went out on one half or two thirds of those calls. He continued to perform physical tasks after becoming a lieutenant. At an EMS call, for example, he would assist with patient transfers and singlehandedly carry various items, including a drug box, a 50-pound "stair chair" and a 20-pound heart monitor. The extent of his physical involvement with patient transfers varied from situation to situation, depending on the patient's needs and environment. If space allowed, he and a member of his crew would use a sheet to transfer the patient from a bed to a stretcher. If the room was cramped, he might have to get up on the bed to help move the patient. Before responding to a fire, he would have

to don 70 pounds of gear. Once the crew arrived at the scene, he would jog around the building to size up the situation and then tell dispatch what equipment would be needed. If a fire had to be fought, he would assist with hose pulling, "unkinking" and positioning. The hoses would be of varying dimensions, from 1 ¾ inch up to 5 inch, and would be "charged." The water flowing through the hoses weighs 8.33 pounds per gallon. He would be the third man into the building and would carry a radio and a light box that provided thermal images. There was a sense of urgency when any active fire was suspected. He also regularly responded to motor vehicle accident scenes. If any individual had to be extracted from a vehicle, he might have to break a window, lift a dashboard, move hydraulic lines, push a backboard under a victim and transfer the victim to a stretcher.

Petitioner testified he regularly oversaw and participated in training exercises. A minimum of 20 hours of training took place each month. The training could consist of relatively routine ladder and equipment inspection or very strenuous, full gear fire simulations during which he might be required to crawl, climb stairs and drag hoses and a "fog" machine through a three-story training tower.

Petitioner testified he reported to work at about 6:40 AM on July 26, 2011. He felt fine when he arrived for his 24-hour shift. He did not leave to attend to any personal business during that shift. He did, however, go out on several calls. He identified PX 11 as a list of the calls he went out on. Four of these calls were of an EMS nature. During two of these calls, he was personally involved in physically transferring individuals. One of these individuals weighed 126 pounds. The second, a man weighing about 220 pounds, required immobilization. On another call, he might have carried a drug box or other equipment. He did not wear gear to these calls. On two other "automatic aid" calls, he wore his required coat and pants and stepped up a distance of 2 ½ feet in order to get into a truck.

Petitioner denied experiencing any symptoms during his July 26-27, 2011 24-hour shift. He went home on the morning of July 27th, after his shift ended. Later that day, in the afternoon, he began experiencing dull pain radiating from his right groin to his scrotal area. He called his personal care physician, Dr. McElligott, and made an appointment to get checked out. The first available appointment was on August 2nd.

Petitioner testified he next reported to work on July 29, 2011. On that day, he met with then Chief Geraci and the current chief, Thomas Styczynski, in Geraci's office. He told these two individuals that after he got home on the 27th, he realized "something was not right" and made a doctor's appointment.

Petitioner testified he worked his regular shift on July 29-30, 2011. He continued performing his regular shifts thereafter through the August 10-11, 2011 shift. At that point, he was still going out on calls but his crew was not letting him perform any physical activities such as lifting.

Petitioner testified that, when he saw Dr. McElligott on August 2, 2011, she examined him but did not appreciate a hernia. She referred him to Dr. Pacella, a surgeon.

Dr. McElligott's handwritten note of August 2, 2011 reflects Petitioner complained of aching pain in the right inguinal area radiating down into the right testicle. The note also documents prior hernia surgery. The note further states: "no specific injury – pt is a fireman, x 2 weeks becoming worse." The doctor referred Petitioner to Dr. Pacella. PX 4.

Petitioner testified he saw Dr. Pacella on August 8, 2011. Dr. Pacella examined his groin/inguinal area more thoroughly and was able to feel that the mesh from the previous repair had torn. Dr. Pacella recommended surgery to repair this tear.

Dr. Pacella's handwritten note of August 8, 2011 is somewhat difficult to read. It reflects Petitioner developed a "double hernia" thirteen years earlier and underwent surgery. It also reflects Petitioner complained of right groin pain that was "worse" during the previous last two weeks. The doctor indicated that Petitioner denied testicular pain and also denied pain when moving his bowels, urinating or engaging in sex. PX 5.

Petitioner testified that an adjuster, Thalia Nevels, called him on approximately August 9, 2011 and asked him various questions about the origin of his claimed recurrent hernia and Dr. Pacella's surgical recommendation. During this conversation, Nevels told him "you might want to use your own insurance" because she anticipated there would be a delay in determining whether the claim would be accepted under workers' compensation. Petitioner testified that, when he went to work the next day, August 10, 2011, he completed a list of calls he had responded to on July 26 and 27, 2011. He gave this list to Geraci the same day. At Nevels' direction, he also gave Geraci a "to/from" memo. He identified PX 2 as this memo. In the first sentence, Petitioner indicated he was submitting the memo "at the direction of our workman's comp adjuster to state the facts for a possible claim." He went on to provide a chronology of events, starting with the onset of "dull aching" in his right inguinal area during the afternoon of July 27, 2011, and referencing his prior hernia repair in August 1998. The last paragraph of the memo reads as follows:

> "My last workday prior to the first onset of the dull aching was July 26, 2011. I cannot say if there was anything specifically that I did to cause the mesh to tear. At this time I feel it is in my best interest to have this hernia repaired in order to avoid it becoming worse which could result in an extended period of time off at work. From the time of August 1st to the present day, I feel a pressure in the area of this rupture but not the same dull aching feeling as of a week and a half ago.
>
> These are the facts as I know them to the best of my knowledge."

On August 11, 2011, Petitioner signed an authorization allowing the Illinois Public Risk Fund to examine and/or copy any and all of his medical records and to discuss those records with his medical providers. PX 9.

Dr. Pacella operated on Petitioner, performing a "recurrent direct right inguinal hernioplasty with insertion of UPPS mesh," on August 12, 2011. In his operative report, he noted a "previous transverse incision" that was "quite heavily scarred." He indicated he made a classic inguinal incision and "worked [his] way through the scar tissue." He described "quite a reaction from the previous surgery that was done thirteen years ago." He indicated that Petitioner had "no evidence of an indirect but rather direct hernia coming through the direct space in the usual fashion." PX 3, 5.

At the first post-operative visit, on August 15, 2011, Dr. Pacella indicated that Petitioner was experiencing some swelling but "doing OK." Petitioner continued to see the doctor periodically thereafter, with the doctor noting no complications. PX 5.

On August 26, 2011, Nevels, [a claims specialist affiliated with the Illinois Public Risk Fund,] wrote to Petitioner acknowledging "receipt of a claim relating to your alleged injury or incident of 7/27/11." Nevels informed Petitioner she would not be able to determine whether the claim would be accepted as work-related until she had obtained and reviewed all of his medical records. PX 9.

On September 26, 2011, Dr. Pacella described Petitioner as having "no issues." He released Petitioner to full duty as of September 27, 2011. PX 5.

Petitioner testified he was required to see Dr. Moisan to obtain clearance despite having been cleared by Dr. Pacella.

On September 26, 2011, Dr. Moisan issued a workers' compensation report finding Petitioner capable of returning to full duty as of September 27, 2011. PX 6.

Petitioner testified that, while off work after the surgery, he used twelve sick days, one vacation day and two furlough days. Blue Cross/Blue Shield, Respondent's group carrier, paid his medical bills.

Petitioner could not recall exactly when he resumed working after being released to full duty. He knows he returned during the first shift that was available to him. He has continued performing full duty since that time.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Liana Palacci, an osteopathic physician, on July 5, 2012. In her report of the same date, the doctor opined that her examination findings were consistent with a successful repair of a recurrent right inguinal hernia, that Petitioner "did not experience a specific event or trauma that could

have contributed to [the] recurrence," that the surgery was reasonable and necessary and that Petitioner had reached maximum medical improvement. Palacci Dep Exh 2.

Dr. Palacci, Respondent's Section 12 examiner, testified by way of evidence deposition on October 29, 2013. Dr. Palacci testified she graduated from the New York College of Osteopathic Medicine in May 2001. She obtained board certification in internal medicine in August 2005. RX 1 at 6. She is currently affiliated with St. Joseph Hospital. RX 1 at 6.

Dr. Palacci testified she devotes about 25 to 33% of her practice to patient care. She spends the rest of her time conducting disability evaluations for the State of Illinois and performing independent medical examinations. RX 1 at 6. She sees about 15 primary care patients weekly in the course of her independent contractor affiliation with Arthritis and Internal Medicine. RX 1 at 7.

Dr. Palacci testified she examined Petitioner on July 5, 2012 but does not recall the examination. She relied on her report while testifying. In connection with the examination, she reviewed various treatment records, including the office notes of Drs. McElligott and Pacella. RX 1 at 8. None of the records she reviewed indicated that Petitioner developed a hernia at work. RX 1 at 8. At the time of her examination, Petitioner informed her he experienced aching in his right groin on July 27, 2011. Petitioner denied performing any excessive or work activities that day or the previous day. He also denied any specific trauma. RX 1 at 10. He further denied engaging in any unusual exercise. RX 1 at 11. He voiced no complaints. RX 1 at 12.

Dr. Palacci testified that Petitioner informed her he underwent a bilateral inguinal hernia repair in 1998. Petitioner denied having any inguinal pain after recovering from this surgery. The doctor opined that a history of a previous hernia/repair is a risk factor for a hernia recurrence. RX 1 at 13.

Dr. Palacci testified that several risk factors are associated with inguinal hernias. Those factors include "male sex, Caucasian race, older age, history of hernia and prior hernia repair, history of smoking [and] family history." Regular exercise or weightlifting is also a possible risk factor. RX 1 at 13. Petitioner's risk factors include his gender and race, the previous repair and the fact his father and brother had developed hernias. RX 1 at 13-14.

Dr. Palacci testified that lifting or straining could possibly put a person at risk for a hernia but that this is "very controversial." She elaborated as follows: "I don't think we know that a one time straining or even multiple straining is a risk factor." RX 1 at 14.

Dr. Palacci testified that, on examining Petitioner, she noted well-healed horizontal inguinal scars consistent with previous surgery and a well-healed diagonal scar below the right horizontal scar consistent with the most recent surgery. She saw no evidence of hernia or bulging. She noted no tenderness to palpation of the scars. She also noted no lymphadenopathy or testicular tenderness. RX 1 at 14.

Dr. Palacci addressed causation as follows:

> "My impression is that the pain that [Petitioner] felt was not associated with a work injury. He did not describe any specific trauma. He wasn't even sure about the exact date of his alleged work injury.
>
> None of his treating records indicated that this was work related in any way. And, in addition, he has multiple other risk factors that would predispose him to a hernia."

RX 1 at 15.

Dr. Palacci was not able to say how frequently hernias recur in individuals who have undergone prior repairs. A recurrence in a person who underwent a repair 10 or more years earlier could be due to the "natural deterioration of the mesh," particularly if there is any weakness in the abdominal wall. RX 1 at 16.

Dr. Palacci further opined that Petitioner is at maximum medical improvement and capable of performing full duty. RX 1 at 16.

Under cross-examination, Dr. Palacci testified that osteopathic physicians undergo the same allopathic training that medical doctors undergo but they also undergo additional training in musculoskeletal diseases and care. Osteopaths practice manipulative therapy. RX 1 at 17.

Dr. Palacci testified she is not certified to perform any kind of surgery. She has never performed any surgeries on her own. While she was a medical student, she assisted with abdominal and cardiac surgeries. RX 1 at 18.

Dr. Palacci testified she spends about 25% of her work time performing independent medical examinations. About 60% of the examinations she performs are for insurance carriers or employers. RX 1 at 18.

Dr. Palacci testified she asked Petitioner whether his pain was associated with any event such as lifting or falling. Petitioner reported performing his usual work activities, which consisted of suppressing fires and providing EMT services. Petitioner indicated that, with assistance, he occasionally lifted very heavy patients weighing as much as 500 pounds. RX 1 at 19. She did not ask him if he had lifted any such patients during the week before he began experiencing pain. She acknowledged it is possible Petitioner developed a recurrent hernia secondary to weightlifting. RX 1 at 20. She did not ask Petitioner about the amount he lifts or whether he is required to maintain a certain level of fitness for work purposes. RX 1 at 20.

Dr. Palacci testified she reviewed Dr. Pacella's operative report. The doctor indicated he inserted mesh. Because mesh deteriorates, it is a possibility Petitioner will have another hernia in the future. RX 1 at 21.

Dr. Palacci testified she is "unsure" about the provision of the Act relating to firefighters who develop hernias. It is possible Petitioner's recurrent hernia developed at work but the literature she has read indicates there are "just about as many patients who develop hernias performing sedentary jobs" as there are who develop hernias while performing more intense straining. RX 1 at 22-23. She cannot say, to a reasonable degree of certainty, that lifting heavy weights does not cause hernias. RX 1 at 23. She also cannot say what exactly caused Petitioner's hernia. She can only identify his risk factors. RX 1 at 23. She cannot say, to a reasonable degree of certainty, which of those factors might have caused the recurrent hernia. RX 1 at 23. She is not sure which percentage of mesh repairs fail within 5 to 10 years. RX 1 at 25. Hernia recurrences can occur in up to 15% of patients. RX 1 at 25. Petitioner's recurrent hernia developed outside of the normal post-surgical time frame of 5 to 10 years. RX 1 at 26. There is no way to predict whether Petitioner's most recent repair will fail. RX 1 at 26-27. It is "always possible" but, in her opinion, "unlikely" that Petitioner developed a hernia from lifting and carrying patients or performing other firefighter duties. RX 1 at 27. There is no indication that Petitioner became symptomatic while performing those duties. RX 1 at 28. Nor is there any indication Petitioner became symptomatic while performing non-work activities. RX 1 at 28. Petitioner told her it was typical for him to move patients, with assistance. Some of those patients weighed as much as 500 pounds. RX 1 at 30.

Dr. Palacci testified she assumes Petitioner underwent an employment-related physical examination annually. RX 1 at 31-32. She is not sure whether she reviewed records from the examination performed before the claimed accident. A doctor performing this examination may or may not have found a hernia. RX 1 at 32. Any such examination findings would not be important to her. RX 1 at 33. Petitioner went to an Emergency Room on January 13, 2010 but the records concerning this visit do not mention any abdominal complaints. However, it would not be typical for an Emergency Room physician to perform an inguinal check if a patient is voicing complaints in other body parts. RX 1 at 34. She is not sure whether a routine annual physical for a firefighter would include an inguinal check if the firefighter had no abdominal complaints. RX 1 at 35.

Dr. Palacci testified she did not receive or review the report Petitioner wrote out for his supervisors. RX 1 at 38-39.

On redirect, Dr. Palacci testified a person who has a hernia can be asymptomatic. RX 1 at 40. While she does not perform surgery, she frequently reviews operative reports and relies on those reports. Petitioner had no complications following his hernia repair. RX 1 at 40-41. Risk factors for hernias can work in combination with one another. In Petitioner's case, it is "very possible" his risk factors led to the hernia. RX 1 at 42. Petitioner denied any specific work injury. RX 1 at 43.

Under re-cross, Dr. Palacci testified a hernia can develop over a period of time. It is possible that repetitive lifting could produce a hernia over time. This would be another possible risk factor. RX 1 at 43.

On redirect, Dr. Palacci testified it is "more likely than not that [Petitioner] had other risk factors that contributed to" his hernia. RX 1 at 45.

Dr. Coe testified by way of evidence deposition on October 31, 2014. Dr. Coe testified he obtained board certification in occupational medicine in 1991. He is an adjunct assistant professor of occupational and environmental health at the University of Illinois Medical Center. PX 8 at 6-7. In this capacity, he supervises doctors who are in training. He also operates Occupational Medicine Associates of Chicago. In this capacity, he conducts pre-employment examinations and people who may be exposed to hazards during the workday. He devotes about one-third of his time to conducting examinations in workers' compensation and civil matters. During the past two years, about 60% of these examinations have been for carriers or employers. PX 8 at 8-10. Prior to that, the majority were for claimants. PX 8 at 10.

Dr. Coe testified he examined Petitioner on December 30, 2013, at the request of Petitioner's counsel. He also reviewed records from Drs. McElligott and Pacella. PX 8 at 10-11.

Dr. Coe testified that Petitioner told him he had undergone a bilateral hernia repair in 1988. Petitioner also described his general duties as a paramedic and firefighter. Petitioner indicated he responded to several calls on July 26, 2011. Petitioner related he lifted and transported patients to hospitals during those calls. The patients varied in weight from 120 to 220 pounds. Petitioner indicated that the lifting involved stair chairs and stretchers and was "often in awkward positions." PX 8 at 13. Petitioner also told him he woke up in pain on July 27, 2011. His pain was in his right groin region. PX 8 at 14-15.

Dr. Coe described a stair chair as a narrow, collapsible chair that can be lifted or wheeled. It permits a person to be transported down stairs and sometimes down ladders through narrow corridors. PX 8 at 14.

Dr. Coe testified that hernias are "weakened areas in surrounding or supportive structures." Hernias "allow projection of the underlying bowel, mostly the small intestine." Some types of hernias are more common in men than women. Some are more common in particular age groups. Dr. Pacella ultimately diagnosed Petitioner with a direct inguinal hernia, i.e., a hernia directly through the anterior abdominal wall in the lower inguinal region. An indirect hernia, in contrast, is a hernia that slides through a ring in the lower abdomen, extending in men into the scrotum. Petitioner did not have an indirect hernia. PX 8 at 16-17.

Dr. Coe testified that, in his operative report, Dr. Pacella indicated he encountered significant scar tissue from the earlier hernia repair. Dr. Pacella moved that scar tissue around, cut through some of it and then "observed a recurrent direct right inguinal hernia." PX 8 at 18. Dr. Pacella used a two-part, two-piece mesh graft to repair the hernia. He performed a "typical

modern hernia repair." PX 8 at 18. Petitioner had an uneventful recovery from the surgery and was able to resume full duty. PX 8 at 19. As of his examination, Petitioner complained of occasional discomfort at the operative or scar site, which he noticed when pushing or pulling. PX 8 at 19.

Dr. Coe described Petitioner as a non-obese individual with a height of 5 feet, 8 inches and a weight of 155 pounds. On examination, he noted both an old scar and a new scar in the right inguinal area as well as one scar in the left inguinal area. He found no evidence of recurrent or residual herniation. There was some tenderness to palpation on the right side as opposed to the left. PX 8 at 21-22.

Dr. Coe opined, to a reasonable degree of medical certainty, that there is a causal relationship between the duties Petitioner performed as a paramedic/firefighter and the development of his recurrent right direct inguinal hernia. PX 8 at 23. He based this opinion on his familiarity with the duties Petitioner described, his regular examinations and treatment of hernia patients and his familiarity with the literature concerning hernias and hernia repairs. PX 8 at 25-26. As he indicated in his report, it is standard medical teaching in occupational medicine that activities involving forceful lifting, pulling, pushing and working in awkward positions are risk factors for the development of inguinal hernias. PX 8 at 27.

Dr. Coe testified that the mesh repair Petitioner underwent has been standard for about twenty years. The recurrence rate is about 5 to 15%, with recurrences generally occurring about ten years or more out. The factors that increase the risk of recurrence following a mesh repair are the same factors that increase the risk of developing a hernia, i.e., obesity, male gender, chronic illnesses giving rise to coughing or vomiting, both of which create intra-abdominal pressure, age and heavy, repetitive straining, lifting, bending and twisting. About 5 to 10% of all men will develop a hernia over their lifetimes but not all hernias are symptomatic. PX 8 at 30-31.

Dr. Coe testified Petitioner is not obese and thus obesity was not a risk factor for him. Nor does Petitioner have any chronic illnesses. Nor was age a factor. Petitioner was 47 when he developed the recurrent hernia. The identifiable risk factors in Petitioner's case are his gender, his job duties and, potentially, his previous mesh repair. PX 8 at 32-34. As for the previous repair, however, Petitioner did not experience a recurrent hernia on the left side. PX 8 at 34-35.

[The Arbitrator sustained Respondent's Ghere-based objections to Coe Dep Exhibit 3, a hernia-related medical article discussed by the doctor. The Arbitrator did not consider this article in reaching her conclusions in this case. The Arbitrator also sustained Respondent's Ghere-based objection to an opinion Dr. Coe rendered concerning the possibility of Petitioner requiring future care. PX 8 at 35-37.]

Under cross-examination, Dr. Coe acknowledged he did not reference Coe Dep Exhibit 3, a medical article, in his examination report. PX 8 at 38-39.

Dr. Coe acknowledged he is not board certified in internal medicine and has not authored any articles concerning hernias or hernia repairs. PX 8 at 40. He does not have a sub-specialty. He takes care of all kinds of work-related medical problems. PX 8 at 41. He has watched hernia repairs but has never performed one. PX 8 at 41. He sutures wounds but does not perform surgeries. PX 8 at 41-42. If a patient with a symptomatic hernia came to him, he would likely refer that person to a surgeon. PX 8 at 42. He did not review any records concerning Petitioner's previous hernia repair. PX 8 at 45. Dr. McElligott's note of August 2, 2011 indicates Petitioner is a firefighter but it contains no mention of Petitioner's work activities. PX 8 at 45-46. Nor does that note mention any specific injury. PX 8 at 45. The mesh used in modern hernia repairs can provoke the growth of scar tissue. Scar tissue can cause discomfort and/or swelling in some individuals, but there is no evidence of that in Petitioner's case. PX 8 at 47. The mesh used currently is different from the mesh used years back. PX 8 at 48. He has not seen any formal description or video of Petitioner's job activities. PX 8 at 49. Nor has he seen any list of the calls Petitioner went to on the date in question. PX 8 at 50. Petitioner did not focus on any particular event. Petitioner also related that his symptoms developed after he got home from work. PX 8 at 50-51. A previous hernia repair is a risk factor for a recurrent hernia. PX 8 at 51. Mesh can deteriorate over time but Dr. Pacella did not describe this in his operative report. PX 8 at 51-52. The type of hernia Petitioner had is not congenital in nature. PX 8 at 52. Forceful weightlifting performed as exercise can cause a hernia. PX 8 at 53. A person who has a sedentary job can develop a hernia. It is also possible for a hernia to develop secondary to everyday activities. PX 8 at 54. Petitioner did not report any difficulty performing his job. PX 8 at 55. None of the medical records he reviewed contain a description of physical activities that could lead to a hernia. PX 8 at 56. His understanding of what happened on July 26, 2011 is based solely on what Petitioner reported to him. PX 8 at 58. Petitioner was already at risk for a recurrence before July 26, 2011, due to his previous mesh repair. PX 8 at 58. He is still at some increased risk for breakdown despite having had another repair. PX 8 at 59. He has not found any medical literature dealing with the issue of the risk of recurrence following multiple repairs. PX 8 at 59.

On redirect, Dr. Coe testified he relied on Petitioner's handwritten call list in formulating his opinions. There is no variance between that document and Petitioner's oral reporting to him. PX 8 at 60-62.

Under re-cross, Dr. Coe acknowledged that Petitioner wrote on the call list that he was unable to remember any specific event that caused the mesh to tear. PX 8 at 62.

Petitioner's counsel filed a petition for penalties and fees on November 24, 2014. The petition alleges that Petitioner completed three work calls on July 27, 2011 and woke the following morning with groin pain, which he reported to his supervisor. PX 10.

In addition to the exhibits previously described, Petitioner offered into evidence a letter dated September 9, 2015 and various documents produced by Respondent in response to Petitioner's FOIA request of August 26, 2015. The documents include a log of calls to which

Petitioner and others responded on July 26, 2011 and "patient care reports" concerning those calls. Most of the information (such as name, address, gender, date of birth, "patient narrative," etc.) concerning the patients has been redacted. They also include a Form 45 dated July 29, 1998 reflecting Petitioner reported a "possible hernia to left side of groin" secondary to lifting a half barrel onto the back of a pick-up truck during a fire extinguisher "class demo" while working as a firefighter/paramedic for Respondent on July 28, 1998. Petitioner's signature appears at the bottom of this document. PX 9.

In addition to the exhibits previously described, Respondent offered into evidence a summary of medical payments totaling $22,603.90 paid by Blue Cross/Blue Shield to Palos Anesthesia, SCR Laboratory, Dr. Pacella and Palos Community Hospital. RX 2. Petitioner stipulated that Respondent is entitled to Section 8(j) credit in this amount. Arb Exh 1.

Petitioner testified he continues to experience a tugging sensation at the incision site. In mid-January 2016, he experienced aching at this site while performing lifting. He related this to Dr. McElligott and she examined him.

Under cross-examination, Petitioner testified worked as a paramedic for Metro Paramedics before being hired by Respondent.

Petitioner acknowledged that, on certain workdays, there could be no calls to respond to. He also acknowledged some calls do not require any strenuous activities. If he and his team respond to an individual who refuses medical treatment, no transfer is required. Four people typically respond to each EMS call. Two ride in the ambulance and two in the engine. A bigger team might be required if people have to be extracted from motor vehicles.

Petitioner testified his non-work activities at the time of the alleged accident included travel and exercise. He had to meet a certain standard of physical fitness to keep his job. He exercised at work and outside of work. He used cardio machines and a Smith machine. He also lifted weights. During a typical week in June or July 2011, he would lift weights two days and perform cardio three to four days. On July 26, 2011, he and his team went out on six calls. During these calls, he was personally involved in lifting and transferring patients who weighed 126 and 220 pounds. The patient who weighed 220 pounds had to be immobilized via straps. He did not perform this lifting unassisted but he did singlehandedly push the patients up into the ambulance. He did not notice any pain or feel any bulging on July 26, 2011. He did not report any symptoms to his co-workers or superiors that day. It was in the afternoon of the following day, July 27, 2011, while he was off work, that he noticed symptoms. He did not make any report on that date. He worked his regular shift on July 29th. He also worked and reported to calls on August 1, 4 and 7. It was on August 9th that he completed the "to/from" memo, in which he stated he was not able to identify any specific event that caused the mesh to tear. He does not know the origin of the pain he experienced on July 27th. He worked during the August 10-11 shift. Teams went out on seventeen calls on that date. He is not sure which calls he went out on. He likely went out on half to two-thirds of these calls but, at that point, his crew was not allowing him to do any heavy lifting due to his diagnosis. When he saw Drs.

McElligott and Pacella, on August 2 and 8, 2011, he did not link the onset of his pain to a specific event. He does not view his injury as an "accident," in the common sense of the word. Rather, it's just the outcome of his regular duties. He provided a honest history to Dr. Palacci. The hernia developed in the same area as his prior mesh repair. His father and brother have also experienced hernias. With the exception of his early 2013 visit to Dr. McElligott, he has not had any treatment relating to the hernia since 2011. Nor does he have any upcoming appointments regarding the hernia. He cannot recall performing any exercise after he left work on July 27, 2011. He did not work out on July 28, 2011 due to the level of pain he was experiencing. He worked his regular shift on July 29th. In his report, he did not attribute his pain to the calls he went out on.

On redirect, Petitioner testified that, when he reported his symptoms to Geraci and Styczynski on July 29, 2011, he told them the pain was new to him and was something he wanted to explore. He noticed this pain the same day his shift ended, i.e., July 27, 2011. There was no visible bulging in the area of the hernia at any point between July 27th and his surgery. His groin pain subsided around August 1, 2011. Dr. Pacella told him he had a ruptured hernia. When his team is alerted that a patient has "passed out," the call takes on additional urgency.

Under re-cross, Petitioner acknowledged he never learned anything from Dr. Pacella as to the underlying cause of the hernia rupture.

Thomas Styczynski testified on behalf of Respondent. Styczynski testified he is currently Respondent's fire chief. He was hired as a firefighter/paramedic in 1997. In 2010, he was promoted to lieutenant. He was made chief in July 2012. He has continued to go out on calls since becoming the chief.

Styczynski testified that any workplace injury has to be reported. Once he has received notice, he sends the relevant paperwork to Respondent's claims administrator.

Styczynski testified that, as of July 2011, Geraci was chief and he was deputy chief. At that time, his primary duty was training. He worked 8-hour shifts, Monday through Friday. He also worked on the weekends at times. He cannot recall if he worked on July 27 or 29, 2011. He knows Petitioner. He vaguely recalls Petitioner reporting groin pain but he cannot recall the date on which Petitioner made this report. He cannot recall any three-way conversation on this topic involving him, Petitioner and Gercaci. If records show Petitioner reported abdominal pain on July 27, 2011 he would not quarrel with the records. To the best of his recollection, Petitioner indicated this pain might be related to his prior hernia surgery. At that point, the "process should have been started for workers' compensation" but he cannot recall if it was. He has no recollection of Petitioner complaining of a hernia. Petitioner later told him he needed surgery.

Under cross-examination, Styczynski testified he does not recall PX 2 [Petitioner's "to/from" memo of August 9, 2011] but might have seen it. When Petitioner submitted PX 2, a

Form 45 and a supervisor's report should have been completed. These forms are only completed when a work injury is reported.

Arbitrator's Credibility Assessment

Petitioner's lieutenant status and lengthy tenure with Respondent weigh in his favor, credibility-wise.

Petitioner's testimony concerning the physical activities he performed during his July 26-27, 2011 24-hour shift was detailed and convincing. Equally compelling was his denial of any similar activities during the brief interval between the end of that shift and the onset of symptoms later that same day.

Respondent did not produce any evidence contradicting Petitioner's account of his work activities, onset of symptoms or reporting of those symptoms. Nor did Respondent refute Petitioner's testimony that his original hernia condition, which required a mesh repair in 1988, was work-related.

Arbitrator's Conclusions of Law

Did Petitioner sustain an accident on July 27, 2011 arising out of and in the course of his employment? Did Petitioner establish causal connection?

Initially, the Arbitrator considers the effect of Section 6(f) of the Act. This section provides, in relevant part, as follows:

> "Any condition or impairment of health of an employee employed as a firefighter, emergency medical technician [EMT], or paramedic which results directly or indirectly from any bloodborne pathogen, lung or respiratory disease or condition, heart or vascular disease or condition, hypertension, tuberculosis, or cancer resulting in any disability (temporary, permanent, total or partial) to the employee shall be rebuttably presumed to arise out of and in the course of the employee's firefighting, EMT or paramedic employment and, further, shall be rebuttably presumed to be causally connected to the hazards or exposures of the employment. This presumption shall also apply to any hernia or hearing loss suffered by an employee employed as a firefighter, EMT or paramedic. However, this presumption shall not apply to any employee who has been employed as a firefighter, EMT or paramedic for less than 5 years at the time he or she files an Application for Adjustment of Claim concerning the condition or impairment with the Illinois Workers' Compensation Commission."

This section has an obvious application to the instant case. Petitioner alleges a hernia and had worked as a firefighter/paramedic for more than five years as of the date he filed his Application. The question for the Arbitrator to resolve is whether the presumption in favor of compensability was successfully rebutted.

The Arbitrator, having considered the timeline and all of the evidence, finds that the statutory presumption was not rebutted and that Petitioner established a compensable accident and causal connection. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible testimony that his original hernia, which required a mesh repair in 1988, was work-related; 2) the Form 45 produced by Respondent in response to Petitioner's FOIA request (PX 9); 3) Petitioner's credible testimony concerning the lifting and other physical activities he performed while working on July 26 and 27, 2011; 4) Petitioner's credible denial of any intervening physical activities between the time his shift ended at 7 AM on July 27, 2011 and the onset of his symptoms later the same day; 5) Dr. McElligott's note of August 2, 2011, which references a prior hernia repair and, in the context of a causation-related comment, describes Petitioner as a fireman; 6) Dr. Pacella's note of August 8, 2011, which also references a prior hernia repair; 7) Dr. Coe's causation-related opinions; and 8) Chief Styczynski's concession that Petitioner's "to/from" memo of August 9, 2011 should have prompted the filing of a Form 45 and a supervisor's report, as required for all work injuries.

The Arbitrator is in the unusual (some might say unenviable) position of having very recently heard and decided another hernia case (Andrew Hufnagl v. Village of Alsip, 14 WC 15052) involving the same statute, employer and Section 12 examiner. As of this writing, the Hufnagl case is pending before the Commission on the claimant's review of the Arbitrator's denial of benefits. At first glance, the two cases appear quite similar, since both claimants are firefighter/paramedic lieutenants with physical duties who became symptomatic away from the workplace. However, the Arbitrator specifically found Hufnagl not credible because of his attempt to link the onset of his symptoms (which he first experienced while having intercourse with his wife) with activities he performed at work a month earlier. Petitioner, in contrast, credibly testified he became symptomatic the same day his shift ended, with that shift having involved at least two instances of assisted lifting of patients and other physical tasks. Petitioner also specifically denied engaging in any physical activities between his departure from work in the morning and the onset of symptoms in the afternoon. Petitioner also offered a causal connection opinion from Dr. Coe, a physician who is board certified in occupational medicine. Moreover, both Dr. Coe and Respondent's examiner targeted the prior mesh repair as, at least potentially, a cause of the recurrent hernia in 2011. Petitioner reported the prior hernia as work-related, as evidenced by the Form 45 produced by Respondent. To the extent a pre-existing condition contributed to the development of the recurrent hernia, it was a work-related condition. Finally, Chief Styczynski, Respondent's sole witness, admitted under oath that Respondent should have generated a Form 45, i.e., a statutory reporting of a work injury, in response to Petitioner's "to/from" memo of August 9, 2011.

Did Petitioner provide Respondent with timely notice of his July 27, 2011 accident?

The Arbitrator finds that Petitioner provided Respondent with timely notice of his July 27, 2011 accident. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible testimony concerning his July 29, 2011 conversation with Chief Geraci and Deputy Chief Styczynski; 2) Petitioner's credible testimony concerning his August 9, 2011 telephone conversation with Thalia Nevels, a claims specialist affiliated with the Illinois Public Risk Fund; 3) Petitioner's credible testimony as to the creation and delivery of the "to/from" memo of August 9, 2011 (PX 2); 4) Nevels' letter of August 26, 2011 to Petitioner, acknowledging receipt of a claim relating to his alleged injury of July 27, 2011; 5) the fact that Petitioner signed an authorization on August 11, 2011 allowing Respondents' claims administrator to obtain his medical records and discuss his condition and care with his providers "to facilitate the evaluation of [his] claim for workers' compensation benefits"; and 6) Chief Styczynski's admission that Petitioner's "to/from" memo of August 9, 2011 should have prompted the creation of a Form 45 and supervisor's report, as required for any workplace injury. All of the referenced oral and written communications occurred within the statutory 45-day notice period. While Petitioner did not report a specific traumatic event within that period, he reported a health condition he viewed as work-related or potentially work-related. The purpose of the notice provision is to allow an employer to conduct a timely investigation of such a claimed condition. By submitting the "to/from" memo of August 9, 2011 and signing the "blanket" authorization on August 11, 2011, again within the 45-day period, Petitioner allowed Respondent access to the facts and records bearing on his claimed condition.

Is Petitioner entitled to temporary total disability benefits?

On the Request for Hearing form (Arb Exh 1), Petitioner claimed he was temporarily totally disabled from August 12, 2011 (the date of surgery) through September 27, 2011. Respondent disputed this claim, based on its other defenses. Respondent did not offer any evidence suggesting the surgery was unnecessary or that Petitioner could have resumed working on an earlier date.

Petitioner testified he had to obtain clearance from Dr. Moisan after his surgeon, Dr. Pacella, released him to full duty. Once he received clearance, he reported to the "first available shift" but could not recall the exact date that shift started.

The Arbitrator has found in Petitioner's favor on the issues of accident, notice and causal connection. Based on the records, which reflect that Drs. Pacella and Moisan released Petitioner to resume full duty as September 27, 2011, the Arbitrator finds that Petitioner was temporarily totally disabled from August 12, 2011 through September 26, 2011, a period of 6 4/7 weeks. Based on the stipulated average weekly wage of $1,400.00, the Arbitrator awards temporary total disability at the rate of $933.33 per week.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner offered into evidence a collection of medical bills from Dr. McElligott, Dr. Pacella and Palos Community Hospital. PX 1. Respondent raised no objection to the admission of these bills. Respondent did not offer any evidence suggesting that Petitioner's medical treatment was unnecessary or excessive.

The bill cover sheet reflects payments made by the group carrier and Petitioner. The cover sheet also lists $482.00 in charge from Dr. McElligott for services rendered between January 11, 2012 and April 15, 2015. These charges are not indicated on the actual bill, which is dated September 30, 2011. The actual bills show various payments but they do not show which person or entity made those payments.

All of the bills reflect $0 balances.

The Arbitrator has found in Petitioner's favor on the issues of accident, notice and causal connection. As noted earlier, there is no evidence suggesting that the medical treatment Petitioner underwent was unnecessary or excessive.

The Arbitrator awards the actual bills in PX 1, subject to the fee schedule and with Respondent receiving Section 8(j) credit in the amount of $22,603.90, in accordance with the parties' stipulation.

What is the nature and extent of the injury?

This is a pre-amendatory case, since Petitioner's accident occurred prior to September 1, 2011. In resolving permanency, the Arbitrator considers the following: 1) Dr. Pacella's operative report and full-duty discharge; 2) Dr. Palacci's admission that the 2011 hernia repair places Petitioner at some degree of risk for a recurrence; and 3) Petitioner's testimony that he was able to resume full duty and experiences only occasional discomfort at the incision site.

The Arbitrator finds that the injury resulted in permanency equivalent to 4% loss of use of the person as a whole, equivalent to 20 weeks of benefits at the applicable maximum permanency rate of $695.78 per week.

Is Respondent liable for penalties and fees?

Petitioner seeks an award of penalties and fees on every aspect of the Arbitrator's award, including permanency. Petitioner maintains Respondent acted in an objectively unreasonable manner in denying benefits. Petitioner accurately points out that Respondent did not obtain a Section 12 examination until July 2012, long after he had resumed full duty following the August 12, 2011 surgery.

Respondent argues it had a valid basis for disputing the claim from the outset, citing Petitioner's initial reporting. Admittedly, Petitioner did not link his recurrent hernia with a specific lifting event when he spoke with his superiors on July 29th and submitted his "to/from"

memo on August 9th. PX 2. He did, however, link that condition with his previous hernia condition, which Respondent knew to be work-related. More significantly, one of the superiors to whom he made these reports admitted, under oath, that Respondent should have treated Petitioner's communications as the reporting of a work injury. As early as August 11, 2011, Petitioner allowed Respondent's claims administrator unfettered access to his treatment records. PX 9. Those records target only his occupation as a cause of the recurrence. They contain no hint of any other possible cause.

It is the Arbitrator's task to examine Respondent's conduct in the light of all of the existing circumstances. The Arbitrator must consider not only the circumstances outlined above but also the fact that, as of both July 2011 and the May 2016 hearing, the controlling statute was untested, in terms of binding appellate review. The Arbitrator also notes that, as of the hearing, Respondent was "armed" with some arbitration and Commission decisions which, while ultimately non-binding, arguably supported its defense. The Arbitrator finds Respondent liable for Section 19(l) penalties in the maximum statutory amount of $10,000.

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

Shirley Lewis,
Petitioner,

vs.

NO: 11WC 9119

Warren Park Health & Living Center,
Respondent,

17IWCC0101

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 denial of reinstatement and being advised of the facts and law, affirms and adopts the Arbitrator's Denial of Reinstatement.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Denial of Reinstatement of the Arbitrator filed November 10, 2014, 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: FEB 14 2017

David L. Gore

Mario Basurto

Stephen Mathis

o012617
DLG/mw
045

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WINNEBAGO

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Marco Medina,

Petitioner,

vs.

NO: 13 WC 20611
14 WC 05523

Brake Parts Inc. F/K/A Affinia,

Respondent,

17IWCC0102

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, prospective medical care, causal connection, 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 February 25, 2016, is hereby affirmed and adopted.

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

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: FEB 14 2017
o012617
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

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

MEDINA, MARCO
Employee/Petitioner

Case# **13WC020611**

14WC005523

BRAKE PARTS INC F/K/A AFFINIA
Employer/Respondent

17IWCC0102

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:

0226 GOLDSTEIN BENDER & ROMANOFF
ARTHUR GERMAN
ONE N LASALLE ST SUITE 2600
CHICAGO, IL 60602

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT E MACIOROWSKI
105 W ADAMS ST SUITE 1150
CHICAGO, IL 60606

17IWCC0102

STATE OF ILLINOIS)
)SS.
COUNTY OF Winnebago)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b) 8(a)

Marco Medina
Employee/Petitioner
V
Brake Parts Inc. F/K/A Affinia
Employer/Respondent

Case # 13 WC 20611

Consolidated cases: 14 WC 5523

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine Ory**, Arbitrator of the Commission, in the city **Chicago**, on **November 18, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident **February 20, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$32,671.60**; the average weekly wage was **$628.30**.

On the date of accident, Petitioner was **44** years of age, **married** with **1** dependent children.

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

Respondent shall be given a credit of **$10,232.40** for TTD, **0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$10,232.40**.

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

ORDER

Medical benefits

The award for prospective medical treatment was made in companion case 14 WC 5523.

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.

Christine Mroy

Signature of Arbitrator

02/19/2016

Date

IC ArbDec19(b)

FEB 25 2016

17IWCC0102

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Marco Medina	)	
Petitioner,	)	
vs.	)	**No. 13 WC 20611**
Brake Parts Inc. F/K/A Affinia	)	
Respondent.	)	
	)	

ADDENDUM TO ARBITRATOR'S DECISION

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing on November 18, 2015 in Rockford under §19b/§8a of the Act. The parties agree that on February 20, 2013 the Petitioner and Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that Petitioner was injured in a work accident that arose out of and in the course of his employment with Respondent on February 20, 2013 and that Petitioner gave Respondent notice of the accident within the time limits stated in the Act. They further agree that in the year preceding the injuries, the Petitioner earned $32,671.60, and that her average weekly wage was $628.30.

At issue in this hearing is as follows:

1. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
2. Whether petitioner is entitled to payment for prospective medical treatment.

The Petitioner does not speak English; his native language is Spanish. He testified with the assistance of Carmen Kelly, a certified interpreter, qualified to translate Spanish to English and English to Spanish. After being duly qualified and accepted by both parties, Ms. Kelly served as an interpreter for the Petitioner.

Petitioner filed three cases against respondent. All three cases had been consolidated. The original claim, case number 10 WC 9954, was for an accident of January 25, 2010. In that accident, petitioner claimed he injured to his neck and shoulder; not his back. For purposes of this hearing, case number 10 WC 9954 was severed from 13 WC 20611 and 14 WC 5523. Petitioner amended the petition for hearing under §19b/8a requesting the prospective cost of surgery to his back.

STATEMENT OF FACTS

Petitioner testified he had been employed by both respondent under both names. On February 20, 2013, petitioner's job duties included picking parts from different locations. On that day, petitioner bent down and stretched his hand to pick a part from underneath a rack. As he pulled the part back he felt his back snap. Petitioner denied having problems or receiving treatment to his lower back before February 20, 2013.

Petitioner testified the part weighed about 40 pounds. After the occurrence, he was not able to straighten up; he remained seated in a chair. A co-worker wheeled petitioner in the chair to the nursing station. He remained at the nursing station for about an hour. When his condition did not improve, he was wheeled in the chair to a car and transported to the McHenry, Centegra Hospital. He went to Centegra four to five times for treatment of his back. Thereafter he came under the care of Dr. Salehi. Dr. Salehi had previously treated petitioner for his neck injury.

Dr. Salehi treated petitioner's lower back with injections. Petitioner reported the injections did not work. Petitioner was off approximately six months. Dr. Salehi released petitioner to return to light duty work. Petitioner returned to a position that did not require him to carry constantly, but he did have to carrying and push boxes of brake parts on a line. Although Dr. Salehi released petitioner to return to light work, Dr. Salehi recommended petitioner undergo lower back surgery. Petitioner's back pain continued after he returned to work.

Petitioner testified he had another work accident on February 4, 2014. On that day, petitioner was working on a line with a co-worker. Petitioner's job was to give the information for each package to the co-worker. The supervisor allowed a lot of boxes to accumulate on the line. As petitioner lifted and pushed a box he felt his back snap. Petitioner estimated the box weighed 30 to 40 pounds.

Petitioner testified he felt immediate pain in his lower back, as well as numbness and pain down both legs; mainly down the left. Petitioner returned to Dr. Salehi. Dr. Salehi expressed surprise to find petitioner had another injury. Dr. Salehi continued to recommend back surgery. Petitioner obtained two additional MRIs. One was done at the direction of Centegra and the other was ordered by Dr. Salehi. The last time petitioner saw Dr. Salehi, approximately one to one-and-a-half years before the hearing, Dr. Salehi continued to recommend back surgery.

Petitioner testified he continues to work for respondent in a less physically demanding job, but continues to have pain, difficulty sleeping and tying his shoes. He drags his leg. The weather has an effect on his back. Petitioner testified his back has gotten worse since the second accident.

Petitioner agreed his job was parcel order picker. Petitioner confirmed he received treatment at Occupational Health Clinic of Centegra Health System at the direction of respondent. Petitioner acknowledged Dr. Salehi had performed surgery to his neck. Petitioner had his first lower back MRI on March 6, 2013. Petitioner first saw Dr. Salehi for his back on March 26, 2013.

Petitioner was examined by Dr. Soriano on August 15, 2013 at respondent's request. Petitioner returned to work after Dr. Soriano's exam on August 15, 2013, until he reinjured his back on February 4, 2014. Petitioner had a second MRI done on March 3, 2014. He returned to Dr. Salehi on March 13, 2014, which is the last time he received treatment to his lower back. Petitioner was reexamined by Dr. Soriano on May 16, 2014.

Petitioner testified he uses a cane and a crutch, but not at work. The cane and crutch were not prescribed by Dr. Salehi. Petitioner admitted he drove from his home in Woodstock to the hearing in Rockford. Petitioner continues to work as he needs income. He performs his job sitting down most of the time. Dr. Salehi advised petitioner to sit 20 minutes and stand 20 minutes.

The records of Centegra were introduced by respondent (RX.1). Petitioner was first seen at Centegra on February 20, 2013. The history contained in these records was consistent with the

work accident. Petitioner's treatment through March 8, 2013 from Centegra for his acute low back pain, back spasms and radiculopathy included bedrest, Norco, Flexeril and Medrol Dose Pak. The MRI showed a left L5-S1 nerve impingement. Petitioner was kept off during the period he was treated at Centegra through March 8, 2013. He was then referred to Dr. Salehi. (RX.1)

Dr. Salehi testified in behalf of petitioner via deposition (PX.1). The records of Dr. Salehi were introduced by petitioner (which did not include the records from March 26, 2013 or June 4, 2013). (PX.2) Dr. Salehi initially seen petitioner on January 27, 2011 as a referral by Dr. Gerber for a cervical injury from the work accident of January 25, 2011 (PX.1, p.6). At the time of Dr. Salehi's initial examination, Dr. Salehi found evidence of some lower back pathology, but no nerve root compression (PX.1, p.8). Dr. Salehi performed a discectomy and fusion at the C5-C7 level on June 13, 2011 (PX.2). On November 10, 2011, Dr. Salehi released the petitioner to return to work without restrictions and released petitioner from his care for the cervical condition. (PX.1, p.14).

On March 13, 2013, petitioner returned to Dr. Salehi with lower back complaints. Petitioner provided a history of injuring his lower back on February 20, 2013 when lifting 30 pounds of pots and pans (sic) from ground level. Within the next few days, petitioner developed bilateral leg pain, more on the left, with numbness and tingling. Petitioner had a positive straight leg raising on the left. (PX.1, p.15)

Dr. Salehi's review of the MRI showed nerve root compression and recommended physical therapy and bilateral injections at the L4-L5 and L5-S1 (PX.1, p.16).

Petitioner returned to Dr. Salehi on April 23, 2013 after obtaining one injection and reported some reduction in pain. Dr. Salehi recommended petitioner continue physical therapy and work light duty. On May 15, 2013, petitioner returned to Dr. Salehi with complaints his pain was getting worse and becoming unbearable (PX.1, p.17)

On June 4, 2013, petitioner saw Dr. Salehi and reported he had ongoing complaints; again surgery was proposed at the L4-L5 and L5-S1 level (PX.1, p.18). Petitioner returned to Dr. Salehi on August 29, 2013 after undergoing an "IME" (PX.1, p.19). Dr. Salehi's recommendation for surgery remained (PX.1, pp.19-20). Petitioner returned to Dr. Salehi on September 26, 2013; Dr. Salehi recommended another MRI and continued to recommend surgery (PX.1, p.20).

Petitioner returned to Dr. Salehi on February 19, 2014 with the same symptoms of low back pain and leg pain; left more than right (PX.1, p.20). Petitioner told Dr. Salehi of his new work accident occurring on February 4, 2014; which resulted from the petitioner pushing something and causing severe pain in his lower back (PX.1, p.21).

Petitioner was last seen by Dr. Salehi on March 13, 2014 (PX.1, p.21). Petitioner brought with him a new MRI (PX.1, p.21). The MRI showed minimal signal at the L4-5 disc and moderate to significant left L5-S1 foraminal stenosis and moderate facet arthropathy at L5-S1 and L4-L5 bilaterally (PX.1, p.22). Dr. Salehi recommended a limited operation of left L5-S1 foraminotomy (PX.1, p.22). Dr. Salehi believed the injuries and need for surgery were caused by the work accidents based upon petitioner's denial of prior problems (PX.1, p.22). After reviewing the new MRI, Dr. Salehi recommend a lesser surgery at only one level (PX.1, pp.22-23).

Dr. Salehi agreed there was inconsistencies with petitioner's straight leg raising test from the laying down position to the sitting position (PX.1, p.37). Dr. Salehi found a minimal bulge of

the L4-L5 disc (PX.1, p.38). For the most part, Dr. Salehi's exam was negative for neurological deficits (PX.1, p. 42). Dr. Salehi's diagnosis was foraminal stenosis at L5-S1 level (PX.1, pp. 42-43). Dr. Salehi defended the need for surgery despite the lack of strength loss or sensation, based upon the MRI findings and petitioner's specific complaints and lack of improvement (PX.1, pp.46-47).

Dr. Soriano testified in behalf of respondent via deposition (RX.5). Dr. Soriano had performed two examinations of the petitioner at the request of respondent; one on August 1, 2013 (RX.3) and the other on May 13, 2014 (RX.4).

Dr. Soriano took a history regarding the February 20, 2013 accident and subsequent treatment, that was consistent with petitioner's testimony (RX.5, pp.8-10). Dr. Soriano reviewed petitioner's MRI of March 6, 2013 and initially testified there was evidence of pressure on the nerve at L5-S1; only a small facet cyst that was mildly narrowing the L5 foramen on the left (RX.5, p.11). Dr. Soriano later testified there was mild narrowing at of the foramen at the L4-5 level that "really didn't cause any significant pressure on the nerve" (RX.5, p.11). Dr. Soriano also testified that the impingement at L5-S1 was mild (RX.5, p.18). Dr. Soriano further testified there was nothing showing impingement of the nerve roots that would correlate with petitioner's subjective complaints of pain (RX.5, p.21).

Dr. Soriano reported petitioner could only bend forward by 45 degrees, extend zero degrees and right and left bending less than 10 degrees (RX.5, p.13). Dr. Soriano at first testified petitioner had three of five positive Waddell signs, which would suggest symptom magnification (RX. 5, p.13). Dr. Soriano then reduced petitioner's positive Waddell signs to only two (RX.5, p.14).

Sr. Soriano testified that petitioner's condition was pre-existing and that there was no relationship between the work accident of February 20, 2013 and petitioner's reported symptoms (RX.5, pp.15-16).

Petitioner's history to Dr. Soriano regarding the February 4, 2014 accident was consistent with petitioner's testimony (RX.5, p.19). Dr. Soriano reviewed petitioner's March 3, 2014 MRI, but made no comment on the L5-S1 level (RX.5, p.22).

Dr. Soriano at first testified that at the time of petitioner's May 13, 2014 exam, petitioner had six positive Waddell signs and then Dr. Soriano later reduced the positive Waddell signs to five (RX.5, p.23 & p.36). Dr. Soriano testified that based upon his exam, petitioner was self-limiting and there was no relationship between petitioner's condition and treatment and the work accident (RX.5, p.25). Dr. Soriano determined petitioner has no restrictions and has no permanent disability from the back injury (RX.5, pp.25-26).

Dr. Soriano could not remember his state of mind in August, 2013 as to why he didn't comment on petitioner's initial evaluation at Accelerated Rehabilitation of August 14, 2013 which showed petitioner was only capable of performing 24.8 percent of the physical demands of his job as a material handler (RX.5, p.33).

Although Dr. Soriano agreed a condition could wax and wane, he would not agree that on the date of his exam of petitioner on August 15, 2013 petitioner could have been having a good day (RX.5, p.46).

CONCLUSIONS OF LAW

F. With respect to the issue of whether the petitioner's condition of ill-being is related to the injury, the Arbitrator finds the following:

The parties stipulated petitioner sustained an injury due to an accident which arose out of and in the course of his employment with respondent on February 20, 2013. Petitioner received treatment from Centegra at the direction of respondent on the day of the accident. The diagnosis by Centegra was acute low back pain, back spasms with radiculopathy. An MRI obtained on March 6, 2013 at the direction of Centegra showed mild general disc bulge at L4-5 and mild facet joint arthropathy, but no significant central spinal canal or foraminal stenosis. There was, however, moderate stenosis abutting and possibly impinging on the left L5 nerve root. Dr. Salehi, who had previously treated petitioner for his neck injury, saw petitioner on March 13, 2013 for the low back injury. Dr. Salehi, based upon his examination and review of the MRI of March 6, 2013, recommended petitioner undergo physical therapy and injections for the nerve root compression.

By the time of Dr. Salehi's June 4, 2013 exam petitioner had undergone physical therapy and had an injection. Despite the treatment, petitioner's condition was worse. Petitioner continued to have pain in the lower back and down the left leg. Therefore, Dr. Salehi recommended petitioner undergo a left L4-L5 and L5-S1 hemilaminotomy and foraminotomy. Dr. Salehi believed this injury, along with the accidents, caused petitioner's back injury for which Dr. Salehi prescribed the two-level back surgery. Dr. Salehi based his opinion on the lack of complaints by petitioner of back or leg pain prior to the work accidents.

Based upon the foregoing, the Arbitrator finds petitioner's back condition, for which he needs surgery at the L5-S1 level, were caused, in part, by the work accident of February 20, 2013.

The Arbitrator makes this finding despite Dr. Soriano's opinion to the contrary due. The Arbitrator discounts Dr. Soriano's testimony due to the inconsistencies and omissions. Dr. Soriano testified there was no pressure on the nerve at L5-S1 and then later testified that there was no significant pressure on the nerve. He also testified that the L5-S1 impingement was mild. Furthermore, Dr. Soriano testified that there was nothing showing impingement of the nerve roots that would correlate with petitioner's subjective complaints of pain. However, petitioner's complaints of pain in the back and pain down his right leg correlate with the impingement finding on the MRIs.

Additionally, Dr. Soriano contradicted himself twice regarding the positive Waddell signs. Waddell signs could signify symptoms magnification. At the time of his first exam of petitioner on August 1, 2013, Dr. Soriano stated petitioner had three of five positive Waddell signs and then later reduced it to two. Also, Dr. Soriano testified at first regarding his May 13, 2014 that petitioner had six positive Waddell signs and then reduced it to five.

Dr. Soriano made no comment of the L5-S1 level after his reviewed of the March 3, 2014 MRI. Dr. Soriano also could not remember his state of mind in August, 2013 as to why he didn't comment on petitioner's initial evaluation at Accelerated Rehabilitation which showed petitioner capable of performing only 24.8 percent of the demands of his job as a material handler.

Finally, although Dr. Soriano agreed petitioner's condition could wax and wane, he would not agree petitioner could be having a good day at the time he examined petitioner on August 15, 2013.

Accordingly, the Arbitrator gives greater weight to the treating physician, Dr. Salehi's opinion which was based upon the objection evidence, over the inconsistent opinions of Dr. Soriano.

For these reasons, the Arbitrator finds petitioner proved by a preponderance of the evidence, that the condition for which petitioner needs lower back surgery, was caused, in part, by the February 20, 2013 accident.

K. In support of the Arbitrator's decision with regard to prospective medical care, the Arbitrator finds the following:

Petitioner has undergone conservative treatment without relief for over two years without relief. The Arbitrator, having found petitioner's condition was caused by the work accidents, finds the surgery at the L5-S1 level as proposed by the treating physician, Dr. Salehi, is reasonable and necessary to cure petitioner of his work injury.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WINNEBAGO

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Marco Medina,

Petitioner,

vs.

NO: 14 WC 05523
13 WC 20611

Brake Parts Inc. F/K/A Affinia,

Respondent,

17IWCC0103

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

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

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

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 $55,000.00. 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: FEB 14 2017
o012617
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

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

MEDINA, MARCO
Employee/Petitioner

Case# **14WC005523**

13WC020611

BRAKE PARTS INC F/K/A AFFINIA
Employer/Respondent

17IWCC0103

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:

0226 GOLDSTEIN BENDER & ROMANOFF
ARTHUR GERMAN
ONE N LASALLE ST SUITE 2600
CHICAGO, IL 60602

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT E MACIOROWSKI
105 W ADAMS ST SUITE 2200
CHICAGO, IL 60603

17IWCC0103

STATE OF ILLINOIS)
)SS.
COUNTY OF Winnebago)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b) 8(a)

Marco Medina
Employee/Petitioner

V

Brake Parts Inc. F/K/A Affinia
Employer/Respondent

Case # 14 WC 5523

Consolidated cases: 13 WC 20611

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine Ory**, Arbitrator of the Commission, in the city **Chicago**, on **November 18, 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. [ ] 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.
K. [x] Is Petitioner entitled to any prospective medical care?
L. What temporary benefits are in dispute?
TPD Maintenance TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident **February 4, 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 **$32,671.60**; the average weekly wage was **$628.30**.

On the date of accident, Petitioner was **45** years of age, **married** with **1** dependent children.

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

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

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

ORDER

Medical benefits

Respondent shall pay the reasonable and necessary costs related to the spinal surgery at L5-S1 as prescribed by Dr. Salehi in accordance with §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.

Christine Mlong

Signature of Arbitrator

02/19/2016

Date

IC ArbDec19(b)

FEB 25 2016

17IWCC0103

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Marco Medina	)	
Petitioner,	)	
vs.	)	**No. 14 WC 5523**
Brake Parts Inc. F/K/A Affinia	)	
Respondent.	)	
	)	

ADDENDUM TO ARBITRATOR'S DECISION

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing on November 18, 2015 in Rockford under §19b/§8a of the Act. The parties agree that on February 4, 2014 the Petitioner and Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that Petitioner gave Respondent notice of the accident within the time limits stated in the Act. They further agree that in the year preceding the injuries, the Petitioner earned $32,671.60, and that her average weekly wage was $628.30.

At issue in this hearing is as follows:

1. Whether petitioner sustained accident injuries that arose out of and in the course of employment with respondent.
2. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
3. Whether petitioner is entitled to payment for prospective medical treatment.

The Petitioner does not speak English; his native language is Spanish. He testified with the assistance of Carmen Kelly, a certified interpreter, qualified to translate Spanish to English and English to Spanish. After being duly qualified and accepted by both parties, Ms. Kelly served as an interpreter for the Petitioner.

Petitioner filed three cases against respondent. All three cases had been consolidated. The original claim, case number 10 WC 9954, was for an accident of January 25, 2010. In that accident, petitioner claimed he injured to his neck and shoulder; not his back. For purposes of this hearing, case number 10 WC 9954 was severed from 13 WC 20611 and 14 WC 5523. Petitioner amended the petition for hearing under §19b/8a requesting the prospective cost of surgery to his back.

STATEMENT OF FACTS

Petitioner testified he had been employed by both respondent under both names. On February 20, 2013, petitioner's job duties included picking parts from different locations. On that day, petitioner bent down and stretched his hand to pick a part from underneath a rack. As he pulled the part back he felt his back snap. Petitioner denied having problems or receiving treatment to his lower back before February 20, 2013.

Petitioner testified the part weighed about 40 pounds. After the occurrence, he was not able to straighten up; he remained seated in a chair. A co-worker wheeled petitioner in the chair to the nursing station. He remained at the nursing station for about an hour. When his condition did not improve, he was wheeled in the chair to a car and transported to the McHenry, Centegra Hospital. He went to Centegra four to five times for treatment of his back. Thereafter he came under the care of Dr. Salehi. Dr. Salehi had previously treated petitioner for his neck injury.

Dr. Salehi treated petitioner's lower back with injections. Petitioner reported the injections did not work. Petitioner was off approximately six months. Dr. Salehi released petitioner to return to light duty work. Petitioner returned to a position that did not require him to carry constantly, but he did have to carrying and push boxes of brake parts on a line. Although Dr. Salehi released petitioner to return to light work, Dr. Salehi recommended petitioner undergo lower back surgery. Petitioner's back pain continued after he returned to work.

Petitioner testified he had another work accident on February 4, 2014. On that day, petitioner was working on a line with a co-worker. Petitioner's job was to give the information for each package to the co-worker. The supervisor allowed a lot of boxes to accumulate on the line. As petitioner lifted and pushed a box he felt his back snap. Petitioner estimated the box weighed 30 to 40 pounds.

Petitioner testified he felt immediate pain in his lower back, as well as numbness and pain down both legs; mainly down the left. Petitioner returned to Dr. Salehi. Dr. Salehi expressed surprise to find petitioner had another injury. Dr. Salehi continued to recommend back surgery. Petitioner obtained two additional MRIs. One was done at the direction of Centegra and the other was ordered by Dr. Salehi. The last time petitioner saw Dr. Salehi, approximately one to one-and-a-half years before the hearing, Dr. Salehi continued to recommend back surgery.

Petitioner testified he continues to work for respondent in a less physically demanding job, but continues to have pain, difficulty sleeping and tying his shoes. He drags his leg. The weather has an effect on his back. Petitioner testified his back has gotten worse since the second accident.

Petitioner agreed his job was parcel order picker. Petitioner confirmed he received treatment at Occupational Health Clinic of Centegra Health System at the direction of respondent. Petitioner acknowledged Dr. Salehi had performed surgery to his neck. Petitioner had his first lower back MRI on March 6, 2013. Petitioner first saw Dr. Salehi for his back on March 26, 2013.

Petitioner was examined by Dr. Soriano on August 15, 2013 at respondent's request. Petitioner returned to work after Dr. Soriano's exam on August 15, 2013, until he reinjured his back on February 4, 2014. Petitioner had a second MRI done on March 3, 2014. He returned to Dr. Salehi on March 13, 2014, which is the last time he received treatment to his lower back. Petitioner was reexamined by Dr. Soriano on May 16, 2014.

Petitioner testified he uses a cane and a crutch, but not at work. The cane and crutch were not prescribed by Dr. Salehi. Petitioner admitted he drove from his home in Woodstock to the hearing in Rockford. Petitioner continues to work as he needs income. He performs his job sitting down most of the time. Dr. Salehi advised petitioner to sit 20 minutes and stand 20 minutes.

The records of Centegra were introduced by respondent (RX.1). Petitioner was first seen at Centegra on February 20, 2013. The history contained in these records was consistent with the

work accident. Petitioner's treatment through March 8, 2013 from Centegra for his acute low back pain, back spasms and radiculopathy included bedrest, Norco, Flexeril and Medrol Dose Pak. The MRI showed a left L5-S1 nerve impingement. Petitioner was kept off during the period he was treated at Centegra through March 8, 2013. He was then referred to Dr. Salehi. (RX.1)

Dr. Salehi testified in behalf of petitioner via deposition (PX.1). The records of Dr. Salehi were introduced by petitioner (which did not include the records from March 26, 2013 or June 4, 2013). (PX.2) Dr. Salehi initially seen petitioner on January 27, 2011 as a referral by Dr. Gerber for a cervical injury from the work accident of January 25, 2011 (PX.1, p.6). At the time of Dr. Salehi's initial examination, Dr. Salehi found evidence of some lower back pathology, but no nerve root compression (PX.1, p.8). Dr. Salehi performed a discectomy and fusion at the C5-C7 level on June 13, 2011 (PX.2). On November 10, 2011, Dr. Salehi released the petitioner to return to work without restrictions and released petitioner from his care for the cervical condition. (PX.1, p.14).

On March 13, 2013, petitioner returned to Dr. Salehi with lower back complaints. Petitioner provided a history of injuring his lower back on February 20, 2013 when lifting 30 pounds of pots and pans (sic) from ground level. Within the next few days, petitioner developed bilateral leg pain, more on the left, with numbness and tingling. Petitioner had a positive straight leg raising on the left. (PX.1, p.15)

Dr. Salehi's review of the MRI showed nerve root compression and recommended physical therapy and bilateral injections at the L4-L5 and L5-S1 (PX.1, p.16).

Petitioner returned to Dr. Salehi on April 23, 2013 after obtaining one injection and reported some reduction in pain. Dr. Salehi recommended petitioner continue physical therapy and work light duty. On May 15, 2013, petitioner returned to Dr. Salehi with complaints his pain was getting worse and becoming unbearable (PX.1, p.17)

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Petitioner returned to Dr. Salehi on February 19, 2014 with the same symptoms of low back pain and leg pain; left more than right (PX.1, p.20). Petitioner told Dr. Salehi of his new work accident occurring on February 4, 2014; which resulted from the petitioner pushing something and causing severe pain in his lower back (PX.1, p.21).

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Dr. Soriano testified in behalf of respondent via deposition (RX.5). Dr. Soriano had performed two examinations of the petitioner at the request of respondent; one on August 1, 2013 (RX.3) and the other on May 13, 2014 (RX.4).

Dr. Soriano took a history regarding the February 20, 2013 accident and subsequent treatment, that was consistent with petitioner's testimony (RX.5, pp.8-10). Dr. Soriano reviewed petitioner's MRI of March 6, 2013 and initially testified there was evidence of pressure on the nerve at L5-S1; only a small facet cyst that was mildly narrowing the L5 foramen on the left (RX.5, p.11). Dr. Soriano later testified there was mild narrowing at of the foramen at the L4-5 level that "really didn't cause any significant pressure on the nerve" (RX.5, p.11). Dr. Soriano also testified that the impingement at L5-S1 was mild (RX.5, p.18). Dr. Soriano further testified there was nothing showing impingement of the nerve roots that would correlate with petitioner's subjective complaints of pain (RX.5, p.21).

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Dr. Soriano could not remember his state of mind in August, 2013 as to why he didn't comment on petitioner's initial evaluation at Accelerated Rehabilitation of August 14, 2013 which showed petitioner was only capable of performing 24.8 percent of the physical demands of his job as a material handler (RX.5, p.33).

Although Dr. Soriano agreed a condition could wax and wane, he would not agree that on the date of his exam of petitioner on August 15, 2013 petitioner could have been having a good day (RX.5, p.46).

CONCLUSIONS OF LAW

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

Petitioner had been released to return to work as of August 23, 2013 after his February 20, 2013 low back injury. He testified, without rebuttal, that he reinjured his back in a specific incident on February 4, 2014, when he lifted and pushed a box weighing 30 to 40 pounds and felt his back snap. Petitioner returned to Dr. Salehi on February 19, 2014 and advised Dr. Salehi of the new accident of February 4, 2014. Petitioner also provided Dr. Soriano a history of the February 4, 2014 accident when he returned to Dr. Soriano on May 16, 2014. Petitioner testified his back pain became worse after the February 4, 2014 accident.

For these reasons, the Arbitrator finds petitioner proved by a preponderance of the evidence he suffered a new injury to his lower back in an accident which arose out of and in the course of his employment with respondent on February 4, 2014.

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:

The parties stipulated petitioner sustained an injury due to an accident which arose out of and in the course of his employment with respondent on February 20, 2013. Petitioner received treatment from Centegra at the direction of respondent on the day of the accident. The diagnosis by Centegra was acute low back pain, back spasms with radiculopathy. An MRI obtained on March 6, 2013 at the direction of Centegra showed mild general disc bulge at L4-5 and mild facet joint arthropathy, but no significant central spinal canal or foraminal stenosis. There was, however, moderate stenosis abutting and possibly impinging on the left L5 nerve root. Dr. Salehi, who had previously treated petitioner for his neck injury, saw petitioner on March 13, 2013 for the low back injury. Dr. Salehi, based upon his examination and review of the MRI of March 6, 2013, recommended petitioner undergo physical therapy and injections for the nerve root compression.

By the time of Dr. Salehi's June 4, 2013 exam petitioner had undergone physical therapy and had an injection. Despite the treatment, petitioner's condition was worse. Petitioner continued to have pain in the lower back and down the left leg. Therefore, Dr. Salehi recommended petitioner undergo a left L4-L5 and L5-S1 hemilaminotomy and foraminotomy. Dr. Salehi believed this injury, along with the accidents, caused petitioner's back injury for which Dr. Salehi prescribed the two-level back surgery. Dr. Salehi based his opinion on the lack of complaints by petitioner of back or leg pain prior to the work accidents.

Based upon the foregoing, the Arbitrator finds petitioner's back condition, for which he needs surgery at the L5-S1 level, were caused, in part, by the work accident of February 20, 2013.

The Arbitrator makes this finding despite Dr. Soriano's opinion to the contrary due. The Arbitrator discounts Dr. Soriano's testimony due to the inconsistencies and omissions. Dr. Soriano testified there was no pressure on the nerve at L5-S1 and then later testified that there was no significant pressure on the nerve. He also testified that the L5-S1 impingement was mild. Furthermore, Dr. Soriano testified that there was nothing showing impingement of the nerve roots that would correlate with petitioner's subjective complaints of pain. However, petitioner's

complaints of pain in the back and pain down his right leg correlate with the impingement finding on the MRIs.

Additionally, Dr. Soriano contradicted himself twice regarding the positive Waddell signs. Waddell signs could signify symptoms magnification. At the time of his first exam of petitioner on August 1, 2013, Dr. Soriano stated petitioner had three of five positive Waddell signs and then later reduced it to two. Also, Dr. Soriano testified at first regarding his May 13, 2014 that petitioner had six positive Waddell signs and then reduced it to five.

Dr. Soriano made no comment of the L5-S1 level after his reviewed of the March 3, 2014 MRI. Dr. Soriano also could not remember his state of mind in August, 2013 as to why he didn't comment on petitioner's initial evaluation at Accelerated Rehabilitation which showed petitioner capable of performing only 24.8 percent of the demands of his job as a material handler.

Finally, although Dr. Soriano agreed petitioner's condition could wax and wane, he would not agree petitioner could be having a good day at the time he examined petitioner on August 15, 2013.

Accordingly, the Arbitrator gives greater weight to the treating physician, Dr. Salehi's opinion which is based upon the objection evidence, over the inconsistent opinions of Dr. Soriano.

For these reasons, the Arbitrator finds petitioner proved by a preponderance of the evidence, that the condition for which petitioner needs lower back surgery, was caused in part, by the February 4, 2014 work accident.

K. In support of the Arbitrator's decision with regard to prospective medical care, the Arbitrator finds the following:

Petitioner has undergone conservative treatment without relief for over two years without relief. The Arbitrator, having found petitioner's condition was caused by the work accidents, finds the surgery at the L5-S1 level as proposed by the treating physician, Dr. Salehi, is reasonable and necessary to cure petitioner of his work injury.

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 Bland,

Petitioner,

vs. No. 15 WC 24011

Jewel Foods,

17IWCC0104

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission corrects the clerical error in the Order part of the Arbitrator's Decision to reflect, consistently with the Findings of Fact and Conclusions of Law, an award of temporary total disability benefits from August 4, 2015, through November 13, 2015. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 16, 2016, is hereby corrected as stated herein, and otherwise 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 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.

FEB 15 2017

DATED:
o-01/19/2017
SM/sk
44

Stephen Mathis

Mario Basurto

David L. Gore

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

BLAND, FRANK
Employee/Petitioner

Case# **15WC024011**

17IWCC0104

JEWEL FOODS
Employer/Respondent

On 6/16/2016, 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:

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

0445 RODDY LAW LTD
PAUL A KRAUTER
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

F. Bland v. Jewel Foods, 15 WC 024011

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Frank Bland
Employee/Petitioner
v.
Jewel Foods
Employer/Respondent

Case # 15 WC 024011

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **02/03/16**. 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, **05/04/15**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$79,688.44**; the average weekly wage was **$1,532.47**.

On the date of accident, Petitioner was **38** 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 **$14,886.90** for TTD, **$0** for TPD, **$0** for maintenance, and **$2,500.00** for other benefits (PPD advance), for a total credit of **$17,386.90.**

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

ORDER

Petitioner's condition of ill-being with regard to his lumbar spine is causally related to the accident of May 4, 2015. The Arbitrator finds that Petitioner's condition of ill-being with regard to his right hand, right arm and cervical spine is not causally related to the accident of May 4, 2015.

Respondent shall pay Petitioner **temporary total disability benefits** of **$1,021.65**/week for **16** weeks, commencing **08/04/15 through 11/13/16**, as provided in **Section 8(b) of the Act**, as explained below.

Respondent shall pay **reasonable and necessary medical services**, pursuant to the medical fee schedule, of **$925.00 to Elmhurst Orthopedics** and **$4,838.29 to ATI**, as provided in **Sections 8(a) and 8.2 of the Act.**

Petitioner's request for prospective medical is hereby 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

June 15, 2016
Date

JUN 16 2016

FINDINGS OF FACT

Petitioner, Frank Bland, testified that he has worked for Respondent, Jewel Foods, since June of 2008 as an order selector. Petitioner picked orders for stores at the Jewel facility in Melrose Park/Franklin Park.

Petitioner testified that he had no prior neck, lower back or arm injuries or treatment. On cross-examination, Petitioner confirmed that he had two prior workers' compensation cases for injuries to his right and left shoulders.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on May 4, 2015. He was in the process of picking an order. While picking product, he emptied a pallet and had to move it from the rack. The empty pallet was located on the floor. Petitioner popped up the pallet with his foot and caught it with his hand. Some of the product started to fall onto him. He arched as the pallet pushed him back. The pallet that Petitioner was holding fell to the ground. Petitioner was pushed over on top of the pallet that he was stocking and he was bent over. Approximately 14 cases of frozen product fell on Petitioner while he was pinned against the pallet. Petitioner laid in this position until a fellow employee pushed the product off of him.

When Petitioner came back standing straight up, he noticed a tightness in his low back. He stated that his hand was also tingling, but he did not pay much attention to it. As he works in the frozen section, his hand was already cold. He noticed a couple of days later that his hand was still tingling.

On May, 4, 2015, Petitioner sought medical treatment at the company clinic, Concentra. Petitioner stated that when he went to Concentra, he told them everything that was bothering him. The records from Concentra show that Petitioner gave a history of low back pain when he was pushed by a pallet. The assessment was: lumbar strain. Petitioner told Concentra about his low back bothering him on each visit. Concentra performed x-rays of his low back that were negative. No other radiographic studies were ordered. Concentra

prescribed physical therapy and provided work restrictions. Petitioner testified that he underwent treatment at Concentra through May 20, 2015. (Px #2)

When he was re-evaluated by Concentra on May 6, 2015, Petitioner complained of low back pain. The medical records did not document any other complaints. The diagnosis remained lumbar strain. He was recommended to continue work restrictions and physical therapy. Petitioner returned to Concentra on May 13, 2015. His complaints were still confined to the low back. All recommended treatment remained the same. The final visit at Concentra was on May 20, 2015. Petitioner continued to complain of pain in his low back. The treatment plan of therapy and restrictions continued. Petitioner received PT at Concentra on May 4, May 6, May 8, May 12 and May 13, 2015. Only low back complaints were noted by the therapists. Petitioner testified that he told Concentra about tingling in his hand, but they declined treatment, as it was not listed on the prescription. (Px #2)

Petitioner then elected to treat with Dr. Kevin Koutsky (a "panel physician"), starting on May 28, 2015. (Px #3) He testified that he told Dr. Koutsky about everything that was hurting. This included the low back and right hand. The records from Dr. Koutsky show that Petitioner presented for evaluation of his low back with pain radiating to bilateral buttocks and thighs, as well as right hand pain with some numbness and tingling. He was assessed by Dr. Koutsky with a right hand crush injury and lumbar strain. He was prescribed an exercise kit, TENS unit and cold therapy. He was recommended to work light duty and prescribed a lumbar MRI. (Px #3)

Petitioner began a course of physical therapy at ATI on June 3, 2015. (PX#4) The records from ATI of June 3 indicate that Petitioner presented with lumbar pain and hand pain. Petitioner testified that the physical therapy provided by ATI in June and July of 2015 was only for his low back. Physical therapy at ATI continued through November 29, 2015. (Px #4)

On June 25, 2015, Petitioner underwent an MRI of the lumbar spine. The impression of the radiologist was a negative MRI. (Px #3)

Dr. Koutsky called Petitioner following the MRI to provide him with the results. The records indicate that Dr. Koutsky advised him that the MRI showed no evidence of any large herniated disk or severe canal stenosis or fracture. There was a transitional lumbosacral segment. (Px #3)

Petitioner was examined by Dr. Koutsky on July 2, 2015. Petitioner's complaints involved his low back and right hand. The records of Dr. Koutsky indicate that on exam, he remained neurologically unchanged. They also discussed pain management for Petitioner's low back. (Px #3)

On August 20, 2015, Petitioner returned to Dr. Koutsky. He indicated that his right upper extremity and low back have pain had been about the same. He was experiencing more numbness and tingling in his right hand. The assessment was lumbar radiculopathy, right hand crush injury with numbness and tingling. He underwent Kenalog trigger point injections to his low back performed by Dr. Koutsky. Dr. Koutsky also prescribed an EMG of the right upper extremity and an MRI of the cervical spine. (Px #3)

Petitioner underwent an MRI of the cervical spine on August 28, 2015. The impression was C3-4 mild/ moderate right C4 foraminal narrowing, C5-6 mild disc degeneration with posterior outer angular fissure and minimal inferior extension of the disc along the posterior superior corner of the C6 endplate. (Px #3)

On September 2, 2015, Petitioner underwent an EMG/NCV by Dr. Goldvehkht based upon referral by Dr. Koutsky. The impression was findings suggestive of a mild active right C5 and/or C6 radiculopathy. Dr. Koutsky called Petitioner and advised that there was evidence of mild active right C5/C6 radiculopathy. He also advised him that there were some changes consistent with right C8/T1 radiculopathy. He also indicated there was suggestion of some carpal tunnel syndrome. He also spoke to Petitioner about the cervical MRI results. (Px #3)

Dr. Koutsky saw Petitioner on September 24, 2015 for follow up for his lumbar radiculopathy, right hand crush injury, and cervical pain associated with radiculopathy. Petitioner's back was noted to be doing better. However, they were still waiting for authorization for therapy to the neck. Dr. Koutsky recommended

therapy for the right hand, low back, and cervical spine. He continued to prescribe pain medication. Dr. Koutsky performed a Kenalog injection into the left paracervical muscle trigger points. (Px #3)

On October 13, 2015, Petitioner was seen by Dr. Thomas Gleason of Illinois Bone & Joint Institute at the request of Respondent, for an independent medical examination. (Rx #2) Dr. Gleason's diagnosis was findings as reflected in the diagnostic studies. The lumbar MRI was normal. He opined that the cervical MRI demonstrated mild disc degeneration of C5-6 with minimal disc bulge and right para-central fisher (sic). There was no evidence of stenosis. There was absence of lordosis. He noted the scan was otherwise unremarkable. Dr. Gleason opined that the EMG/NCV suggested mild active right C5 or C6 radiculopathy. The diagnosis included right cubital tunnel syndrome unrelated to the accident of May 4, 2015. He also diagnosed diminished range of motion of the right hip, unrelated to the accident of May 4, 2015. Dr. Gleason concluded that Petitioner required no further medical treatment, was capable of working full duty, and was at maximum medical improvement for his work related injury. (Rx #2)

On October 19, 2015, Dr. Koutsky authored a report to Edward Lichtenstein. Dr. Koutsky opined that the numbness and tingling Petitioner experienced in his right hand was due to cervical radiculopathy, causally related to his work injury. He stated that this was confirmed with an MRI scan which showed evidence of stenosis at the C5-6 level. (Px #3)

Petitioner was examined by Dr. Koutsky on November 2, 2015. He continued to complain of radicular symptoms into his right upper extremity and right hand. On exam, it was noted that he was neurologically unchanged. He did have some significant paracervical muscle trigger points with associated spasm, tenderness and swelling. He underwent Kenalog injections into the right and left paracervical muscle trigger points. (Px #3)

Dr. Koutsky referred Petitioner to his colleague, Dr. Jacob Miller, for treatment of his right hand. Petitioner had initial treatment with Dr. Miller on November 11, 2015. Dr. Miller's impression was right cubital tunnel syndrome and EMG findings consistent with either radiculopathy at C8-T1 on the right side or

focal neuropathy at the elbow. Dr. Miller recommended conservative treatment, given the mild pain complaints. He prescribed limiting flexion of the elbow during sleep and use of an anti-inflammatory compound cream. Petitioner should continue with Dr. Koutsky for the neck. If symptoms continued, Dr. Miller indicated that he would consider a diagnostic and therapeutic injection into the cubital tunnel. (Px #3)

Petitioner was next examined by Dr. Koutsky on December 7, 2015. (Px #3) He underwent additional Kenalog injections and trigger point injections to the bilateral left and right paracervical muscular regions. (Px #3)

On December 17, 2015, Petitioner had a pain management evaluation with Dr. Patel. Dr. Patel charted that the patient would return for a C3-4 epidural steroid injection. (Px #3)

On December 23, 2015, Petitioner was examined by Dr. Miller. The impression was cervical radiculopathy and likely cubital tunnel syndrome on the right side. He recommended holding off on doing anything diagnostic to the right elbow, as the patient was being scheduled for cervical injections. He wanted to see if the cervical injections helped, given the equivocal EMG findings. (Px #3)

In January of 2016, Petitioner underwent an epidural steroid injection to his cervical spine performed by Dr. Patel. He had additional trigger point injections on January 18, 2016.

Petitioner testified that he still feels a tingling in his neck. He does not feel right. He has tingling in his third, fourth, and fifth fingers. He has had numbness in his hand since day one. He stated that his low back has gotten pretty fine. He is not currently receiving treatment for his low back. Elmhurst Orthopedics had prescribed him quite a few medications. Petitioner stated that he has the medication but tries not to take it.

Dr. Koutsky has kept Petitioner on work restrictions since May of 2015. Respondent has not accommodated those restrictions. With regard to future medical care, Petitioner stated that the shots into his spine did not help. He does want to undergo further medical care with Elmhurst Orthopedics. This will involve deep tissue injections.

Dr. Gleason authored a second report at the request of Respondent. (Rx #2) Although the report is dated October 13, 2015, the body of the report indicates that it was drafted in January of 2016. In this report, Dr. Gleason referenced multiple medical bills related to prescriptions that he reviewed in this case. He opined that the medications prescribed were largely excessive, as well as unnecessary. He also opined that the charges for the prescriptions were neither reasonable nor customary for the geographic area. (Rx #2)

Respondent's Exhibit 1 was a group of Utilization Review documents. (Rx #1) This group of exhibits was a retrospective review of the medical bills of Integrity Billing Solutions, which totaled $31,328.05 for prescriptions written by Dr. Koutsky. Petitioner's claimed bills were submitted as Petitioner's Exhibit 1.

The Parties agreed that Petitioner was entitled to TTD for the time period of August 4, 2015 through November 13, 2015 (16 weeks). Petitioner sought additional TTD from November 14, 2015 through the date of trial (February 3, 2016), a further period of 10-3/7 weeks.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

WITH REGARD TO ISSUE "F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY REALTED TO THE INJURY", THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that Petitioner's current condition of ill-being regarding his low back (status post lumber strain, resolved, with a normal lumbar MRI) is causally related to the injury based upon the testimony of Petitioner and the medical records.

The Arbitrator finds that Petitioner's current condition of ill-being regarding his right hand is not causally related to the accident of May 4, 2015. Petitioner received treatment from a physician (or PA-C) at Concentra on four occasions from May 4, 2015 to May 20, 2015. Petitioner testified that he did mention his right hand injury to Concentra and alleged that they would not treat him for it, as it was not on his prescription. The records from Concentra do not reference any complaints of pain with regard to the right hand noted by the therapists or the treatment providers. The only complaints noted were regarding the low back. The initial

treatment records do not support an injury to Petitioner's right hand. Petitioner's testimony that he did report right hand problems to Concentra does not persuade the Arbitrator that the Concentra records are inaccurate or defective.

The Arbitrator finds that the current condition of Petitioner's cervical spine is not causally related to the accident. The records from Concentra do not reference any complaints or problems with regard to the cervical spine. The record from the initial visit with Dr. Koutsky on May 28, 2015 is also devoid of any reference to the cervical spine. Dr. Koutsky's diagnosis was right hand crush injury and lumbar strain. Dr. Koutsky did not prescribe or recommend treatment for the cervical spine until three months after Petitioner's initial visit. The record from Dr. Koutsky's second exam of Petitioner on July 2, 2015 is also devoid of any reference to the cervical spine. That record indicates that the patient was neurologically unchanged. The assessment remained low back pain and hand pain. The first reference in this case to Petitioner's cervical spine was not until Petitioner was seen by Dr. Koutsky on August 20, 2015. This was approximately 15 weeks after the date of accident. There was a reference by Dr. Koutsky to tingling in the upper extremity. A cervical spine MRI and an EMG of the right upper extremity were ordered. The 15 week period after the accident with no reference to cervical spine related complaints or findings is too long for the Arbitrator to find that any condition of ill-being regarding Petitioner's cervical spine is causally related to the accident. Dr. Gleason does not support causal connection regarding Petitioner's cervical spine condition and the Arbitrator believes that this is the correct opinion.

Finally, the Arbitrator finds that any condition of ill-being regarding Petitioner's right elbow is not causally related to the accident. There were no complaints or findings regarding Petitioner's right elbow/ulnar nerve (cubital tunnel syndrome) for months after the accident. The gap in time after the accident is too long for the Arbitrator to find that any condition of ill-being regarding Petitioner's right elbow/ulnar nerve is related to the accident. Further, Dr. Gleason does diagnos cubital tunnel syndrome, but notes persuasively that it is unrelated to the May 4, 2015 injury.

WITH REGARD TO ISSUE "L. WHAT TEMPORARY BENEFITS ARE IN DISPUTE? TTD", THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that Petitioner is not entitled to TTD benefits after November 13, 2015. The medical records from Elmhurst Orthopedics of November 2, 2015, and all subsequent visits, document that treatment was focused primarily on the cervical spine with some reference to the right hand and right upper extremity. There was no treatment provided for Petitioner's low back. Therefore, the treatment plans prescribed by Elmhurst Orthopedics on and after November 2, 2015, were for body parts that the Arbitrator has found not to be causally related to the accidental injuries of May 4, 2015.

Respondent stipulated that Petitioner was entitled to TTD benefits for 16 weeks, from August 4, 2015 through November 13, 2015. The Arbitrator finds that no further TTD benefits are owed after November 13, 2015, based upon the Arbitrator's findings regarding causal connection, above and the opinion of Dr. Gleason that Petitioner had reached MMI with respect to the low back injury sustained on May 4, 2015.

WITH REGARD TO ISSUE "J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?", THE ARBITRATOR FINDS AS FOLLOWS:

The Petitioner offered four medical bills into evidence. (Px #1) The Arbitrator will address each medical bill separately.

The first bill submitted is from Elmhurst Orthopedics in the amount of $6,078.00. (Px #1) The bill and the records of this provider are difficult to match up. The Arbitrator awards charges in the amount of $600.00 for date of service of June 25, 2015 (lumbar MRI) and $325.00 for date of service of September 29, 2015 (actual visit 9/24/2015?) for follow-up on lumbar radiculopathy and other conditions. This award is per the medical bill fee schedule under Section 8.2 of the Illinois Workers' Compensation Act. All other outstanding charges from Elmhurst Orthopedics are denied. It is noted that remaining claimed balance is for treatment rendered on or

after November 2, 2015. Those dates of treatment were for body parts that the Arbitrator has already found not to be causally related to the injury of May 4, 2015.

The second bill submitted is from ATI in the amount of $5,175.44. (Px #1) The treatment dates reflected in the bill are from October 5, 2015 through December 1, 2015. The records from ATI do not clearly indicate which body parts were treated on each particular date. On September 24, 2015, Dr. Koutsky prescribed additional therapy for the low back, right hand, and cervical spine. On November 2, 2015, Dr. Koutsky was focusing treatment on the right hand and cervical spine. Therefore, the Arbitrator awards the charges from ATI from October 5, 2015 through October 29, 2015. The total amount awarded for those dates is $4,838.29. That amount is subject to the medical bill fee schedule under Section 8.2 of the Illinois Workers' Compensation Act. All other claimed bills for dates of service subsequent to October 29, 2015 are denied.

The third bill submitted is from Integrity Billing Solutions in the amount of $31,238.05. (Px #1) This bill was for prescriptions written by Dr. Koutsky. The Arbitrator denies this bill. The Arbitrator finds these charges to be unreasonable and excessive. In support of this finding, the Arbitrator relies upon the Utilization Review of the charges (Rx #1) and the opinion of Dr. Gleason (Rx #2).

The fourth claimed bill is from DOCRX for prescriptions ordered by Dr. Koutsky on December 7, 2015, in the amount of $902.73. (Px #1) This is for conditions not causally related to the injury of May 4, 2015 and is denied.

This award of medical expenses is made pursuant to §§8(a) and 8.2 of the Act and Respondent is entitled to a credit for all awarded bills that it has paid.

WITH REGARD TO ISSUE "K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?", THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator denies Petitioner's request for prospective medical care. The medical records (including the report of Dr. Gleason) and the testimony of Petitioner confirm that Petitioner currently has no problems with

his low back. The requested medical treatment is for conditions not causally related to the accident of May 4, 2015 and, therefore, the request is denied.

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

Johnnie L. Llacy,

Petitioner,

vs.

NO: 12 WC 27306

17IWCC0105

Tri-County Coal, LLC,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of occupational disease, permanent partial disability, 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 7, 2015, is hereby affirmed and adopted.

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

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

17IWCC0105

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: FEB 16 2017
TJT:yl
o 2/6/17
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LLACY, JOHNNIE L
Employee/Petitioner

Case# **12WC027306**

TRI-COUNTY COAL LLC
Employer/Respondent

17IWCC0105

On 12/7/2015, 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 0.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

17IWCC0105

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

JOHNNIE L. LACY
Employee/Petitioner

Case # **12 WC 027306**

v.

TRI-COUNTY COAL, LLC
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the **Honorable Molly Dearing**, Arbitrator of the Commission, in the city of **Springfield**, on **September 24, 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 **Sections 1(d)-(f) of the Occupational Diseases Act**

FINDINGS

On **January 15, 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.

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

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

In the year preceding the injury, Petitioner's average weekly wage was **$927.08**.

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

Petitioner claims no medical.

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

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

ORDER

Because Petitioner failed to prove by a preponderance of the evidence that he sustained an occupational disease arising out of and in the course of the exposures of his employment, and that his current condition of ill-being is causally related to the exposure, 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.

Arbitrator Molly Dearing

November 20, 2015
Date

DEC 7 – 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JOHNNIE L LACY
Employee/Petitioner

17IWCC0105

v.

Case #12 WC 027306

TRI-COUNTY COAL, LLC
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

At the time of his accident, Petitioner was sixty-two years of age and employed by Respondent as a coal miner at its Crown III mine. Petitioner testified that prior to working in the coal mine, he graduated from high school and thereafter earned a degree in mining technology from Rend Lake College. He also earned a welding certificate, hydraulics certificate and electrical cards while working in the mine as an electrician or repairman. Petitioner graduated from Southern Illinois University of Edwardsville with a license in Wastewater and Water Control.

Petitioner began mining coal in September 1972 for Peabody Coal Company. He worked for Peabody for six years primarily running a continuous miner, which he explained which cuts the coal at the face and produces a significant amount of dust. Petitioner was laid off from his employment with Peabody and he then went to work at Old Ben Coal Company for approximately a year and a half from 1979 to 1980 as a face boss, or foreman of the crew working at the face of the mine. He returned to Peabody Coal for eleven months as a face boss. After being laid off for approximately three years, Petitioner went to work at Carter Coal from 1985 until 1986 as a miner operator. He was again laid off for three and a half years when that mine closed. Petitioner returned to Carter Coal, also known as Apogee Coal, from 1989 to 1995 as a miner operator where he worked until the mine closed in 1995. He worked for U.S. Steel in Alabama from 1996 to 1998 as an electrician before he returned to Illinois to work for Apogee Coal Company as a miner operator. Petitioner began working for Respondent in 2001 as a miner operator. He occasionally dug underpasses, which he described as dusty because the coal dust "just stays with you…it's almost no air", and he worked for Respondent for six months as a slinger duster, which spread rock dust consisting of a powdered limestone of very fine consistency throughout the mine. At the time of his accident, he was working as an inby situated at the face of the mine, where he testified he was directly exposed to coal dust.

Petitioner worked approximately thirty-one years as a coal miner, all of which he worked underground. During that time, Petitioner testified that he was regularly exposed to coal dust, silica dust, and roof bolting glue fumes. Petitioner testified that when he began working as a coal miner in 1972, "the dust was so thick you could not see the head turn which is 20 feet away. After that it got a little better. They come up with scrubbers and they - it actually got better, a lot more water sprays, but as it progressed along the scrubbers helped out a lot but still you are exposed to it. You don't know how much. Sometimes the air is not enough to take it away. They say it always is but it's not. You still get dust." He stated that the coal dust would get clogged in his nose and "[w]henever you

get done of an evening you get black junk out of there and you spit it up. You have got a lot of, I mean you know you got it."

Petitioner testified that he began to experience breathing difficulties when he would exert himself, lift something heavy or shovel, at which time he would become short of breath. He testified that his breathing difficulties worsened somewhat from the time he noticed them until he left the mine, though his breathing problems remained the same since he retired from coal mining.

On January 15, 2010, Petitioner retired from coal mining and he testified that he was exposed to coal dust on that date. He signed a resignation on January 15, 2010 that severed all of his rights to be recalled to work for Respondent. Petitioner testified that he retired because he had recently turned sixty-two years of age and he was able to receive his retirement pension and Social Security. He stated that he also desired to return home to his family in Southern Illinois after having lived way from them for nine years. After retiring from coal mining, Petitioner worked for Holzhauer Ford in 2011 for approximately one year retrieving new cars for the dealership.

Petitioner testified that he presently does not take any breathing medication. He has bilateral knee difficulties, which he began experiencing prior to his retirement from coal mining and for which he received treatment at the Orthopedic Institute of Southern Illinois. Petitioner testified that as a result of his bilateral knee condition, he experiences pain with walking on uneven surfaces, difficulty with carrying heavy items, walking long distances and climbing stairs. Petitioner testified that due to his breathing difficulties, he is unable to push mow for prolonged periods of time and "it makes it where you just can't -- if you are going to go take a long walk or something or walking up a hill or digging – I dig sweet potatoes and I plant sweet corn and do a lot of gardening and you get out of breath and you have to rest." He stated that he could walk "half a quarter of a mile" before becoming short of breath and climb one flight of stairs before having to stop and rest. Petitioner testified that he did not discuss his breathing difficulties with his treating physician, Dr. Greg Fozard, because "I guess that's just something that you live with." He owns an eighty-acre farm that he testified he doesn't "do anything with it", and he stated that he spends his time tending to his large garden and caring for his elderly mother-in-law. Petitioner has never smoked cigarettes.

Dr. Glennon Paul examined Petitioner on February 12, 2013 at the request of Petitioner's counsel and he testified by way of evidence deposition on April 27, 2015. Dr. Paul is the medical director of St. John's Respiratory Therapy and Clinical Assistant Professor of Medicine at Southern Illinois University Medical School. Dr. Paul is a senior physician at the Central Illinois Allergy & Respiratory Clinic, and specializes in allergy and pulmonary diseases, as well as the care of patients with respiratory diseases, critical care, allergic diseases and some internal medicine problems. Dr. Paul is not a B-reader and he is not board certified in pulmonary disease. Dr. Paul testified that he reads approximately 5,000 chest x-rays per year and he interprets approximately the same number of pulmonary function tests. In his practice, he has had occasion to treat coal miners for coal mine induced lung disease and he has also frequently examined coal miners at the request of coal companies. PX 1.

On February 12, 2013, Petitioner reported to Dr. Paul that he suffered a chronic cough that only became severe when he had an upper respiratory tract infection. Petitioner denied shortness of breath. A physical examination revealed normal inspiratory and expiratory effort, no chest wall deformities, no dullness to percussion, and no wheezes or rales. Dr. Paul administered a Methacholine challenge test to Petitioner, which demonstrated a 22% fall in FEV1 after three

breaths of methacholine. Dr. Paul interpreted the test as positive for asthma. Dr. Paul testified that Petitioner's forced vital capacity and FEV1 were both normal, as was Petitioner's FEV1/FVC ratio and total lung capacity. Dr. Paul testified that there was no evidence of obstruction or restriction in Petitioner's pulmonary function testing, and his diffusion capacity was normal and indicated no impairment in gas exchange. Dr. Paul reviewed Petitioner's chest x-ray and interpreted same as showing fibrous lesions throughout all lung fields to a rather significant degree. He described the opacities present as being "coal" and he did not measure the profusion on the chest x-ray. Dr. Paul was unable to recall the date of the x-ray he reviewed and he testified that he did not review any of Petitioner's treating medical records. PX 1.

Dr. Paul assessed Petitioner with coal workers' pneumoconiosis, chronic obstructive pulmonary disease, chronic bronchitis, chronic cough and asthma caused by the exposure to coal dust in the coal mine environment. Dr. Paul testified that in light of the diagnoses, Petitioner could have no further exposure to the environment of a coal mine without endangering his health. Dr. Paul opined that Petitioner has clinically significant pulmonary impairment in the form of pulmonary symptoms and complaints causally related to his diagnoses, and that he has radiographically apparent pulmonary impairment related to his coal workers' pneumoconiosis. Dr. Paul opined that Petitioner's impairment and diagnoses preclude him from working in a coal mine and that Petitioner would not be capable of performing heavy manual labor throughout the course of the day based upon his examination. PX 1.

Dr. Paul testified that coal workers' pneumoconiosis is a tissue reaction from the deposition of coal mine dust in the lungs called scarring or fibrosis. Dr. Paul testified that the portion of the lung that is scarred cannot perform the normal function of healthy lung tissue and that there is no cure for coal workers' pneumoconiosis. By definition, if one has coal workers' pneumoconiosis, he would have some impairment in the function of the lung at the site of the scarring regardless of whether it can be measured by spirometry. Dr. Paul testified that it is possible to have injury or disease to the lung despite having normal pulmonary function test results, and an individual with radiographically significant coal workers' pneumoconiosis may have normal pulmonary function testing, normal blood gasses, and a normal physical examination. Dr. Paul testified that simple coal workers' pneumoconiosis is a condition that typically is asymptomatic. He stated that coal workers' pneumoconiosis is considered a progressive disease that can be life threatening and can progress even after the miner ceases his exposure in the coal mine, though Dr. Paul testified that it is unlikely that simple pneumoconiosis will progress once the exposure ceases. Dr. Paul testified that there is no cure for coal workers' pneumoconiosis and that continued exposure may increase the progression of the disease. PX 1.

Dr. Henry K. Smith, board certified radiologist and B-reader, interpreted Petitioner's chest x-ray of November 13, 2012, film quality 1, as positive for coal workers' pneumoconiosis with a profusion 1/1 and P/P opacities in all lung zones. PX 2. Dr. Alexander, board certified radiologist and B-reader, also interpreted Petitioner's chest x-ray of November 13, 2012 as positive for coal workers' pneumoconiosis with a profusion of 1/0 and P/Q opacities in all lung zones except for the lower left zone. He noted minimal scarring or plate atelectasis in the left lower lung zone. PX 3.

Records from NIOSH were admitted into evidence. These records include A and B readings of Petitioner's chest x-rays dated May 16, 1979, November 14, 1984, August 15, 1989, and January 21, 1998. Dr. Eldridge Derring interpreted Petitioner's chest x-ray of May 6, 1979 as negative for coal workers' pneumoconiosis, as did Dr. Sanford Rabuska. Drs. Michael Hogan and

Ronald Burr interpreted Petitioner's chest x-ray dated November 14, 1984 as negative for coal workers' pneumoconiosis, and Drs. Robert Harrison and William Hummal interpreted Petitioner's chest x-ray of August 15, 1989 as also negative for the disease. Dr. Ronald Burr and Dr. David Foraman interpreted Petitioner's chest x-ray dated January 21, 1998 as negative for coal workers' pneumoconiosis. RX 3.

At the request of counsel for Respondent, Dr. Cristopher A. Meyer reviewed Petitioner's chest x-rays and he testified by way of evidence deposition on July 16, 2014. Dr. Meyer has been board certified in radiology since 1992 and he has been a B-reader since 1999. Dr. Meyer testified that a B-reader looks at the films and the lungs to ascertain whether there are any small nodular opacities or any linear opacities, and based on size and appearance of those small opacities, B-readers assign a letter score. Dr. Meyer explained that specific occupational lung diseases are described by specific opacity types. He stated that coal workers' pneumoconiosis is characteristically described by small, round opacities and is typically an upper zone predominant process. Dr. Meyer further explained that the last component of a B-reader's interpretation is the determination of the extent of lung involvement, or the profusion, which defines the density of the small opacities in the lung. RX 1.

Dr. Meyer interpreted Petitioner's chest x-rays of January 21, 1998, June 2, 2007, and November 13, 2012. He also reviewed a chest CT scan dated June 9, 2007. Dr. Meyer testified that the films were of diagnostic quality. The chest x-ray of January 21, 1998 was a quality 2 due to overexposure. The June 2, 2007 and November 13, 2012 chest x-rays were quality 1. Dr. Meyer testified that the 1998 chest x-ray was normal. On the examination of June 2, 2007, Dr. Meyer noted a linear opacity in the left lung base that was consistent with plate atelectasis or a linear scar, but no background small opacities were present to suggest pneumoconiosis. Dr. Meyer testified that the plate atelectasis is usually an area of inflammation or infection that occurs and leaves behind a focal area of scarring that may be caused by a small area of pneumonia or if the patient "had something go down the wrong pipe and aspirated and had a little inflammation down there." Dr. Meyer testified that the chest CT scan also revealed no findings of coal workers' pneumoconiosis. Dr. Meyer testified that the chest x-ray of November 13, 2012 demonstrated that the single linear opacity in the left base had been present for a sufficient time period such that it was unlikely to be linear atelectasis. Dr. Meyer testified that there were no findings of coal workers' pneumoconiosis. Dr. Meyer reviewed the three chest x-rays in comparison to each other and that, other than the linear scar he described, he found no significant change from the earliest film to the latest one. RX 1.

Dr. Meyer testified that manifestations of coal workers' pneumoconiosis are a body's ability to clear the coal dust depositions in the lungs. Dr. Meyer stated that there would be some change in the function of the lung at the site of the tissue reaction to the coal dust regardless of whether it could be measured. He explained that the macule of coal workers' pneumoconiosis is a permanent abnormality and can progress even once the worker leaves the site of exposure. Dr. Meyer stated that there is no treatment to reverse the progression of coal workers' pneumoconiosis and that the best response to the disease is to remove the worker from the exposure. He testified that if an individual has coal workers' pneumoconiosis, then he likely had some level of the disease when he left the coal mine. Dr. Meyer testified that coal workers' pneumoconiosis may develop at any time during a miner's career, and may even manifest itself radiographically after the miner leaves the coal mine environment. RX 1.

Dr. Jeff Selby examined Petitioner at the request of Respondent's counsel on October 3, 2013 and he testified by way of evidence deposition on September 1, 2015. Dr. Selby has been board certified in internal medicine and pulmonary disease since 1980 and 1984, respectively, and a B-reader since 1985. He performs general pulmonary work and treats patients with lung disease on a daily basis. Dr. Selby has occasion to see individuals who have the disease process of coal workers' pneumoconiosis, and he performs evaluations on behalf of claimants and employers. RX 2.

At the time of his examination, Dr. Selby took a medical history from Petitioner. Petitioner's chief complaint was knee problems and he stated that he required knee replacements. Petitioner denied any breathing problems with the exception of some shortness of breath while climbing stairs. He reported to Dr. Selby that he could walk at least one mile on level ground at his own pace, but that his knee difficulties would preclude from walking further before his breathing would. Petitioner denied a cough, wheezing, shortness of breath and chest pain. A chest examination showed clear breath sounds with good airflow. Dr. Selby caused a chest x-ray to be taken, which he testified showed a grade 2 quality film due to underinflation. Dr. Selby found no parenchymal or pleural abnormalities consistent with pneumoconiosis. He testified that the film was negative for pneumoconiosis. Petitioner underwent pulmonary function testing as part of Dr. Selby's examination, which revealed a forced vital capacity of 129% of predicted, a forced expiratory volume of 129% of predicted, and an FEV1/FVC of 80%. Petitioner's lung volumes demonstrated a total lung capacity of 129% of predicted and his diffusion capacity was 125% of predicted. Dr. Selby interpreted the pulmonary function testing as a normal spirometry with normal lung volumes and normal diffusion capacities. Petitioner underwent a Methacholine Challenge test on October 3, 2013 that showed no inducible bronchospasm and which Dr. Selby interpreted as negative. Petitioner also underwent exercise testing as part of Dr. Selby's examination. He completed Stage III or nine minutes of total exercise time employing Bruce Protocol. He stopped due to his bilateral knee condition and shortness of breath. Dr. Selby testified that Petitioner exhibited a normal response to exercise and no pulmonary or cardiac limitation to exercise, which Dr. Selby testified confirmed no heart or lung abnormality that interfered with heavy manual labor or exertion. Dr. Selby testified that he considers exercise testing to be the best objective method of determining the presence of a cardiopulmonary impairment. Dr. Selby testified that based upon the exercise testing, Petitioner was capable of heavy manual labor from a ventilatory standpoint, and he explained that if he applied the AMA Guidelines to the evaluation of the pulmonary impairment to the results he obtained in his pulmonary function testing on Petitioner, he would be placed in a class zero. RX 2.

Dr. Selby reviewed Petitioner's treatment records from 1993 to 2012. He did not recall a diagnosis of chronic bronchitis or asthma in those records, and he testified that there was no pathologic evidence of coal workers' pneumoconiosis. Dr. Selby reviewed chest x-rays dated January 21, 1998 and November 13, 2012. He also reviewed a CT of the chest dated June 9, 2007. He testified that there was no evidence of pneumoconiosis on those films. Dr. Selby opined that Petitioner does not have coal workers' pneumoconiosis of any variety, and he found that Petitioner does not suffer from obstructive lung disease, restrictive lung disease, chronic bronchitis, asthma or emphysema. Dr. Selby testified that based on Petitioner's occupational and medical history, physical examination and various laboratory data, Petitioner did not suffer from any respiratory or pulmonary abnormality as a result of coal mine dust inhalation or coal mine employment. He specifically found that Petitioner did not suffer from coal workers' pneumoconiosis, and that he has a normal pulmonary or respiratory system. Dr. Selby stated that, "[i]f he had never set foot in a coal mine, he would have the same or worse pulmonary function." Dr. Selby disagreed with the Methacholine Challenge test administered by Dr. Paul, and he described Dr. Paul's methacholine challenge

methodology as "erroneous" and "resulted in a false positive." He explained that the "methacholine testing done at my office was done correctly according to the strict method recommended by the manufacturer and the American Thoracic Society." RX 2.

Dr. Selby testified that coal workers' pneumoconiosis is a tissue reaction to coal mine dust called scarring or fibrosis. He stated that by definition, if an individual has pneumoconiosis, he would have impairment in the function of his lung at the very site of his scarring irrespective of whether that impairment could be measured by spirometry. Dr. Selby testified that it is possible for an individual to have an entire lobe of lung surgically removed or lose up to one third of their breathing capacity and still have pulmonary function tests within the range of normal. He testified that it is also possible for a person to have radiographically significant coal workers' pneumoconiosis and have normal findings on physical examination of the chest, a normal pulmonary function test, and a normal arterial blood gas test. Dr. Selby testified that it would be unlikely, yet possible, for coal workers' pneumoconiosis that appears radiographically to manifest itself in the last year of exposure. He stated that if a coal miner has worked in a coal mine environment for approximately thirty years, then that miner will never be able to evacuate all of the coal mine dust from their lungs and that that coal dust will be present in the lungs until their death. Dr. Selby testified that coal workers' pneumoconiosis does not have a cure and that the only treatment for the disease is to remove the individual from further exposure. He explained that coal workers' pneumoconiosis can progress with continued exposure, but that the vast majority of miners with Category 1 pneumoconiosis do not progress without further exposure. Dr. Selby testified that a diagnosis of chronic bronchitis is one made by patient history. He testified that asthma is something which waxes and wanes over time in terms of pulmonary function, symptoms and complaints, and he explained that an asthmatic patient may have normal pulmonary function testing on one day and abnormal on another. RX 2.

Petitioner's medical records of Dr. Greg Fozard of Family Medical Center were admitted into evidence. Petitioner underwent a chest x-ray on January 27, 1993, which demonstrated minimal right major fissural fibrosis, unchanged when compared to the chest x-ray of November 14, 1984. Petitioner also underwent a chest x-ray on March 15, 1995, which revealed mild aortic atherosclerosis with no active pulmonary infiltrate or evidence of congestive heart failure. His lungs were noted to be clear. On January 21, 1999, Petitioner telephoned Dr. Fozard's office complaining of a cold and persistent cough. Dr. Fozard prescribed him Robitussin. Petitioner underwent a chest x-ray on February 15, 1999, which revealed no change when compared to the x-ray of March 15, 1995, and no current radiographic evidence of active pulmonary infiltrate or congestive heart failure. On July 13, 1999, Petitioner telephoned Dr. Fozard's office complaining of a productive cough, sore throat, stuffy nose and congestion. Petitioner was prescribed Zithromax. Petitioner presented to Dr. Fozard on December 18, 2000 for a checkup. He demonstrated no dyspnea. On November 12, 2002, Petitioner presented to Dr. Fozard for a checkup. A review of systems on that date showed no dyspnea and a chest examination revealed clear lungs. Petitioner's wife telephoned Dr. Fozard's office on December 30, 2002 and reported that Petitioner had a non-productive cough, a cold, runny nose, achiness, and a sore throat. Zithromax was prescribed. On November 28, 2003, Petitioner presented to Dr. Fozard for a checkup. He demonstrated no dyspnea. Petitioner presented to Dr. Fozard on November 6, 2004 with complaints of bilateral knee pain, worse on the left. He reported being unable to fully bear weight at times. A physical examination revealed significant crepitus in the left knee and crepitus in the right knee with decreased range of motion. On December 21, 2004, Petitioner presented to Dr. Fozard for a check up without any complaints. He reported some shortness of breath at work "because he has to wear a large support belt around

his waist, which pushes on his abdomen, otherwise, doesn't have trouble." A physical examination of the chest revealed the lungs clear to percussion and auscultation. On February 10, 2006, Petitioner telephoned Dr. Fozard's office and complained of chest congestion, sinus drainage, and requested an antibiotic as he "won't be home this weekend." Petitioner presented to Dr. Fozard on December 26, 2006 for a checkup. His review of systems revealed no dyspnea, and a physical examination of the chest revealed the lungs to be clear to percussion and auscultation. PX 4.

Petitioner presented to Dr. Fozard on June 2, 2007 with complaints of a mildly productive cough over the past three weeks. He reported coughing up occasional yellowish-tinged sputum and some mild shortness of breath. A physical examination of the chest revealed a few coarse breath sounds bilaterally, but no wheezing. Dr. Fozard prescribed him a Z-pack and ordered he undergo a chest x-ray. The chest x-ray of June 2, 2007 revealed very mild aortic atherosclerosis and an interval faint, approximately one centimeter, left lateral basilar soft tissue nodular density for which a CT chest scan was recommended. Petitioner underwent a CT of the chest on June 9, 2007, which demonstrated no suspicious pulmonary nodules or masses. The radiologist's impression was that the small nodular densities identified at the lateral aspect of the left lung base on the recent chest radiograph likely related to minimal pleural scarring seen anterolaterally at the left lung base on the CT scan. On June 14, 2008, Petitioner presented to Dr. Fozard with complaints of a sore throat and sinus drainage that began two weeks prior. His lungs were clear on that date and Petitioner was assessed with persistent pharyngitis and upper respiratory allergy. Petitioner's wife telephoned Dr. Fozard's office on June 23, 2008 and reported that her husband suffered from head cold, cough, sore throat, drainage and hoarseness. Medication was prescribed for Petitioner to address same. When Petitioner presented to Dr. Fozard on August 29, 2009, he complained of cough that was slightly productive that had been present for three to four days with upper respiratory problems and some nasal congestion. A physical examination revealed coarse breath sounds in the lungs bilaterally. The assessment was acute bronchitis. A Z-pack was prescribed as well as Tussi Caps. On September 21, 2009, Petitioner's wife telephoned Dr. Fozard's office and reported that her husband had symptoms of head congestion, stuffy nose, and sinus pressure, but he denied a cough or fever. She requested a generic Z-pack be prescribed for him. Petitioner presented to Dr. Fozard on December 3, 2010 for a checkup. A review of systems was negative for chest pain, dyspnea or edema at that time, and a physical examination of the chest revealed the lungs to be clear to percussion and auscultation. PX 4.

On March 14, 2012, Petitioner telephoned Dr. Fozard's office with complaints of a bad cough, chest congestion and runny nose. A Z-pack was prescribed for him. Petitioner presented to Dr. Fozard on March 4, 2013 for a checkup. Petitioner's review of systems was negative for chest pain, dyspnea, edema or cough, and a physical examination of the chest was normal. He reported that he "was told at a mine exam that he has a small amount of black lung. Does not require medicine." Petitioner presented on March 18, 2013 for a Hyalgan injection to his knee. Petitioner related some mild chest discomfort with straining, such as ascending and descending stairs or lifting. Dr. Fozard noted that "[h]e gets a little short of breath." A physical examination of the chest revealed the lungs to be clear. Petitioner underwent a chest x-ray on March 27, 2013 for palpitations and it revealed a heart size within normal limits with mild atherosclerotic changes in the thoracic aorta, unchanged minimal scarring above the left costophrenic angle, no acute infiltrates or effusions, and pulmonary vascularity within normal limits. There was no change when this film was compared to that of June 2, 2007. Petitioner presented to Dr. Fozard on April 1, 2013 for bilateral knee complaints. A review of systems was negative for chest pain, dyspnea, and edema at that time. Petitioner presented to Dr. Fozard on June 3, 2014 for an annual examination. A review of

respiratory systems revealed no dyspnea. Petitioner returned on June 11, 2014 for a Hyalgan injection in both knees. A review of systems revealed no dyspnea, and a physical examination of the chest demonstrated his lungs to be clear to percussion and auscultation. PX 4, RX 4.

OPINION AND ORDER

In regard to disputed issues of accident and causal connection, pursuant to Section 1(d) of the Workers' Occupational Diseases Act, "the term 'Occupational Disease' means a disease arising out of and in the course of the employment or which has become aggravated and rendered disabling as a result of the exposure of the employment. Such aggravation shall arise out of a risk peculiar to or increased by the employment and not common to the general public." To recover compensation under the Act, a claimant must prove that he suffers from an occupational disease and that a causal connection exists between the disease and his employment. *Bernardoni v. Indus. Comm'n*, 362 Ill. App. 3d 582, 596 (2005). An occupational exposure need not be the sole or principal causative factor, as long as it was a causative factor in the development of the condition of ill-being. *Id.*

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he suffers from coal workers' pneumoconiosis. In so concluding, the Arbitrator notes that Petitioner proffered two B-reading opinions, that of Drs. Smith and Alexander, who both interpreted Petitioner's chest x-ray of November 13, 2012 as positive for coal workers' pneumoconiosis. PX 2, 3. Respondent also proffered two B-reading opinions from Drs. Meyer and Selby, who interpreted Petitioner's chest x-ray of November 13, 2012 as negative for the disease. RX 1, 2. While Petitioner admitted the opinions of Dr. Paul, who opined that Petitioner suffered from coal workers' pneumoconiosis, the Arbitrator is not persuaded by his opinions. Dr. Paul is not a B-reader, he could not ascertain the date of the chest x-ray he reviewed, he did not assign it a profusion, and he testified that the type of opacity he observed on Petitioner's chest x-ray was "coal" (PX 1), which is not a medically recognized type of opacity of coal workers' pneumoconiosis. RX 2. Simply put, the Arbitrator finds the opinions of Dr. Paul unreliable and therefore, the Arbitrator gives them no weight. Moreover, the Arbitrator finds the opinions of Drs. Meyer and Selby more persuasive than the opinions of Drs. Smith and Alexander. Drs. Meyer and Selby reviewed multiple x-rays of Petitioner's, in which Dr. Meyer compared one film to another to ascertain any changes amongst the series (RX 1, 2), while Drs. Smith and Alexander only reviewed Petitioner's chest x-ray of November 13, 2012. PX 2, 3. Further, Dr. Meyer's and Dr. Selby's interpretations of Petitioner's chest x-ray of January 21, 1998, in which they found no evidence of coal workers' pneumoconiosis, is consistent with the interpretations of the same x-ray by Dr. Ronald Burr and Dr. David Foraman, both independent NIOSH B-readers who interpreted the x-ray for reasons independent of this action. RX 3. The Arbitrator finds that Dr. Meyer's and Dr. Selby's interpretations consistent with the NIOSH B-readers' interpretation of Petitioner's x-ray of January 21, 1998 lends great weight to the opinions of Drs. Meyer and Selby, and in turn strengthens their interpretations of Petitioner's November 13, 2012 x-ray in which they found no evidence of coal workers' pneumoconiosis. RX 1, 2.

In finding that Petitioner failed to establish the present of coal workers' pneumoconiosis, the Arbitrator relies, in part, upon the B-readings of the NIOSH B-readers, but recognizes the temporal remoteness of those B-readings to Petitioner's date of accident and that coal workers' pneumoconiosis may develop even after a coal miner ceases exposure from the coal mine environment. RX 1, 2. Nonetheless, the Arbitrator finds the NIOSH B-readers' interpretations of Petitioner's x-rays as negative for coal workers' pneumoconiosis significant and indicative of the lack

of the presence of the disease through January 21, 1998, and the Arbitrator further finds the reverberation of opinions amongst the NIOSH B-readers, Dr. Meyer and Dr. Selby concerning Petitioner's x-rays taken over the course of thirty-three years from 1979 to 2012 compelling.

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he suffers from chronic obstructive pulmonary disease, chronic bronchitis, chronic cough or asthma. In so concluding, the Arbitrator notes that Petitioner denied shortness of breath upon presenting to Dr. Paul in 2013 and he reported experiencing a severe cough only with an upper respiratory tract infection. PX 1. Petitioner similarly denied breathing difficulties when he was examined by Dr. Selby, and he reported experiencing shortness of breath only with climbing stairs. RX 2. The Arbitrator further notes that Petitioner's treatment records, which date back to 1993, lack any diagnoses or treatment for chronic obstructive pulmonary disease, chronic bronchitis, chronic cough or asthma, and although Petitioner testified that he did not discuss his breathing difficulties with Dr. Fozard, his records lack any frequent or persistent complaints indicative of those conditions. Any symptomatology present in Petitioner's treatment records in which he exhibited shortness of breath, chest congestion, or a cough were generally associated with an ailment, and appeared intermittent and transient in nature. In addition, Dr. Selby's examination of Petitioner on October 3, 2013 revealed a normal spirometry, normal lung volumes and normal diffusion capacity, which negates the presence of an pulmonary obstruction, restriction or abnormality (RX 2), as did Petitioner's physical examination and pulmonary function studies taken during Dr. Paul's examination of Petitioner. PX 1.

Furthermore, in concluding that Petitioner does not suffer from chronic obstructive pulmonary disease, chronic bronchitis, chronic cough or asthma, the Arbitrator finds the opinions of Dr. Selby to be more informed and well-founded in the record than those of Dr. Paul. Dr. Selby reviewed Petitioner's treating records, whereas Dr. Paul did not. The Arbitrator notes that Dr. Selby's opinion that Petitioner does not suffer from chronic obstructive pulmonary disease, chronic bronchitis or asthma is consistent with the lack of any such diagnoses by Petitioner's treating physician, as well as the absence of findings upon physical examination and objective testing suggestive of such conditions. PX 4, RX 4. The Arbitrator further notes that Dr. Paul only diagnosed Petitioner with coal workers' pneumoconiosis and asthma during his examination of February 12, 2013; he did not proffer a diagnosis of chronic obstructive pulmonary disease, chronic bronchitis or chronic cough until his deposition over two years later. PX 1. While the diagnosis of asthma is supported by the positive Methacholine challenge test administered by Dr. Paul on February 12, 2013 (PX 1), Dr. Paul's findings are undermined by the negative methacholine challenge test administrated by Dr. Selby on October 3, 2013. RX 2. Although Dr. Selby testified that asthma is a condition which waxes and wanes over time in terms of pulmonary function, symptoms and complaints, and he explained that an asthmatic patient may have normal pulmonary function testing on one day and abnormal on another, which may explain the disparity between Petitioner's positive and negative methacholine challenge tests, the Arbitrator notes that Petitioner's treating records do not support a diagnosis of asthma nor do Petitioner's physical examinations and pulmonary function studies. PX 1, RX 2.

Based upon the foregoing and the totality of the record, the Arbitrator concludes that Petitioner failed to prove that he suffers coal workers' pneumoconiosis, chronic bronchitis, chronic obstructive pulmonary disease, or asthma that arose out of or in the course of the exposures of his coal mine employment, and that his current condition of ill-being is causally related to the coal mine exposures of that employment. All benefits are denied. The remaining issues are rendered 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

William G. Bates,

Petitioner,

vs.

NO: 12 WC 1164

17IWCC0106

State of Illinois Youth Center - Pere Marquette,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 24, 2015, is hereby affirmed and adopted.

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

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

DATED: FEB 16 2017
TJT:yl
o 12/19/16
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BATES, WILLIAM
Employee/Petitioner

Case# **12WC001164**

ST OF IL IYC PERE MARQUETTE
Employer/Respondent

17IWCC0106

On 11/24/2015, 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 0.35% 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:

5174 EDMONDS LAW OFFICE PC
J ROBERT EDMONDS
1012 PLUMMER DR SUITE 201
EDWARDSVILLE, IL 62025

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

3291 ASSISTANT ATTORNEY GENERAL
DIANA E WISE
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

1350 CENTRAL MANAGEMENT SYSTEMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

NOV 24 2015

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

17IWCC0106

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

WILLIAM BATES
Employee/Petitioner

v.

STATE OF ILLINOIS, IYC PERE MARQUETTE
Employer/Respondent

Case # **12** WC **001164**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **9/24/15**. 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 **11/7/11**, 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 **$90,546.00**; the average weekly wage was **$1,741.27**.

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

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

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

Respondent shall be given a credit of **$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 be given a credit of $0 for medical benefits that have been paid by group health insurance, 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 reasonable and necessary medical services, pursuant to the medical fee schedule, of $93.00 to Dr. James Ricci, $13,719.00 to Alton Memorial Hospital, $629.00 to Dr. Bruce Vest, Jr., $2,974.00 to Neurology Associates of Alton, $5,793.89 to Dr. Michael Beatty, $11,215.55 to Anderson Hospital and $1,763.20 to Millennium Anesthesia as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $695.78 per week for a period of 57 weeks as provided in Section 8(e) of the Act, because the injuries sustained caused permanent partial disability to the extent of 15% of the right hand and $15% of the left hand.

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

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

Edward Lee
Signature of Arbitrator

11/24/15
Date

NOV 2 4 2015

17IWCC0106

FINDINGS OF FACT

Petitioner is currently 53 years old and worked at Respondent's youth detention center for a little over 30 years. (T pgs 7-8) He is right hand dominant. (T pg 10) During the last 20 years the Petitioner worked at that facility, (1991-2012) his position was that of a Youth Supervisor IV/Juvenile Justice Supervisor. (T pgs 10-11) During this 20 year period, Petitioner's duties remained the same. (T pg 11) Petitioner always worked at least 8 hours a day 5 days a week, and often worked 6 days a week. (T pgs 12-13) Petitioner's position involved not only supervising junior supervisors, but also acting as coordinator for numerous committees which duties required a lot of typing/computer keyboarding and handwriting. (T pg 12)

Petitioner testified that after carrying out his early morning duties, he had an approximate 3 hour window of time during which he completed his keyboarding activities more or less uninterrupted. (T pg 14) Most of these activities required him to transfer information from paper to a computer system, similar to a data entry clerk. Petitioner acted in a number of capacities such as vehicle coordinator, radio coordinator, contraband officer, etc. All of those positions required him to move information from one place (paper) to another (computer system). (T pg 15) Petitioner used a computer keyboard/mouse while entering information. Petitioner worked 5 to 6 days a week and typically performed data entry functions on a computer keyboard and mouse for about 3 hours per day, and sometimes longer. (T pgs 15-16) Petitioner testified that his keyboarding/data entry functions were not done on an intermittent basis and that aside from bathroom breaks or occasional interruptions, he typically spent about 3 continuous hours per day entering data via computer keyboard/mouse. (T pg 16) He also spent approximately 1 hour per day handwriting reports during the same 20 year period. (T pgs 16-17)

In the fall of 2010 Petitioner began to notice pain and numbness in his hands/fingers and pain in his wrists. Initially, the symptoms were intermittent, but the more he used his hands, the worse the symptoms got. He testified that any use of his hands increased the symptoms, but they were most severely aggravated by his computer keyboarding activities at work. (T pgs 17-19)

Petitioner saw his primary care physician, James Ricci on October 17, 2011. This was a regularly scheduled visit. Petitioner was not specifically seeking treatment for his hands. However, when asked about other problems, he told Dr. Ricci of the pain and numbness in his hands and wrists. He was told he might have carpal tunnel syndrome, and Dr. Ricci ordered an EMG/NCS to confirm. (T pgs 19-21, PX 10) The tests were conducted at Alton Memorial Hospital on 10/31/11. (PX 3) Petitioner was then referred to Dr. Bruce Vest (orthopedic surgeon) for follow up care. Petitioner saw Dr. Vest on 11/7/11 and complained of numbness and tingling in both hands and also complained of dropping objects. Petitioner reported that the symptoms were worse with the use of computers, typing and using a telephone. Dr. Vest noted that Petitioner had conducted repetitive use activity with his hands at his job for almost 30 years and that this could be a contributing factor to his condition. Dr. Vest prescribed hand braces initially. (PX 11, T pg 23). Petitioner testified that his symptoms got worse and he contacted Dr. Vest's office again for follow up. Petitioner spoke with someone in Dr. Vest's financial office and was told that Dr. Vest was not treating patients with worker's compensation claims against the State of Illinois due to untimely payments. Petitioner then sought further medical care. (T pgs 24-25)

Petitioner then treated with Dr. Michael Beatty (a hand surgeon) on 2/02/12. (T pg 26, PX 2) Dr. Beatty testified by way of evidentiary deposition. (PX 21) He is a plastic surgeon with a subspecialty in hand surgery. He is Board Certified in plastic, reconstructive and upper extremity surgery. He has been in practice 30 years. Approximately 45-50 percent of his practice is devoted to hand surgery, and he performs approximately 300-350 hand surgeries per year. (PX 1, PX 21 pgs 4-5). Dr. Beatty's office notes, including operative reports were

admitted into evidence. (PX 2) Petitioner complained to Dr. Beatty of numbness and tingling in the fingers and both hands, night pain and it was noted that the symptoms were increasing in severity. (PX 21 pgs 6-8)

Petitioner provided Dr. Beatty with a typewritten job duty list (PX 2). Dr. Beatty also gathered a verbal job history from Petitioner wherein he learned that Petitioner had worked at the same job for approximately 30 years as a juvenile justice supervisor. (PX 21 pgs 6-7) Petitioner told Dr. Beatty that his hand symptoms increased with the use of computers and handwriting at work. (PX 21 pg 9) Petitioner also complained of "triggering" (snapping or clicking) involving the index fingers of both hands. (PX 21 pgs 9-10) Dr. Beatty reviewed the 10/31/11 EMG which confirmed bilateral carpal tunnel syndrome and an ulnar nerve compression in the left hand. (PX 21 pgs 10-11) Dr. Beatty also performed a clinical neurological test which confirmed bilateral carpal tunnel syndrome, ulnar nerve compression in the left hand and bilateral trigger finger of the index fingers. He recommended surgical intervention for bilateral carpal tunnel syndromes, a left ulnar nerve release and injections for bilateral trigger finger. Authorization from the worker's compensation carrier for the recommended treatment was denied. (PX 21 pgs 10-12) Petitioner retired from the facility in May 2012. (T pg 11)

Dr. Beatty testified that Petitioner returned to his office for follow up on 9/17/12. He continued to complain of ongoing bilateral hand problems including loss of grip, pain and triggering of both index fingers. (T pgs 12-13) Dr. Beatty ordered a follow up EMG study which was completed at Alton Memorial Hospital on 10/3/12. (PX 21 pg 13, PX 4) The test again confirmed bilateral carpal tunnel syndrome. (PX 21 pg 14) Petitioner followed up with Dr. Beatty on 11/6/12 and at that time provided additional information relative to his job at the youth facility. (PX 2, P 21 pg 14) Petitioner's description of his job confirmed that he had worked at the facility for 30 years and that for the past 20 years, on average, he worked 6 days a week and spent approximately 3 hours a day performing keyboarding activities, 1 hour per day hand writing and had to turn approximately 30 keys per day. (PX 21 pgs 14-16) Based upon the information provided, it was Dr. Beatty's opinion that Petitioners work activities were a causal factor in the development of Petitioners condition of ill-being which including bilateral carpal tunnel syndrome, bilateral trigger finger of the index fingers and a left ulnar nerve compression neuropathy in the left hand at Guyon's canal. (PX 21 pgs 16- 18)

As a result of his examination, Dr. Beatty recommended bilateral carpal tunnel release, instillation of Kenalog to the bilateral index fingers and ulnar nerve release in the left hand at Guyon's canal. (PX 21 pg 19) Dr. Beatty had Petitioner undergo a preoperative EKG. (PX 21 pg 19, PX 5) On 1/15/13 Dr. Beatty performed right carpal tunnel release, and a Kenalog injection of the right index trigger finger. During the procedure, Dr. Beatty was able to observe compression of the right median nerve. (PX 21 pgs 20-21, PX 6)

Petitioner underwent additional preoperative testing on 4/9/13. (PX 21 pgs 21-22, PX 7) Dr. Beatty again performed surgery on 4/16/13 at which time he carried out a left carpal tunnel release and a release of the ulnar nerve at Guyon's canal. (PX 21 pgs 22-23, PX 8) During the procedures, Dr. Beatty was able to visualize compression of the nerves. (PX 21 pg 23)

Dr. Beatty released Petitioner as of 5/1/13. (PX 21, pg 23) It was Dr. Beatty's opinion, based upon a reasonable degree of medical certainty, that all the medical treatment associated with Petitioners conditions of ill-being which included Dr. Ricci, both EMG/nerve conduction studies, Dr. Vest, the two surgeries, injections, and preoperative testing were all reasonable, necessary and related medical treatment associated with the work injuries. (PX 21 pgs 23-24)

Respondent had a Section 12 examination performed on Petitioner by Dr. Ryan Calfee on 5/6/15. (RX 11) Dr. Calfee's deposition and report were admitted into evidence. (RX 11, 12) Dr. Calfee's understood that Petitioner's job duties over the previous 20 years included 3 hours of keyboarding and 1 hour of handwriting 5-6 days a week. Dr. Calfee testified he did not believe that he had clear evidence that Petitioner's job contributed

to or caused bilateral carpal tunnel syndrome or compression of the ulnar nerve at Guyon's canal. (RX 12 pgs. 9-12).

Dr. Calfee was cross examined by Petitioner's counsel. Dr. Calfee agreed that Petitioner had bilateral carpal tunnel syndrome, compression of the ulnar nerve in the left hand at Guyon's canal and bilateral trigger finger. (RX 12 pg 23) He agreed that the medical treatment Petitioner received relative to his alleged conditions of ill-being were appropriately treated and that Petitioner underwent reasonable treatment before proceeding to surgery. (RX 11 pg 3, RX 12 pg 24) Dr. Calfee agreed that hand use over time can play a role in the development of carpal tunnel syndrome and that keeping the wrist bent for a long period of time can be a causative factor in the development of carpal tunnel syndrome. (RX 12 pgs 21-23).

Although Dr. Calfee was aware Petitioner worked on computer keyboard 3 hours a day and performed handwriting 1 hour a day, he did not agree that such job duties could be a causal factor in the development of carpal tunnel syndrome and ulnar nerve compression or that such work activities were a risk factor for the development of those conditions. (RX 12 pg 25)

Dr. Calfee could not recall an instance where he had ever related keyboarding activities to the development of carpal tunnel syndrome in a worker's compensation case. (PX 12 pgs 25-26) Dr. Calfee testified that he does not see keyboarding and handwriting as activities that contribute to the development of carpal tunnel syndrome. (PX 12 pg 26) He admitted that even if the evidence showed that an individual spent 8 hours a day keyboarding in an office environment, he would still have the same opinion that there was no causal connection between that activity and the development of carpal tunnel syndrome. (PX 12 pgs 34-35)

Dr. Calfee agreed that if an employee was seeking worker's compensation benefits based on the development of carpal tunnel syndrome caused by keyboarding several hours a day in an office environment, and if the employer's insurance carrier asked Dr. Calfee to perform an independent examination, his opinion would essentially always be that the keyboarding activity was not a factor in the causation of carpal tunnel syndrome. (PX 12 pgs 35-36)

Dr. Calfee understood that two of Petitioner's treating physicians (Dr. Bruce Vest and Dr. Michael Beatty) both held opinions that Petitioner's work activities were causal factors in the development of his conditions of ill-being, but he disagreed with those opinions. (RX 12 pgs 31-32) Dr. Calfee admitted that his opinion that typing, in an office environment, cannot cause carpal tunnel syndrome could be wrong. (PX 12 pgs 32-33)

Dr. Calfee's testified that, in his opinion, the cause of Petitioner's carpal tunnel syndrome was idiopathic. Although he thought obesity could be a contributing factor, he could not say that if Petitioner was not obese, he would not have developed carpel tunnel syndrome. (RX 12 pgs 29-30).

Dr. Calfee works for Washington University Physicians which advertises, on its website, as providing independent medical evaluations. (RX 12 pgs 41-43, PX 26) He allows time to provide 1 IME per week. (RX 12 pg 43) He charges approximately $1,000.00 for an IME and $1,500.00 an hour for a deposition. (RX 12 pg 45) Most of the IMEs he has performed have been on behalf of the employer or its worker's compensation insurer. He has previously been hired by the Illinois Attorney General's office to perform IMEs. (RX 12 pgs 47-48)

Dr. Calfee acknowledged that Petitioner still has residual problems with his hands. (RX 12 pgs 36-41) At the time of the IME (5/16/15) Petitioner continued to experience aching in both hands. Additionally, Petitioner filled out a hand questionnaire document. (PX 12 pgs 38-39, PX 25) On the questionnaire, Petitioner indicated that he continued to have severe difficulties with activities such as opening a jar, carrying a shopping bag and using a knife to cut food. He indicated his hand pain had been severe and that his hand problems had interfered

with his normal activities quite a bit in the previous week. (RX 12 pgs 39-41, PX 25) Petitioner also indicated that he had severe difficulty doing heavy household chores or participating in activities that take force or impact through the hand and that, in the previous week, he had been very limited in his regular daily activities as a result of his hand problem. (PX 25)

Petitioner testified that he continues to have persistent pain anytime he uses his hands. The pain is constant if he uses his hands to twist, turn or grip. He constantly changes hands on the steering wheel while driving and indicated that after holding his hand on the wheel for about 10 minutes the hand begins to ache. His grip strength is about half of what it had been previously. As a result, he finds it hard to complete activities such as heavy housework, cleaning floors, pushing a lawn mower, using a weed eater and washing/waxing a car. He has difficulty gripping small objects. It is difficult for him to open anything with a vacuum seal. Lifting a gallon jug of milk is painful. He has difficulty picking up small or flat objects and constantly drops things. He has difficulty picking up coins, paper or any small or flat object that is on the floor. He drops things like keys, coins, items in a store, etc. He is not able to sense that he is gripping an object. He experiences pain in the hands when he uses a computer keyboard or holds a telephone. He has pain in his hands daily and hand intensive activities cause the pain to increase. (T pgs 9-34)

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above.

ISSUE (C): DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT WITH RESPONDENT?

The Arbitrator concludes that an accident did occur that arose out of and in the course of Petitioner's employment with Respondent. Petitioner worked for Respondent for approximately 30 years. His duties in the last 20 years remained essentially the same. The evidence established that during that time period Petitioner spent nearly 3 hours a day, 5 to 6 days a week entering data into a computer system via a keyboard and mouse with only occasional interruptions and that he spent approximately 1 hour a day, 5 to 6 days a week, handwriting reports with interruptions. The Petitioner performed repetitive tasks on a daily basis in preparing various reports and this work was hand intensive. Petitioner testified that he slowly began to develop pain, numbness and tingling and loss of grip in his hands. He testified and the medical records reflect that his work activities aggravated these symptoms. Petitioner did not engage in activities outside of work that would have exposed his hands to repetitive trauma.

ISSUE (F): IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

The arbitrator concludes that Petitioner's current condition of ill-being is causally related to the injury that occurred on 11/7/11. Petitioner testified, in detail, as to the repetitive and hand intensive nature of his job duties that required him to operate a keyboard approximately 3 hours a day and handwrite approximately 1 hour a day over the previous 20 year period. The medical records and job description were consistent with this testimony. Dr. Beatty testified as to the causal relationship between the repetitive trauma associated with Petitioner's job functions and the development of Petitioner's bilateral carpal tunnel syndrome, ulnar nerve compression in the left hand at Guyon's canal and bilateral trigger finger. Respondent's Section 12 examiner, Dr. Calfee, is of the opinion that the cause of Petitioner's carpal tunnel syndrome was idiopathic, other than to say that obesity might be a risk factor. Additionally, Dr. Calfee simply does not subscribe to the theory that keyboarding, at virtually

any level in an office environment, can be a causative factor in the development of carpal tunnel syndrome. From his perspective, it wouldn't matter whether Petitioner was using a computer keyboard for 3 hours a day or 8 hours a day, as he would never relate that activity to the development of carpal tunnel syndrome and would always have the opinion that there was no causal connection. The opinions of Dr. Beatty are more credible than those of Dr. Calfee.

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 that the medical services provided to Petitioner were reasonable and necessary. It is undisputed that Petitioner suffered bilateral carpal tunnel syndrome, ulnar nerve compression in the left hand and bilateral trigger finger of the index fingers as testified to by Dr. Beatty and the IME physician, Dr. Calfee. Petitioner's treating physician, Dr. Beatty, testified that all of the medical treatment delineated in Petitioner's Exhibits 2-8, 10-11 was reasonable, necessary and causally related to the work injury. (PX Pg 23-24) Dr. Calfee agreed that the medical treatment Petitioner received relative to his alleged conditions of ill-being were appropriately treated. (RX 11 pg 3)

Respondent has not paid all appropriate charges for all reasonable and necessary medical services as itemized in Petitioner's exhibits. (PX 9,12-20 and 22) In connection with the Arbitrator's finding that the above-referenced medical treatment was reasonable, necessary and causally related to the work injury, Respondent is ordered to pay those charges, pursuant to the medical fee schedule, of $93.00 to Dr. James Ricci, $13,719.00 to Alton Memorial Hospital, $629.00 to Dr. Bruce Vest, Jr., $2,974.00 to Neurology Associates of Alton, $5,793.89 to Dr. Michael Beatty, $11,215.55 to Anderson Hospital and $1,763.20 to Millennium Anesthesia as provided in Sections 8(a) and 8.2 of the Act.

ISSUE (L): WHAT IS THE NATURE AND EXTENT OF THE INJURY?

For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

(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.

The Act provides that no single enumerated factor shall be the sole determinant of disability. With respect to these factors, the Arbitrator notes:

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor. The Arbitrator finds that a permanent partial disability can and shall be awarded in the absence of an impairment rating or impairment report being introduced.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as a Youth Supervisor IV/Juvenile Justice Supervisor at the time of the accident and that he retired from that position a few months prior to undergoing surgery. However, based upon the evidence presented relative to Petitioner's ongoing problems and the hand-intensive nature of his job, it is doubtful Petitioner would have been able to return to work in his prior capacity without accommodation as a result of said injury. The Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 49 years old at the time of the accident. Because the Arbitrator considers the petitioner to be a somewhat younger individual and concludes that Petitioner's permanent partial disability will be more extensive than that of an older individual because he will have to live with the permanent partial disability longer, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner has retired from his positon. Because no evidence was presented that Petitioner's future earning capacity will be diminished, 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 Dr. Beatty diagnosed Petitioner with bilateral carpal tunnel syndrome, compression of the ulnar nerve in the left hand at Guyon's canal and bilateral trigger finger of the index fingers. The IME physician concurred with the diagnosis of these conditions. Dr. Beatty performed bilateral carpal tunnel releases, a release of the ulnar nerve at Guyon's canal in the left hand and provided injections in both index fingers. Dr. Calfee agreed that the treatment was reasonable and necessary. Petitioner is right hand dominant. Petitioner testified he has pain in his hands daily. He has constant pain when he uses his hands to twist, turn or grip. He must constantly change hands on a steering wheel. His grip strength is about half of what it had been previously. It is hard for him to complete activities such as pushing a lawn mower, using a weed eater and washing/waxing a car. He has difficulty gripping small objects. Lifting a gallon jug is painful. He has difficulty picking up small or flat objects and he drops things constantly. He is not able to sense that he is gripping an object. He experiences pain in the hands when he uses a computer keyboard. Respondent's Section 12 examiner confirmed that Petitioner still has residual problems with his hands. When Petitioner filled out a hand questionnaire at the time of the IME he indicated that he continued to have severe difficulties with tasks like opening a jar, carrying a shopping bag and using a knife to cut food. He indicated that his hand problems had interfered with his normal activities quite a bit and that, in the previous week, his hand pain had been severe. He reported that he had severe difficulty doing heavy household chores and participating in activities that take force or impact through the hand. He indicated that in the previous week he had been very limited in his regular daily activities as a result of his hand problem. Petitioner testified credibly regarding the residual problems he experiences with his hands. Because of the consistency in Petitioner's testimony, the medical records and the IME relative to Petitioners residual hand problems, the Arbitrator gives greater weight to this factor. It is specifically noted that Petitioner is right hand dominant and that in addition to a carpal tunnel release, Petitioner also underwent release of the ulnar nerve at Guyon's canal in the left (non-dominant hand).

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 15% loss of use of the right hand and 15% loss of use of the left hand pursuant to §8 (e) of the Act.

ISSUE (N): IS RESPONDENT DUE ANY CREDIT? 17IWCC0106

Respondent is not due any credit at this time as it has offered no evidence of amounts paid by group health insurance for which it might be entitled to credit under Section 8(j) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF MC LEAN)

☒ 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 Gaines,

Petitioner,

vs.

NO: 14 WC 29686

17IWCC0107

Multiband Corp.,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 13, 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.

17IWCC0107

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

DATED:
TJT:yl
o 2/6/17
51

FEB 16 2017

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

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

GAINES, TIMOTHY
Employee/Petitioner

Case# **14WC029686**

MULTIBAND CORP
Employer/Respondent

17IWCC0107

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:

1824 STRONG LAW OFFICES
SEAN D OSWALD
3100 N KNOXVILLE AVE
PEORIA, IL 61603

0000 RUSIN & MACIOROWSKI LTD
JENNIFER C MEJIA
2506 GALEN DR SUITE 108
CHAMPAIGN, IL 61821

17IWCC0107

STATE OF ILLINOIS)
)SS.
COUNTY OF McLean)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION – 19B

TIMOTHY GAINES
Employee/Petitioner

v.

MULTIBAND CORP.
Employer/Respondent

Case # **14** WC **29686**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Peoria**, on **02/25/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0107

FINDINGS

On **4/16/14**, 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 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 **$28,444.68**; the average weekly wage was **$677.25**.

On the date of accident, Petitioner was **49** years of age, ***single*** with **0** 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

Because Petitioner failed to meet his burden of proving that he sustained an accident which arose out of and in the course of his employment with Respondent, failed to provide notice of the alleged accident as required by the Act, and further failed to prove that his current condition of ill-being is causally related to her employment, benefits are denied.

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

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

Signature of Arbitrator

4/29/16
Date

ICArbDec p 2

MAY 13 2016

FINDINGS OF FACT

On the date of accident Petitioner was a 49 year old satellite system installer/repairman. He had been so employed since 2013. Petitioner testified that on 4/16/14 he was installing a new satellite system at a home in Carlock, IL. The home was new construction and sod had not yet been laid. Petitioner submitted photographs of the job site into evidence. (Px 4) He testified that in order install the system he had to prepare to ground the system along with the electric service in the home. This was located on the northwest corner of the home. Petitioner testified that while carrying his tools to that location he saw a hole in the yard and tried to avoid it by stepping beside the hole. When he did so, however his right foot slipped in the mud and slid into the hole getting jammed in the depression. He stated he felt an immediate burning sensation in the foot. He testified that he sat for a few minutes and when he stood up he did feel pain in the foot, but it was not so bad that he could not work. He completed the job and continued to work through 4/29/14. He testified that in the intervening time the foot became much more painful and began to swell significantly.

Petitioner testified that on the evening of 4/28/14 he photographed the swelling in his right foot (Px 5) and sent it via text message to his supervisor, Mr. Berkholder. He indicated he went to work the next morning, but after completing one service call he phoned Mr. Berkholder and advised he was going to seek medical treatment and could not take any further work assignments at that time.

Petitioner testified that he had previously fractured both his right ankle and his right leg, and indicated the pain and loss of function he had been experiencing in the right foot following the accident was not anywhere near as severe as what he had experienced with the prior fractures.

Petitioner first sought treatment with his primary care physician, Dr. William Ray, on 4/29/14. Petitioner gave a history of experiencing pain and swelling in his right foot for one week's time. The note did not indicate Petitioner had sustained any specific trauma or injured his foot at work. Dr. Ray indicated Petitioner had diffuse mild redness on his right foot with tenderness over the distal second and third metatarsals. (Px. 9). That same day an x-ray of Petitioner's right foot performed at Bloomington Radiology was negative for any abnormalities.

Petitioner presented to OSF St. Joseph Medical Center on 5/09/14. He was evaluated by Dr. Roberto Cipolla. Petitioner gave a history of experiencing right foot pain for the past one to four weeks. Dr. Cipolla documented there was "no reported injury." Petitioner was assessed with right foot pain, and he was referred to see Dr. Cortese. (Px. 8).

On 5/12/14, Petitioner met with Dr. Craig Cortese, a podiatric surgeon. Petitioner gave a history of experiencing right foot pain since about 4/21/14. Petitioner stated his foot pain has gotten progressively worse with weight-bearing and had been relieved by rest. Specifically, Petitioner related "no history of trauma." (Px. 13). Dr. Cortese assessed Petitioner with a stress fracture to the second metatarsal of the right foot. He also assessed Petitioner with arthralgia, metatarsalgia, edema, and foot pain. Dr. Cortese fitted Petitioner with an boot and a CAM walker. Dr. Cortese indicated Petitioner should stay off work. (Px. 13).

Petitioner continued to treat with Dr. Cortese. He met with Dr. Cortese on 5/19/14, 5/28/14, 6/11/14, and 6/30/14. Dr. Cortese did not document a history of a work accident in any of these treatment notes. (Px.

13). During his deposition, Dr. Cortese confirmed Petitioner did not report a work accident during these visits (Px. 15, p. 45).

On 7/14/14, Petitioner gave a history to Dr. Cortese that he was injured at work on 4/16/14. Petitioner stated he stepped in a hole while walking along the side of a house, and his foot was wedged in the hole. He felt a sharp, burning when he pulled his foot out of the hole. He indicated he experienced pain for approximately the next 5-10 minutes, but then the pain went away. Petitioner continued to work until he noticed his right foot had begun swelling and was painful about three days later. Petitioner had pain to palpation and with range of motion of the second and third metatarsals of the right foot. Dr. Cortese recommended Petitioner remain off work. (Px. 13).

Petitioner testified he told Dr. Cortese that he was injured at work during the 5/19/14 visit. (T. 43). He testified he gave no history of the work accident to Dr. Ray initially because at that point he did not associate the pain with the incident of 4/16/14. Petitioner testified that when Dr. Cortese told him the foot was fractured he wondered "how could I have broken my foot." Upon reflection he concluded the slip into the muddy hole on 4/16/14 must have been when he did it. The Arbitrator notes that Dr. Cortese had diagnosed the fracture by 5/19/14, but the medical records in evidence as well as the testimony of Dr. Cortese establish that Petitioner first mentioned a work accident to Dr. Cortese during the visit of 7/14/14.

Petitioner testified that he then phoned Mr. Berkholder on 5/12/14 and advised he would be off 10-12 weeks. He indicated Mr. Burkholder asked how it happened and he told him it was when he stepped in the hole on the Carlock job. The cell phone records corroborate a call to Mr. Burkholder on that date. (PX7) Petitioner testified that Mr. Burkholder called back a short time later and indicated he needed to turn in his company equipment. He indicated he returned the equipment on 5/13/14 to Kim Hany, who was his point of contact at Respondent's office. He indicated he told Ms. Hany the injury was work related and was given the phone number of Ms. Samuelson in HR. He testified he was told that if he did not hear from them within a couple of weeks he should call her. When he did not hear from them he phoned Ms. Samuelson in June and she indicated Mr. Burkholder needed to report the accident. Petitioner then sent a text to Mr. Burkholder. (PX6)

On 7/28/14, Petitioner complained of ongoing pain in his right foot. Dr. Cortese recommended Petitioner continue with the CAM walker. He also ordered a right foot MRI. (Px. 13). The MRI was performed on 7/29/14 and showed a subacute, nondisplaced intra-articular fracture at the second metatarsal base. (Px. 13).

On 7/30/14, Dr. Cortese fitted Petitioner with a non-walking cast and surgical shoe. Petitioner was also given a pair of crutches. Dr. Cortese indicated Petitioner should be non-weight-bearing with crutches until further notice. Dr. Cortese recommended a bone stimulator given that Petitioner's fracture had not healed after 11 weeks of treatment. (Px. 13). On 8/20/14 Dr. Cortese replaced the cast, and instructed Petitioner to remain non-weight-bearing with crutches. (Px. 13). On 9/24/14 Dr. Cortese removed the cast and placed Petitioner in a CAM walker. Dr. Cortese instructed Petitioner to continue to use crutches and be non-weight-bearing. (Px. 13). Petitioner had a CT-scan of his right foot performed on 9/25/14. The CT-scan showed an intra-articular fracture at the second metatarsal base with evidence of an incomplete bony union. (Px. 13). Petitioner continued to follow up with Dr. Cortese. Petitioner had an updated CT-scan of his right foot performed on 1/02/15. The CT-scan showed a healing fracture at the base of the second metatarsal without complete osseous union. The radiologist noted that there had been some healing since the prior CT-scan on 9/25/14. (Px. 13).

A CT-scan of Petitioner's right foot was performed on 4/15/15. The CT-scan showed a minimal linear lucency at the second metatarsal consistent with a residual non-displaced fracture line. (Px. 13). Petitioner saw Dr. Cortese on 7/30/15. Dr. Cortese recommended Petitioner continue to use the CAM walker when walking long distances. Dr. Cortese stated Petitioner may use a rigid-soled tennis shoe in the house and for shorter distances. (Px. 13). Petitioner had another CT-scan of his right foot performed on 7/31/15. The CT-scan showed a complete osseous fusion when compared to the prior scan. (Px. 13). On 8/05/15 Dr. Cortese recommended that Petitioner begin weaning out of the CAM walker over the course of the next two weeks. (Px. 13). When Petitioner saw Dr. Cortese on 10/23/15 he was experiencing little to no pain in his right foot, and was able to be on his feet nearly a full day. Upon exam, Petitioner had minimal tenderness to palpation of the second metatarsal. Petitioner also had no pain on range of motion of his right foot. Petitioner was fitted for a custom molded orthotic. (Px. 13). Petitioner's final appointment with Dr. Cortese was on 11/23/15. Petitioner noted that his right foot pain had continued to improve. He indicated he was able to balance on his right foot with minimal discomfort. Upon exam, Petitioner had minimal tenderness to firm palpation to the second metatarsal, and he had no pain with range of motion. (Px. 13). Dr. Cortese gave Petitioner a pair of custom orthotics, and he trimmed the orthotics to appropriately fit into Petitioner's shoes. Dr. Cortese recommended Petitioner slowly begin wearing his orthotics and supportive tennis shoes over the next two to three weeks. Petitioner was released to return to work without any restrictions, and released from care. (Px. 13).

Dr. Cortese testified by way of an evidence deposition on 11/17/15. When asked about the causal relationship between the alleged accident and the condition of Petitioner's foot the doctor responded "I certainly feel that it's well within the range of possibilities that he could have injured his foot and caused that type of fracture, absolutely.". (Px. 15, p. 40-42). On cross examination, Dr. Cortese testified that his causation opinion is dependent on having an accurate history, and he stated that his opinion could change if the history provided was inaccurate. (Px. 15, pps. 43-44). He admitted Petitioner did not mention anything about his foot injury being related to a work accident until his sixth visit on 7/14/14. Dr. Cortese acknowledged that the history given to him on 7/14/14 was inconsistent with the previous history given to him at Petitioner's initial appointment on 5/12/14. (Px. 15, pps. 44-45). Dr. Cortese testified there had been a delay in healing of Petitioner's stress fracture (Px. 15, p. 47-48). Dr. Cortese indicated that other than on one occasion, shortly before his visit of 8/13/14 when Petitioner had to bathe his dog which had gotten sprayed by a skunk, he did not believe Petitioner was walking on his cast. (Px. 15, p. 48-50). Dr. Cortese also testified that Petitioner arrived at the 9/26/14 office visit without the use of crutches. Dr. Cortese opined that Petitioner's act of walking on his cast and not using crutches was not helping his recovery. (Px. 15, p. 51). Dr. Cortese also testified, however that he never considered Petitioner non-compliant with treatment. (Px. 15, p. 52).

Petitioner presented to Dr. Samuel Vinci pursuant to §12 on 2/09/15. Dr. Vinci testified by way of an evidence deposition on 1/20/16. He opined that Petitioner's right foot condition was not causally related to a work accident on 4/16/14 (Rx. 1, p. 11). Dr. Vinci opined that a stress fracture could be related to anything, and he indicated that the majority of stress fractures are unrelated to work and are not caused by a trauma. (Rx. 1, p. 19, 21). He stated that a stress fracture could be related to something as simple as stepping out of bed in the morning. (Rx. 1, p. 19). Dr. Vinci indicated that even though Petitioner made complaints of foot pain a few weeks after alleged accident date, there was no documented evidence that those particular complaints were related to anything at work. Due to the lack of documentation of a work accident or trauma by three different doctors on three different occasions until several months after the alleged accident, Dr. Vinci opined he could

not correlate Petitioner's foot condition to work. (Rx. 1, p. 17-21). Dr. Vinci testified Petitioner had been non-compliant with Dr. Cortese's instructions which contributed to the delayed healing. (Rx. 1, p. 13).

At the time of hearing Petitioner testified he had been released to return to work without any restrictions, and he stated he had not been back to see Dr. Cortese since 11/23/15. (T. 53, 55). Petitioner testified he had mild, but bearable discomfort in his right foot as of the time of trial.

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?

Petitioner testified he did not tell any of the doctors he met with prior to 5/12/14 that he had been injured at work or describe the incident of falling into a hole to his doctors because he did not believe at that point that his foot condition was related to work or that his injury was serious. He alleged that when he received the diagnosis of a stress fracture at the 5/12/14 visit with Dr. Cortese, he began to question when he may have injured the foot. He then, at some point, surmised that his foot condition was caused by the incident on 4/16/14. Although Petitioner testified he told Dr. Cortese about his work accident during his second visit, the first documentation in the records is 7/14/14. No doctor who saw Petitioner prior to that date noted any work accident. In fact, the record clearly indicates Petitioner had repeatedly reported no injury or trauma. The Arbitrator finds the lack of documentation of a work accident or trauma by three different doctors on a number of visits until several months after the alleged accident to be significant.

Dr. Vinci opined that Petitioner's right foot condition was not causally related to a work accident on 4/16/14 (Rx. 1, p. 11). Dr. Vinci indicated that even though Petitioner made complaints about foot pain a few weeks after the alleged accident date, there was no documented evidence that those particular complaints were related to anything at work. Dr. Vinci opined that the majority of stress fractures are unrelated to work and are not caused by a trauma.

Dr. Cortese testified that it was "within the range of possibilities" that Petitioner could have sustained the stress fracture in the manner he alleges. He conceded, however that his causation opinion is dependent on having an accurate history, and he stated that his opinion could change if the history provided was inaccurate. He admitted Petitioner did not mention anything about his foot injury being related to a work accident until his sixth visit with Petitioner on 7/14/14. The Arbitrator finds the testimony and opinions of Dr. Vinci more persuasive than those of Dr. Cortese.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has failed to meet his burden of establishing that he sustained accidental injuries which arose out of and in the course of his employment. Petitioner has further failed to establish that his current condition of ill-being is causally related to his employment with Respondent

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

Petitioner admitted he did not report a work accident to Stacey Burkholder on 4/29/14. He merely told Mr. Burkholder he had injured his foot. Petitioner alleged he called and told Mr. Burkholder on 5/12/14 that he

had injured his foot at work, and he claims that his phone logs document he called Mr. Burkholder's number on that day. While the telephone log does show a call to Mr. Burkholder on that date, Petitioner himself testified that 5/12/14 was the date he began to wonder how he could have fractured his foot. Following his diagnosis on 5/12/14 Petitioner returned to Dr. Cortese on 5/19/14, 5/28/14, 6/11/14, and 6/30/14. There is no mention in any of these notes regarding an accident at work. The first recording of the work accident came on 7/14/14. The Arbitrator finds it implausible that Petitioner could have told Mr. Burkholder on 5/12/14 that he had sustained an injury at work when Petitioner himself had apparently not arrived at the conclusion by that time.

Based upon the evidence in the record, Petitioner did not provide notice of a work accident until 6/11/14 when he contacted Laura Samuelson in Respondents human resources department. Further, based on a text message sent by Petitioner on 6/11/14 at 1:19 p.m., Petitioner informed Mr. Burkholder he had spoken to Laura Samuelson about his foot injury. The text documents Petitioner told Mr. Burkholder that Ms. Samuelson instructed him to file his injury as a workers' compensation claim. Based upon this text communication it appears to the Arbitrator that Petitioner had not previously informed Mr. Burkholder that his injury happened at work.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner first gave notice of his alleged accident on 6/11/14. Thus Petitioner failed to provide proper notice within 45 days of the alleged accident as required by the Act.

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

Based upon the Arbitrators findings with regard to issues C, E, and F Petitioner's claim for medical, temporary total, and permanent partial disability benefits is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF DuPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Elaine Sauer,

Petitioner,

vs. No. 11 WC 36176

Red Door Spa Holdings,

17IWCC0108

Respondent.

DECISION AND OPINION ON REVIEW

This claim stems from a motor vehicle accident on October 2, 2008, resulting in multiple injuries to Petitioner. The Arbitrator awarded Petitioner medical expenses in the sum of $103,265.42 pursuant to sections 8(a) and 8.2 of the Workers' Compensation Act (the Act) and wage differential benefits of $912.56 per week, beginning December 3, 2014 and for the duration of the disability. Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical care, benefit rates, permanent disability/wage differential, and section 5(b) subrogation/credit, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner testified that she held Illinois and international esthetic (beautician) licenses. She had also completed some "business college course work." After receiving an esthetic license in 1989, Petitioner worked as an esthetician for a day spa. From 1991 to 1998, Petitioner worked as an esthetic trainer for Aveda. From 1998 to 2000, Petitioner worked for Murad Skin Care. Petitioner worked for Respondent from 2000 through February of 2011.

Petitioner further testified that Respondent is a holding company for Red Door Spas (Red Door) and Mario Tricoci spas. Respondent hired Petitioner to be a national spa director. Petitioner was in charge of two divisions. Petitioner described her job duties as follows:

> "For Red Door I headed up the training team. We had trainers in face and body that handled our regional stores. Everything from new hire training to ongoing training, new launch training. So that was my key responsibility there as well as standards and traveling to all of our stores. This was during a growth phase of 12 Red Doors and we grew that to 31 over my eleven or ten years there. ¶ And then for Mario Tricoci I had that role plus I was in charge of the spa directors at each of the locations, roughly 400 employees and day-to-day operations, driving sales, *** coming up with services and products, meeting with our vendors to plan out launches. We did seasonal launches, spring and fall. I would host twice a year train-the-trainer events which would roll out new services and things like that for them to then facilities. ¶ In addition, all the media, I handled all the media, traveled to all the locations. Had monthly meetings, weekly meetings, purchased equipment, *** everything that really fell into those departments of face and body."

In 2007 or 2008, Petitioner took on an additional responsibility for the nail department of Mario Tricoci, which at the time had 28 locations across the Midwest. Petitioner's schedule was split 50/50 "between the field and the office." In addition to working from 8 a.m. to 5 p.m., Petitioner answered phone calls after hours, attended industry events, and traveled out of town. Petitioner had been featured in Today's Chicago Woman, the Wall Street Journal and Time magazine. Regarding physical requirements of the job, Petitioner testified she moved or helped move equipment, furniture and product, noting: "There is usually a lot of support around." Petitioner agreed her job did not require heavy physical exertion. Petitioner denied prior treatment for neck, low back or hip problems. Petitioner also denied prior concussions, autoimmune disease or having been diagnosed with fibromyalgia.

Respondent's description of the position of national training director states: "Provides counsel on product assortment for respective department. Creates protocols on new services and develops training materials to ensure flawless execution by Technical Department Leads. Provides ongoing educational support to respective department technicians through periodic essays and other communications. Provides ongoing review of protocols and compliance with technical and guest service standards by respective department personnel."

On October 2, 2008, Petitioner was injured in an automobile accident while traveling between two of Respondent's locations. Another car struck Petitioner's SUV head on. Petitioner testified the SUV was totaled as a result. Petitioner was wearing a seatbelt. Petitioner described her injuries as follows: "I had a severe head injury. My head hit the windshield. My body went forward. My knees hit the front. The steering wheel hit my pelvic bone." Petitioner's husband came to the scene and took Petitioner to an urgent care facility. Medical records from

Central DuPage Hospital show that on October 2, 2008, Petitioner received emergency care for complaints of pain in the neck and low back, as well as headache and dizziness. X-rays were unremarkable. Petitioner was diagnosed with a whiplash injury.

Petitioner further testified that after the accident, she took one day off and returned to work. Pain medication helped her get through the day. The week following the accident, Petitioner began treating at West Chicago Family Chiropractic. After several months of treatment, the chiropractor referred her to Suburban Orthopaedics. Petitioner testified her treatment was interrupted when she was diagnosed with thyroid cancer in the spring of 2009. She was off work for the surgery and radiation therapy.

The medical records from West Chicago Family Chiropractic show that Petitioner intermittently received chiropractic treatment from Chiropractor Michael Bauer from October 10, 2008, through December 3, 2014. The imaging reports in evidence show that on December 31, 2008, Petitioner underwent cervical and lumbar MRIs. The cervical MRI showed straightening of the normal cervical lordosis, a small central disc extrusion at C5-C6, and a thyroid mass. The lumbar MRI showed a mild diffuse disc bulge at L4-L5 and mild congenital narrowing of the spinal canal, resulting in focal minimal central canal compromise and mild left neural foraminal narrowing. The medical records from Suburban Orthopaedics, which are cursory, show that in February of 2009, Petitioner sought treatment for neck, low back, bilateral hip, right arm and right knee pain. Dr. Thomas McNally diagnosed cervical and lumbar disc displacement and recommended pain management and physical therapy. Electrodiagnostic studies performed March 2, 2009, were unremarkable. In January of 2010, Petitioner returned with complaints of neck, bilateral shoulder, right arm, left elbow and sciatic pain. Once again, Dr. McNally diagnosed cervical and lumbar disc displacement and recommended pain management and physical therapy. In February of 2010, Dr. Neeraj Jain performed one set of lumbar epidural steroid injections. Petitioner testified that she did not experience much relief from the injections. In November of 2010, Petitioner returned with complaints of left shoulder and bilateral hip pain. Dr. Ankur Chhadia diagnosed biceps and hip flexor tendonitis. In January of 2011, Petitioner sought treatment for right upper extremity pain and numbness, which Dr. Chhadia attributed to degenerative disc disease. In his work status notes, Dr. Chhadia checked the box indicating Petitioner's condition was work-related, and placed Petitioner on light duty.

On January 12, 2011, Dr. Jay Levin at Adult & Pediatric Orthopedics examined Petitioner at Respondent's request. Dr. Levin thought Petitioner had an element of autoimmune illness. In a supplemental report dated February 11, 2011, Dr. Levin opined that Petitioner had an underlying autoimmune illness with secondary myofascial pain syndrome involving her cervical and lumbar areas and left shoulder. Dr. Levin elaborated: "With an underlying autoimmune illness, following trauma, a patient's symptoms can flare up and remain so. The specific diagnosis of fibromyalgia is still controversial, but I clearly believe that [the patient] had some element of autoimmune illness prior to the occurrence being discussed, and she had a soft tissue inflammatory reaction post-injury which has persisted and is the cause of her current

complaints." Dr. Levin further stated regarding causal connection: "The examinee appears to have a pre-existing underlying autoimmune illness which has been aggravated by the occurrence of October 2, 2008, from which she continues to be symptomatic." Dr. Levin recommended a pain management program at Marianjoy Medical Group (Marianjoy). Regarding Petitioner's work status, Dr. Levin stated she may continue to work full duty, as she was doing so at the time of the examination.

The medical records in evidence further show that Petitioner treated at Marianjoy from November of 2010 through February of 2014 for complaints of chronic pain in multiple locations, including neck, upper back, left shoulder, low back, groin/hips/pelvis and right leg, as well as fatigue. During her course of treatment, she also reported dizziness, memory problems and anxiety. In November of 2010, Dr. Gouri Chaudhuri diagnosed fibromyalgia and possible early rheumatoid arthritis, and recommended a 20 percent reduction in the work hours with respect to the diagnosis of fibromyalgia. An MRI of the left shoulder performed April 14, 2011, was unremarkable. In April of 2011, Dr. Jeffrey Oken diagnosed chronic pain, myofascial pain and fibromyalgia. Petitioner's treatment at Marianjoy included: acupuncture from November of 2010 through April of 2011; physical therapy from December of 2010 through February of 2012; comprehensive half day pain management program from April 25, 2011, through May 26, 2011; and trigger point injections in 2012, 2013 and early 2014. In March of 2012, Dr. Megan Parkes referred Petitioner for further physical therapy at a facility closer to home. Petitioner underwent the physical therapy at Central DuPage Hospital during the remainder of 2012 for myofascial pain and exacerbation of pelvic floor dysfunction. Also, Petitioner treated at DuPage Medical Group. The medical records from DuPage Medical Group are notable for diagnoses of migraines, anxiety and fibromyalgia.

The medical records from Marianjoy further show Petitioner reported gradual improvement with treatment. In August of 2012, Petitioner indicated to Dr. Parkes she felt ready to try to return to work part-time. Dr. Parkes issued a return to work note for 20 hours a week. In December of 2012, Petitioner discussed her work status with Dr. Parkes, stating she did not feel she could work full-time. She stated she could only tolerate two to three hours of work at a time, and work caused her pain to flare up. Dr. Parkes issued a work status note in connection with Petitioner's claim for long-term disability benefits, stating Petitioner could not perform sedentary work for eight hours a day, five days a week because of "myofascial pain + SI joint dysfunction with associated pain – flares [secondary to] prolonged activity or sitting of any kind, unable to tolerate working more than 3 hrs at a time." An MRI of the right hip performed May 7, 2013, showed mild osteoarthritis and anterior/superior labral tear. In May of 2013, Petitioner discussed her right hip labral tear with Dr. Oken, indicating she was considering surgery.

Dr. Oken, a physical medicine, rehabilitation and pain medicine specialist, testified by evidence deposition on August 22, 2013, that he was the medical director of the interdisciplinary pain management program at Marianjoy. Dr. Oken diagnosed Petitioner with chronic neck, left shoulder and bilateral hip pain, bilateral iliopsoas tenderness, myofascial pain and fibromyalgia. Regarding the diagnoses of fibromyalgia and myofascial pain, Dr. Oken explained:

"Fibromyalgia is a more diffuse and centralized disease which *** means that some of its problems reside in the brain. Myofascial pain is more localized and so myofascial pain may be just in around the neck, may be just in like an arm or up around a shoulder versus the fibromyalgia which *** is typically both above and below the waist and most of the time is both right and left side." Dr. Oken did not think Petitioner suffered from rheumatoid arthritis. Dr. Oken further testified the pain management program Petitioner underwent was a 21-day program spread over the course of five weeks that included cognitive and behavioral therapy, psychotherapy and physical therapy. Petitioner also received trigger point injections. Dr. Oken felt Petitioner obtained significant benefit from the program, but needed ongoing medical treatment. Regarding the restrictions imposed by Dr. Parkes, Dr. Oken testified they were permanent and causally connected to the work accident.

The medical records in evidence further show that on May 10, 2013, Petitioner consulted Dr. Shane Nho at Midwest Orthopaedics at Rush about bilateral hip pain, right greater than left, and pelvic pain she attributed to the accident. Dr. Nho noted the MRI finding of anterior/ superior labral tear, and performed an injection into the right hip. On June 7, 2013, Petitioner reported temporary improvement. Dr. Nho recommended surgery. On July 1, 2013, Dr. Nho performed an injection into the left hip. On January 20, 2014, Petitioner returned, complaining of ongoing bilateral hip pain, right greater than left, and some buttock pain. Dr. Nho diagnosed bilateral hip labral tears and deep gluteal space syndrome. He continued to recommend surgery on the right hip.

On February 6, 2014, Dr. Alfonso Bello, a rheumatologist at the Illinois Bone & Joint Institute, examined Petitioner at Respondent's request. Petitioner reported moderate to severe pain, as well as depression and anxiety due to the pain. Dr. Bello diagnosed fibromyalgia and placed Petitioner at maximum medical improvement. Regarding causal connection, Dr. Bello stated: "I believe that [the patient's] current condition of fibromyalgia is not necessarily possibly related by a motor vehicle accident dated October 2, 2008. While she did sustain initial injury from the motor vehicle accident, I am uncertain as to whether there is a direct relationship to the motor vehicle accident of October 2, 2008 while various forms of trauma have been associated with triggering fibromyalgia. Many have questioned the link between trauma and fibromyalgia. As a result I do not feel that trauma can at this time be directly related to the diagnosis of fibromyalgia." Dr. Bello opined Petitioner could return to work on sedentary to light duty and progress to full duty with work conditioning.

On July 31, 2014, Dr. Kenneth Candido, a pain management specialist and chairman of anesthesiology at the Advocate Illinois Masonic Medical Center, examined Petitioner at Respondent's request. Petitioner complained of significant pain in the low back and hip flexor muscles, which increased with activity, and widespread musculoskeletal pain. Dr. Candido found: "There are sufficient complaints consistent with a diagnosis of fibromyalgia and sufficient tender point areas for a diagnosis of fibromyalgia to be supported." Regarding causal connection, maximum medical improvement and work status, Dr. Candido stated: "While her complaints have certainly persisted for far longer than one would expect based upon her reports

of the October 02, 2008 accident, it is possible that her accident did transiently stimulate her pain. However, the etiology of fibromyalgia is not definitively linked to any trauma, and furthermore, there is no evidence that a transient traumatic event can lead to 'irreversible fibromyalgia or myofascial type pain.' * * * I agree with Dr. Bello that the MVA did not cause the fibromyalgia; that [the patient] is at MMI; and that she should be working full (sedentary to light) duty at present with the restrictions as noted above." Dr. Candido then clarified that Petitioner could return to her job with Respondent full duty.

Dr. Candido testified by evidence deposition on October 9, 2014. Dr. Candido explained his causal connection opinion as follows: "[B]ased upon my careful dissection and review of the medical literature that's been conducted over the past 30 years or so, in terms of finding an etiology for fibromyalgia, we recognize now that it's due to an imbalance between the ascending and descending pathways in the central nervous system and the chemical mediators that occur in response to nociceptive stimulation, meaning painful impulses, and we know that trauma has not been definitively linked or even competently linked with anecdote to be a reasonable source for the development of fibromyalgia. It was thought years ago that it could have been an association, but it's never been proved." Dr. Candido explained his opinion that Petitioner could return to her job with Respondent full duty as follows: "[S]he certainly continued working in a full duty capacity for some time following the motor vehicle accident; and allegedly or according to what she stated, it wasn't—at least temporally, it wasn't until after she saw Dr. Oken that she subsequently was reduced down to a 20-hour per week work restriction, and then she ultimately stopped working in January 2011. But for some time following the motor vehicle accident, she did continue to work in an unrestricted, unlimited fashion in her usual and customary duties."

On cross-examination, the following colloquy took place:

> "Q. Your opinion as you sit here on October 9, 2014 is you do not believe there is sufficient research or medical evidence in any case to show that fibromyalgia can be caused by a trauma. Would you agree with that?
>
> A. Yes.
>
> Q. So no matter what medical records, evidence, facts, evidence depositions, whatever counsel had sent you as relates to [Petitioner], that would be your opinion, true?
>
> A. True, because I believe I know the literature as well or better than many of these people, if not all of them. So yes."

Upon further questioning, Dr. Candido qualified: "[I]f somebody could provide some evidence of an objective basis which would corroborate or substantiate that relationship, I would certainly be willing to not hold fast and take an opinion to the grave ***. I think I'm willing to learn at all times new information and new findings."

Petitioner testified regarding her ability to work that after her cancer treatment, she returned to work for a period of time. Petitioner stated she was able to work because she regularly received massages, did stretching exercises and took breaks as needed. When asked how her employment with Respondent ended, Petitioner responded: "[A]s I was going through Marianjoy with Dr. Chaudhuri, *** she has recommended that I reduce my work by 50 percent and I said there is no way I could do that. Number one, I had a lot of responsibility and accountability to my department, my team. I couldn't even fathom it. And she wrote a prescription for a 20 percent reduction in work hours." Petitioner felt she owed to Respondent for "somebody to be fully and present that was able to function in their daily duties to do the role." In November or December of 2010, Petitioner gave Respondent a three month resignation notice because she did not feel well enough to fully perform her job. Petitioner continued to work for Respondent for those three months. Petitioner stated it was a very difficult decision to walk away from such a high paying job. The sole reason she left her job was the injuries she sustained in the automobile accident. On cross-examination, Petitioner agreed that Respondent accommodated her restrictions and she had a very supportive team. Petitioner further agreed that she continued to work full duty for Respondent after the accident until voluntarily leaving Respondent's employ in February of 2011, only taking time off for cancer treatment. On redirect examination, Petitioner explained her reasons for leaving Respondent's employ as follows: "I think the biggest thing for me right then is the pain that I was going through every day was weighing so much on *** what I could—everything from judgment *** it was really frustrating to me to get through the day. Whether we were in a ten-hour meeting, those were obviously very challenging. Occasionally we would have to go through two days of long meetings and that would be very difficult." Petitioner further stated the amount of driving she had to do was difficult physically and psychologically because of anxiety.

On October 16, 2014, Susan Entenberg, Petitioner's vocational rehabilitation counselor, issued a vocational rehabilitation evaluation report noting the following in addition to Petitioner's work restrictions: "[The client] states that she has significant difficulties with memory and recall, both short and long term. She states that she forgets appointments and needs to work off lists and write everything down. She was very disturbed that she forgot [Respondent's] mission statement, which was something that was imbedded in her memory for many years. She also indicates difficulty with energy and lack of stamina and has diminished senses of taste and smell." Ms. Entenberg opined that Petitioner sustained a reduction in earning power and a loss of job security. Ms. Entenberg estimated an earning capacity of approximately $30.00 an hour, working 20 hours a week.

A vocational assessment report dated December 5, 2014, from Respondent's vocational rehabilitation expert, Edward Steffan, states that Petitioner was "highly placeable and employable in management, training, product development, or marketing positions in the spa or health and beauty aid industry." Relying on the opinions of Dr. Candido and Dr. Bello, Mr. Steffan further opined that, absent Petitioner's subjective complaints, Petitioner "could return to work at her former occupation with no loss of wages or wage earning potential." However,

taking into consideration Petitioner's complaints and Dr. Oken's report, Petitioner at best "could possibly earn approximately half of her pre-injury wages due to being available for work on a part-time basis."

Petitioner testified that she has looked for work on her own and with the help of a vocational rehabilitation counselor. Petitioner was able to get three short-term consulting contracts—with Jurlique, Allured Publishing Corporation (Allured) and Lucas Brand Equities (Lucas). The contract with Jurlique paid $6,000.00 a month for six months, and the contract with Allured paid $15,000.00 for three months. At the time of the arbitration hearing, Petitioner was completing a contract with Lucas for the term from December of 2014 through May of 2015. She had earned $23,500.00 from the contract so far and hoped the contract would be extended. Regarding her work hours, Petitioner testified the work for Jurlique took approximately ten hours a week. The work for Allured took a little less than two days a week, and the work for Lucas took approximately two days a week. Petitioner's contract with Lucas involved "training for a product company within their portfolio." Petitioner was responsible for "[d]eveloping the training, overview and protocol, Power Point, and delivering the training to prospective accounts and estheticians and physicians." Regarding her ability to complete contract work, Petitioner testified: "I think just my stamina level is much different. The pain affects my energy and my stamina quite a bit. I think as far as delivering the training, it's about an hour and a half presentation. Do I do what I need to do within that time period from sitting to standing? Yes, I do, *** I work around my situation."

Petitioner further testified the injections she received from Dr. Nho provided very little relief and she was considering hip surgery. On December 3, 2014, Chiropractor Bauer declared Petitioner at maximum medical improvement, noting significant improvement in the neck and back symptoms. At the time of the arbitration hearing, Petitioner used a topical anti-inflammatory/pain cream and took Celebrex and an herbal supplement. She also performed home exercises. Petitioner described her condition as follows: "Every day I have chronic pain throughout my back, my spine. I have ongoing dizzy spells. Another thing that changed from that head injury was my loss of smell and taste has changed. I still have anxiety that accompanies this pain. I still don't sleep well through the night. And memory and just recall is also an ongoing issue." Petitioner also testified to difficulty learning new things and struggling to remember things like ingredients. Lastly, Petitioner testified that she received long-term disability and Social Security disability benefits.

The Commission agrees with the Arbitrator's award of wage differential benefits. The record shows the injuries Petitioner sustained left her unable to function at a high level executive capacity in her usual and customary line of employment.

Turning to medical expenses and Respondent's right under section 5(b) to suspend benefits, the Commission notes that at the outset of the arbitration hearing, the parties stipulated to the following: "[B]ased upon an auto accident from which this Workers' Compensation case stems *** there was an arbitration award entered [in the circuit court] in the amount of

$500,000." The parties further stipulated that Petitioner repaid Respondent's workers' compensation carrier the sum of $23,997.75, resulting in a zero workers' compensation lien. The sum of $23,997.75 represented the lien amount at the time of the settlement, less 25 percent for Respondent's share of attorney fees. With respect to any future payments due in the workers' compensation case, Respondent claimed a credit and a right to suspend benefits "until future obligations equal the third party recovery *** less the 25 percent attorney's fees and expenses." Petitioner's counsel agreed.

The Commission notes the medical bills and the record of payments made show that most bills had been paid by the group medical carrier or the workers' compensation carrier. During the arbitration hearing, the parties stipulated that most of the medical bills had been satisfied, and Respondent should be given appropriate credit. In their respective briefs, the parties agree the payments made by Respondent's workers' compensation carrier (which Petitioner since paid back) total $31,991.77. The parties also agree the Arbitrator incorrectly calculated the award of medical expenses, although they disagree on the dollar amount. The Commission awards the medical bills in evidence, totaling $71,273.65, pursuant to sections 8(a) and 8.2, less the $31,991.77 paid and reimbursed.

As to Respondent's right under section 5(b) to suspend benefits, the Commission reiterates that the parties stipulated Respondent has the right to suspend benefits until its obligations equal the third party recovery, less the sum of 25 percent for attorney fees and *pro rata* litigation costs.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 12, 2016, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner wage differential benefits of $912.56 per week, beginning December 3, 2014 and for the duration of the disability, as provided in §8(d)1 of the Act and subject to Respondent's §5(b) rights.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is liable for the medical bills in evidence, totaling $71,273.65, pursuant to §§8(a) and 8.2 of the Act, less the $31,991.77 paid and reimbursed, subject to Respondent's §5(b) rights.

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.

17IWCC0108

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: FEB 16 2017
o-01/26/2017
SM/sk
44

Stephen Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SUER. ELAINE
Employee/Petitioner

Case# **11WC036176**

17IWCC0108

RED DOOR SPA HOLDINGS INC
Employer/Respondent

On 4/12/2016, 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 0.35% 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:

0924 BLOCK KLUKAS & MANZELLA PC
THOMAS J MANZELLA
19 W JEFFERSON ST
JOLIET, IL 60432

2623 McANDREWS & NORGLE LLC
BRYAN D McCARTY
53 W JACKSON BLVD SUITE 315
CHICAGO, IL 60604-3607

17IWCC0108

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

ELAINE SAUER
Employee/Petitioner

v.

RED DOOR SPA HOLDINGS, INC.
Employer/Respondent

Case # **2011** WC **36176**

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 A. HEGARTY**, Arbitrator of the Commission, in the city of **WHEATON AND ELGIN**, on **5/26/15 AND 7/13/15**. 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 **5(b)**

FINDINGS

On **10/2/2008**, 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 **$140,000.00**; the average weekly wage was **$2,692.30**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **2** dependent children.

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

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

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

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

ORDER

TTD: Petitioner failed to prove by the preponderance of the credible evidence that she is entitled to Temporary Total Disability or Temporary Partial Disability Benefits. (See Addendum to Arbitration Decision).

Medical benefits: Respondent shall pay reasonable and necessary medical services of **$103,265.42**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of **$0.00** for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

PPD/Wage differential:

Respondent shall pay Petitioner permanent partial disability benefits, commencing **12/3/14,** of **$912.56/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.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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. Wright

Signature of Arbitrator

4/8/16

Date

APR 12 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ELAINE SAUER,

Petitioner,

v. Case No.: **2011 WC 36176**

RED DOOR SPA HOLDINGS,

Respondent.

ADDENDUM TO ARBITRATOR'S DECISION

On May 26, 2015 and July 13, 2015 this matter was heard before the Arbitrator in Wheaton, Illinois.

The disputed issues in this case are:

- Accident
- Causation
- Medical bills
- TTD/TPD/Maintenance
- Nature and extent
- Other: 5(b) credit

Petitioner is a 53-year-old married mother of two adult children. She graduated from high school in 1980 and later obtained an Illinois esthetic license (in 1989) as well as an international esthetic license and some college-level business courses. After becoming licensed, she worked as an esthetician in a day spa with beauty companies such as Aveda and Murad Skin Care, and was an esthetic trainer for seven years.

Petitioner was hired by Respondent, Red Door Spa Holdings, in the fall of 2000 as a Corporate Director. She was in charge of two different divisions – Red Door Spas and Mario Tricoci. She headed the Respondent's Red Door Spa training team for the "face and body" department, which included new hire training and ongoing training of existing employees. She traveled to all of the Respondent's 31 storefronts over her eleven years of employment. She had a similar role with Respondent's Mario Tricoci, while being in charge of the spa directors, 400 employees, day-to-day operations, sales, services and products. During her time she was featured in Today's Chicago Woman, Wall Street Journal, Time Magazine, and other magazines and television interviews. In 2007, she also operated as the head of the "nail" department within the Mario Tricoci division, which essentially mirrored her duties and responsibilities with the "face and body" department across approximately 28 of Respondent's Midwest locations.

Petitioner's typical work day consisted of a 50/50 split between field and office work and traveling to Respondent's storefront locations. Her job duties were sometimes physical in nature when dealing with training Respondent's employees, including moving equipment like facial consoles, produce, tables, etc.

Her average weekly wage was $2,692.30. (Arb. 1)

Petitioner testified that prior to the accident she had no treatment for symptoms regarding her neck or low back, no prior concussions, no prior hip pain, nor was she diagnosed with any autoimmune diseases or fibromyalgia.

On October 2, 2008, Petitioner was involved in an automobile accident when she was traveling from Respondent's Bloomingdale location to St. Charles. She was driving her personal vehicle, a 2003 Toyota Sequoia SUV, headed westbound, in the process of making a left hand turn onto Fair Oaks Road when she was struck by another vehicle in the front/left driver's side. Upon impact, her head hit the windshield and her knees and pelvic area impacted portions of the vehicle's interior. She was bleeding on the left elbow and knee. Immediately after the crash, she experienced pain in her head, neck, back, knees, and left shoulder.

Records from Central DuPage Hospital note that Petitioner presented with complaints of pain to her neck and lower back as well as headache and dizziness. X-rays of the cervical spine were unremarkable. Petitioner was diagnosed with a whiplash-type injury after a high speed motor vehicle collision. (PX2).

Petitioner sought treatment at the West Chicago Family Chiropractic clinic on October 10, 2008 with complaints of back pain, fatigue, headaches, neck pain, neck stiffness, tension and blurred vision (PX 3(a) at 4). Petitioner reported that the pain made it difficult to sit, stand and walk. (Id. at 7). She was diagnosed with cervicalgia, lumbago, thoracic pain and muscle spasms. The treatment plan noted spinal adjustments were to be performed in three to four regions to improve the function of the segments of the spine that were fixated, the use of cryotherapy to reduce inflammation and pain in the involved areas, along with electric muscle stimulation and myofascial release to increase range of motion and decrease muscle spasms. (Id. at 4).

On February 9, 2009, Petitioner presented to Dr. McNally at Suburban Orthopaedics with complaints of neck, lower back, bilateral hip and right knee pain since the date of the collision. (PX6 at 25). Petitioner also reported tightness in her neck and shoulder blade areas, with radiating pain into her head, causing headaches. She further complained of achiness in her right arm and numbness on the back of her right shoulder and the 2nd and 4th fingers of the right hand. The doctor noted Petitioner's complaints of pain in her bilateral hips that increased when sitting or standing for long periods of time. Petitioner reported her hip pain radiated down both legs, to the knees, the right being worse than the left. She informed the doctor that she had been alternating advil, Tylenol and Aleve for the pain with some relief, also relaying to the doctor that she had undergone chiropractic treatment with Dr. Bauer, who had been performing electrical stimulations and manipulations with no relief. (Id. at 25). Petitioner was diagnosed with cervical disc displacement and lumbar disc displacement. (Id. at 30). Dr. McNally recommended an evaluation for interventional pain management for possible LESI's; continued physical therapy for her neck and back and a bilateral upper extremity EMG. (Id.).

On March 2, 2009, Petitioner underwent an upper extremity nerve conduction study that was unremarkable. (PX6 at 36).

Petitioner treated with the Way to Optimal Health clinicians from May 6, 2009 through July 6, 2009. (PX9).

Petitioner was diagnosed with thyroid cancer in the spring of 2009, undergoing a surgery in May of 2009 and subsequent radioactive iodine treatment, all of which, delayed her treatment for her symptoms related to the October 2, 2008 automobile collision.

On January 29, 2010, Petitioner presented to Suburban Orthopaedics on a referral from Dr. McNally for initial evaluation. Bethany Stork PS-C, noted a history of lower back pain extending into the left posterolateral lower extremity, left knee pain, cervical spine pain, and left elbow pain following a head on motor vehicle crash with a car travelling 70-75 miles per hours on October 2, 2008. (PX6 at 33). Her cancer treatment was complete at this point and she was still experiencing symptoms related to the October 2, 2008 crash with minimal benefits from anti-inflammatory medications and chiropractic treatment. (Id.). She stated her lower extremity pain was worse than her lower back pain on this date, describing the pain as moderate, aching, throbbing with unbearable aching in the left hip that is present nearly 24 hours per day. She rated her pain at a 8-10/10 with associated numbness in her right hand and fingers. Exacerbating factors included walking, sitting, driving, and overhead activities. She reported an overall decrease in her activity level, stopping several times a day to sit or lie down to control the pain. She reported she was unable to maintain sleep. (Id.). The MRI of December 31, 2008 (cervical) was referenced in the report (Id. at 19) with an impression of straightening of the normal cervical lordosis and a small central disc extrusion at C5-6. The MRI of December 31, 2008 (lumbar) which noted mild diffuse disc bulge at L4-5 and very mild congenital narrowing of the lumbar spine canal, resulting in minimal central canal compromise and mild left neural foraminal narrowing was also referenced. The treatment plan at this point consisted of of a bilateral L4-5 and L5-S1 transforaminal epidural steroid injection to address her pain symptoms. Pending the outcome of the initial injection, a series may be ordered, along with the re-initiation of physical therapy and maintenance of her current work status of full-time, full duty, and current medication regimen. At this point, MMI was indeterminable (Id. at 34).

On February 26, 2010, bilateral L4-L5 and L5-S1 transforaminal epidural steroid injections with selective nerve root blocks were administered to Petitioner at Suburban Orthopaedics. (Id. at 31).

On April 25, 2011, Petitioner consulted with Dr. Jeffrey E. Oken who specializes in physical medicine and rehabilitation at Marianjoy Rehabilitation Hospital in Wheaton . (PX10, 11, 12). Petitioner's complaints of bilateral shoulder, left arm, bilateral hip, pelvic, neck and buttock pain at an 8/10 were noted. (PX14 at 13). Petitioner reported the onset of complaints following the auto collision of October 2, 2008. She further reported experiencing pain all day that increased with sitting, driving, walking and sleeping. On examination, Dr. Oken recorded swelling in her legs, decreased range of motion of the left upper extremity, internal rotation and A-B-reduction, decreased active range of motion in the left lower extremity with A-B-reduction, 15 out of 18 tender points present, tenderness in her left glenohumeral joint, in the inferior border of her left scapula, biceps, and pain down her leg, tenderness in her left rhomboid trapezius and iliopsoas muscle bilaterally. (Id. at 16). On neurological examination, she had decreased sensation in the ulnar nerve distribution of her hands bilaterally, positive Hoffmann's

sign of the left, positive Adson's sign bilaterally, positive Hawkins test on the right and positive Speed's test on the left. (Id. at 16-17).

Dr. Oken noted Petitioner had become isolated and sad since the accident. Functionally, she was limited in dressing, laundry, housekeeping, shopping, exercising, stair climbing, driving, and playing sports. Dr. Oken diagnosed Petitioner with chronic neck, left shoulder, and bilateral hip pain; iliopsoas tenderness bilaterally; myofascial pain; and fibromyaligia (Id. at 17). The plan at this point was to admit Petitioner into a 21-day, interdisciplinary chronic pain management program at Marianjoy. (Id. at 18). Petitioner entered the program immediately. (PX14 at 19).

Dr. Oken testified that the 21-day program is an interdisciplinary, chronic pain rehabilitation program, which includes group and individual physical therapy, psychological therapy, physician visits, education as well as biofeedback (Id. at 25). Trigger point injections were administered to Petitioner's left trapezius muscle and bilateral rhomboid muscles. According to Dr. Oken, Petitioner improved significantly throughout this course of treatment (Id.). At discharge, increased range of motion in her left shoulder and improvement of abduction and internal rotation was noted. Myofascial bands around Petitioner's bilateral trapezius and rhomboids muscles were indicated. (Id. at 24). Dr. Oken diagnosed chronic neck, shoulder pain and myofascial pain as well as fibromyalgia, hypothyroidism, insomnia. (Id. at 23). The doctor noted a history of thyroid cancer. (Id.)

At discharge, Petitioner was able to sit for 60 minutes, stand for 45 minutes, walk 1.5 miles on the treadmill for 30 minutes, lift 10 pounds from floor to waist and from floor to mid-body, and from waist to overhead upon completion of the program (Id. at 26). Petitioner was instructed to complete stretching and strengthening exercises every day, work on sleep, hygiene and use Therecane for myofascial pain syndrome. (Id. at 27).

The doctor instituted permanent work restrictions limiting Petitioner to 20 hours/week, alternating between sitting and standing every 30 minutes and no lifting, pushing or pulling more than 10 pounds (Id. at 30).

On November 18, 2011, Dr. Chadia of Suburban Orthopaedics completed a work duty status report related to Petitioner, which indicated her current condition is related to work, she was to be on light duty, return to the clinic in seven weeks, and was to avoid prolonged sitting due to her diagnosis of shoulder and hip tendonitis with radiculopathy. An injection to the left shoulder, continued physical therapy and medications, along with the completion of an MRI of the cervical spine was recommended. (PX6 at 4).

Petitioner underwent physical therapy through Central DuPage Hospital from May 9, 2012 to August 22, 2012. (PX2 at 43-120).

On May 10, 2013, Petitioner presented to Midwest Orthopaedics at Rush, Dr. Shane Nho, on referral from her general practitioner at Dreyer Medical Clinic, Dr. Shah (PX13). After a physical examination and review of diagnostic studies, the doctor administered an intra-articular right hip injection for diagnostic and therapeutic purposes. (Id. at 9).

On May 29, 2013, Petitioner presented to Dr. Oken reporting continued pain in her neck, hips, knee, lower back and buttocks. The plan at this point, was to treat the labral, continue with her exercise program and future bilateral hip injections. (Id. at 35).

On June 7, and July 1, 2013 Petitioner followed-up with Dr. Nho, who administered an injection into Petitioner's left hip at the July visit.

Treatment with the West Chicago Family Chiropractic clinic continued through December 3, 2014. At discharge, Petitioner reported that she felt she has reached pre-injury status even with discomfort still noted in her upper back and neck (PX3(b) at 65). Her sacro-iliac discomfort was noted as improved. Palpation revealed areas of subluxation at C6, C7, T21, T2 and T3, while palpation of the muscles revealed hyper tonicity in the right cervical and right cervical dorsal areas. Petitioner was released from chiropractic care and noted to have reached maximum medical improvement from her injuries related to the collision.

On January 20, 2014, Petitioner presented to Dr. Nho with complaints of bilateral hip pain, right greater than left. (PX13 at 4). The doctor diagnosed bilateral labral tears and deep gluteal space syndrome. The doctor recommended right hip arthroscopic labral repair, acetabular rim trimming, debridement, synovectomy, femoral osteochodroplasty, capsular placation, and examination and debridement of the deep gluteal space, given that she had exhausted her conservative treatment options and responded fairly well to an intra-articular cortisone injection.

On September 19, 2014, Petitioner underwent a Vocational Rehabilitation Evaluation through Rehabilitation Services Associates at the request of Petitioner's counsel. (PX15). The following records were referenced in the evaluation: 1/15/13 letter from Dr. Oken; 11/16 and 2/3/10 notes from Dr. Chaudhuri; 1/29/13 and 2/6/14 IME reports from Dr. Bello; 2/11/11 IME report from Dr. Levin, and; the 7/31/14 IME report from Dr. Candido. The following was noted by the rehabilitation counselor conducting the evaluation: Petitioner presented as a 52-year-old married female with two dependent children. She graduated high school and subsequently attended 600 hours at the Southern Nevada University of Cosmetology in 1989 (Id. at 1). She received her license through the State of Illinois as an esthetician and her International License as an esthetician in 1994. She had taken numerous courses and seminars in management, marketing and leadership over the years.

Petitioner reported that she went to CDH Urgent Care and was seen by Dr. Bauer, a chiropractor, post-collision, while continuing to work with Respondent. She stated she was referred to Dr. McNally and underwent an injection to her left shoulder. She also saw a rheumatologist and was diagnosed with fibromyalgia (Id.). Due to ongoing pain, Petitioner presented to Dr. Chaudhuri at Marianjoy in November of 2010. Petitioner reported that she stopped working on February 1, 2011, as she could no longer adequately function to perform her job with Respondent (Id.). Thereafter, she underwent a 21-day outpatient pain management program at Marianjoy under the care of Dr. Oken in March/April of 2011, followed by 26 weeks of pelvic physical therapy (Id). Her diagnoses have been fibromyalgia, iliopsoas tendonitis, myofascial pain to the neck and shoulders, as well as hips, sacroiliac joint dysfunction, pelvic floor dysfunction, anxiety and insomnia (Id.). Dr. Oken placed her on restrictions of no lifting,

pushing or pulling over ten pounds, alternate sitting and standing every 30 minutes, and a 20-hour work week (Id.).

Petitioner reported she continued to receive treatment at Marianjoy at this point every few months, consisting of trigger point injections to the upper and lower back. (Id.). She reported experiencing constant deep, aching pain from the base of the neck down the spine to her tailbone. Petitioner noted burning pain in her upper back and constant aching bilateral hip flexor and buttock pain, as well as shoulder pain and intermittent numbness down the right arm to the fingers (Id.). It is noted that Petitioner is right-hand dominant.

Petitioner reported to the rehabilitation counselor that she had significant difficulties with memory and recall, both short and long term, forgetting appointments and needing to work off lists and write everything down (Id.). She also indicated difficulty with energy and lack of stamina, with diminished senses of taste and smell. A typical day for Petitioner at this point in time consisted of waking up at 4:30-5:00 AM, stretching in bed, doing dishes, cooking and laundry in the morning, but no vacuuming or mopping. She reported the ability to exercise and ride a bike for approximately 20 minutes per day. She reported typically needing an afternoon nap for approximately ½ hour.

The report noted that Petitioner was incapable of performing her past work with Respondent and that she is an appropriate candidate for vocational rehabilitation. Given her work restrictions, licensure and work experience, it was deemed appropriate that Petitioner pursue related positions within her restrictions that can be accomplished on a part time basis, such as esthetician, esthetician instructor, trainer and sales representative. Possible wages for employment were noted at $13.11 to $28.96 per hour. (Id.)

On December 5, 2014, EPS Rehabilitation Inc. performed a Vocational Rehabilitation interview and assessment of Petitioner at Respondent's request (RX7). The rehabilitation counselor found Petitioner employable in management, training, product development, and marketing positions in the spa or health and beauty industry (Id.). Noting Dr. Oken's January 11, 2013 notations, "at best, Ms. Sauer could possibly earn approximately half of her pre-injury wages due to being available for work on a part-time basis" (Id. at 8). The rehabilitation counselor noted that without vocational placement assistance, Petitioner would have difficulty accessing employment or maximizing her wage earning potential. Recommendations included completion of labor market sampling and further vocational rehabilitation. Possible wages for employment were not specifically discussed.

According to her testimony, during her treatment for the October 2008 collision, Petitioner continued to work in spite of significant pain. She was receiving regular massages, stretching, taking breaks during the day, etc., to cope with her symptoms and make it through the workdays. Petitioner testified that Dr. Chaudhuri recommended she reduce her workload by 50%. Due to her responsibilities and accountability to Respondent, she felt she was unable to do so, and so Dr. Chaudhuri wrote a prescription for a 20% reduction in work hours. She presented this to her direct supervisor, Larry, Silvestri, at which point she had a realization she was not well enough to continue working for Respondent. She provided her resignation to Mr. Silvestri with three-month's notice. She testified that the reason for leaving Respondent's employ was due to the injuries she sustained in the October 2, 2008 collision.

Dr. Jeffrey E. Oken

Jeffrey E. Oken, M.D. (physical medicine and rehabilitation) is the associate medical director of the outpatient services at Marianjoy as well as the medical director of the interdisciplinary pain management program, which includes cognitive behavioral programs to focus on teaching patients how to manage their pain better and improve their abilities to do more activity in life. (PX14 at 8). The 21-day, comprehensive pain program that Petitioner participated in is based on three pillars: First, education where the patient is taught about pain and pain treatment. Second, a physical component where individual and group therapy is used to improve functioning, like walking, sitting, standing anything where a patient may have limitations. Third, a psychological component, so patients with long term persistent pain can better deal with anxiety, depression, trouble sleeping, and other components of pain that affect their life (PX14 at 8-9). The philosophy of the program is management, not curative. (PX14 at 11).

Dr. Oken prepared a report on January 13, 2013 after reviewing Petitioner's medical record/chart. The doctor noted that Petitioner started at his clinic on April 25, 2011, with an onset of problems related to an October 2, 2008 motor vehicle collision. (PX14 at 29). Petitioner was on chronic medication for her pain, and was diagnosed with fibromyaligia, iliopsoas tendonitis, myofascial pain to the neck and shoulder as well as the hips, sacroiliac joint dysfunction, pelvic floor dysfunction, anxiety and insomnia. (Id.). Dr. Oken Instituted permanent work restrictions of 20 hours/week, alternate sit/standing every 30 minutes and no lifting, pushing or pulling more than 10 pounds. (Id. at 30).

Dr. Oken testified that Petitioner's medical condition and permanent work restrictions are related to the motor vehicle collision of October 2, 2008. (Id. at 30). He further testified that Petitioner did not have complaints of pain to her neck, low back, shoulder, etc. prior to the October 2, 2008 motor vehicle collision (PX14 at 36). There is no history or evidence of any subsequent accidents, injuries or traumas to any of those body parts. Her prognosis as of the last date of treatment with Dr. Oken is "guarded", meaning, he would not expect her condition would disappear or be cured. (Id.). Dr. Oken testified that the treatment provided by him and Marianoy was reasonable, necessary and customary within his field of medicine, and that all such treatment was related to the October 2, 2008 work accident (Id. at 37).

According to the doctor, Petitioner would need ongoing medical treatment for her myofascial pain, including trigger point injections, four to six times per year (Id. at 32). Typically fibromyaligia involves further physical therapy and indefinite usage of medications for pain, also antidepressant medication to help reduction of pain while improving general sense of well-being and daily activities (Id. at 33). Fibromyaligia is not a curative disease and is considered a permanent condition (Id.).

Respondent's Medical Evidence

Respondent submitted four (4) IME Reports into evidence: : Dr. Jay Levin (1/12/11)(Rx2); Dr. Jay Levin (2/11/11)(Rx3); Dr. Alphonso Bello (2/6/14)(Rx4); and Dr. Kenneth Candido (7/31/14)(Rx5). (Rx 2-5).

Dr. Levin examined Petitioner on January 12, 2011, and prepared a report in which he summarized her work duties, work accident, medical history. The doctor performed a physical examination and reviewed Petitioner's diagnostic test results. Dr. Levin noted he was not in possession of all of the necessary records and diagnostics on this date. The doctor provided no opinion other than he believed "she appears to have an element of autoimmune illness." (Rx 2 at Pg. 5).

Dr. Levin's second Report notes that Petitioner was asymptomatic prior to the accident date of October 2, 2008. The doctor further noted that Petitioner has "an underlying autoimmune illness with a secondary myofascial pain syndrome involving her cervical and lumbar areas and her left shoulder:

> *This examinee appears to have a pre-existing underlying autoimmune illness which has been aggravated by the occurrence of October 2, 2008, from which she continues to be symptomatic. An integrative pain treatment center for myofascial pain such as that offered by Marianjoy is appropriate medical treatment in this situation.* (Rx 3 at Pg. 7)

With respect to causation, the doctor opined that "Certainly the autoimmune/inflammatory condition is the reason for her more prolonged symptoms from this trauma." The doctor noted Petitioner's report that she was "asymptomatic prior to the occurrence, and the aggravation of her condition is the reason for her current complaints." (Id.)

Dr. Alfonso Bello (rheumatology) examined Petitioner on February 6, 2014, reviewed certain medical records, obtained a history and performed a physical examination. Dr. Bello's diagnosis/impression was that Petitioner's *"signs and symptoms are consistent with a diagnosis of fibromyalgia. There is no evidence of other rheumatologic or musculoskeletal disorders."* (Rx 4 at Pg. 3).

With respect to causation the doctor stated:

> *I believe that her current condition of fibromyalgia is not necessarily possibly related by a motor vehicle accident dated October 2, 2008. While she did sustain initial injury from the motor vehicle accident, I am uncertain as to whether there is a direct relationship to the motor vehicle accident of October 8, 2008 while various forms of trauma have been associated with triggering fibromyalgia. Many have questioned the link between trauma and fibromyalgia. As a result I do not feel that trauma at this time can be directly related to the diagnosis of fibromyalgia.* (Rx 4 at Pg. 3)

Dr. Bello further opined:

> *As noted above, I do believe that the petitioner does have the ability to return back to work at a minimum sedentary position and much of her problems are due to work tolerance rather than from a distinct medical disability.* (Rx 4 at Pg. 4).
>
> *At the time of examination, I do not see any signs of magnification, inconsistent pain behavior or malingering. I believe that she is truly symptomatic due to her*

fibromyalgia. There were no other strenuous or unusual behaviors noted. (Rx 4 at Pg. 4).

Dr. Bello recommended a functional capacity exam ("FCE") and possible work conditioning based on the results of the FCE. (Id.) The doctor did not relate the need for this treatment to the motor vehicle accident. (Id.)

The final IME that Respondent submitted into evidence is the report of Kenneth Candido, M.D. (Rx5) along with his deposition transcript (Rx 6). Dr. Candido is the CEO of two corporations, Chicago Anesthesia Associates and Chicago Anesthesia Pain Specialists. (Id. at 5) The doctor authored a (21) page report that documents Petitioner's medical history, motor vehicle accident of October 2, 2008, physical examination findings and a summary of Dr. Candido's review of the prior IMEs and Dr. Oken's transcript. Dr. Candido's "Issues/Opinions" are set forth on pages 11 to 16 of (Rx 5). In summary, Dr. Candido agrees the Petitioner has fibromyalgia, there is no evidence that Petitioner had a pre-existing condition related to immune dysfunction and he does not believe that the motor vehicle accident caused Petitioner's fibromyalgia. (Id. at 10-13). Dr. Candido further opined that Petitioner could return to work with restrictions consisting of alternate sitting and standing every hour and no lifting pushing or pulling in excess of 25 lbs. The doctor found the aforementioned restrictions are not permanent and re-assessment should be undertaken at six months and at one year. (Id. at 13-14). With respect to symptom magnification or inconsistent pain behavior, Dr. Candido concured with Dr. Bello that Petitioner likely has pain that results in subjective symptoms of unwellness at a moderate level. (Id. at 14).

Dr. Candido testified that there is a split amongst doctors whether trauma can cause fibromyalgia. (Rx 6 at 37)

The doctor testified that Petitioner's medical condition is unlikely to improve significantly as she has not had a regression or remission in 6 years (Id. at 49). He would not call Petitioner's medical condition permanent... instead labeling it as chronic. (Id. at 49-50).

As it relates to Petitioner's work duties, Dr. Candido agreed that Petitioner had no work restrictions prior to October 2, 2008 and that he and Dr. Oken both placed permanent (although different) work restrictions upon Petitioner. (Id. at 50-51 and 58).

Dr. Candido testified that- putting causation aside- as a whole, he agreed that all of the medical treatment that Ms. Sauer received and that he reviewed was reasonable, necessary and customary for her complaints and diagnosis. (Id. at 66) He disagrees with Dr. Oken only as it relates to causal connection and permanency. (Id. at 67)

Petitioner's Testimony regarding her current condition and employment since her resignation

Petitioner testified regarding that experience in the 21-day pain management program with Marianjoy Medical Group helped her deal with pain and was beneficial from a psychological standpoint of understanding how to move through life while experiencing chronic pain.

Petitioner has looked for employment since her resignation from Respondent's employ, including online searches, industry associations, prior industry contacts, and headhunters. She applied for employment as she found postings. Petitioner has collected long-term disability benefits since February 2011 and receives Social Security Disability Income benefits.

Since 2011, she gained employment on three different occasions as a consultant with: 1)Allured Publishing Corporation, an approximate three-month research project contracted at $15,000.00; 2. A contract project with Jurlique for a period of six months that paid approximately $36,000.00 and, 3. A contract from December of 2014 through May of 2015 with Lucas Brand Equities, where she was training estheticians and physicians via Power Point presentations. Her total income from Lucas to the date of the Arbitration Hearing was $23,500.00. She worked this contract approximately ten hours per week over the course of two days per week.

As of the date of the Arbitration Hearing, Petitioner takes daily prescription and over-the-counter medications, both topical and oral, and continues with a home exercise physical therapy program.

She testifies that she currently does the best that she can with her current limitations, but notes a decrease in stamina, an increase in pain, and that it is often difficult to sit/stand for 1 ½ hour presentations. The scope of the work that she currently does is far different then her pre-injury position. She testified that she received both long-term and short-term disability, and she is currently on Social Security Disability. She experiences daily pain throughout her back, ongoing dizziness, continued loss of smell and altered sense of taste, anxiety, poor sleep, and poor memory/recall. She struggles with remembering specifics, like ingredients or numbers.

CONCLUSIONS OF LAW

IN SUPPORT of the Arbitrator's Decision regarding "C" (Accident), the Arbitrator makes the following findings and conclusions:

There is no dispute the Petitioner was traveling for work. It was Petitioner's custom and practice to travel to the multiple locations owned and operated by Respondent. The work accident was the result of auto collision in which Petitioner, while in the process of making a left hand turn, was struck by another vehicle traveling at a high rate of speed. As such, the Arbitrator finds that Petitioner did suffer a work related accident within the meaning of the Act.

IN SUPPORT of the Arbitrator's Decision regarding "F" (Causation), the Arbitrator makes the following findings and conclusions:

As of the accident date, Petitioner had been employed by Respondent for approximately 8 years and had performed her various duties without physical issue or difficulty. It appears that Petitioner was well-respected and relied upon by Respondent who vested her with a great degree of responsibility as a Corporate Director.

There is no evidence in the record that Petitioner had any treatment, complaints or diagnosis(es) similar to fibromyalgia at any time prior to the October 2, 2008 accident nor is there evidence of any subsequent accidents, injuries or traumas to any of those body parts.

After the automobile crash, Petitioner sought immediate medical care and continued having pain and treating with various medical providers. Petitioner testified that after the crash she was able to work with the pain in a modified capacity, all-the-while continuing to satisfactorily perform all necessary job functions for Respondent. The medical record indicates that Petitioner's symptoms of ill-being developed immediately after the accident and progressed. Her medical diagnoses changed over time when she was referred to and/or examined by the appropriate physicians in the proper fields of medicine. Petitioner was compliant with her medical care. No doctor opines that she was malingering. The fact that a proper diagnosis of fibromyalgia was not reached until sometime after the crash has no bearing on Petitioner's case. Petitioner is not a doctor and does not direct her own medical care. The fact that Petitioner continued to work while under medical care and with great pain is commendable, and the change in her health during her employment (and following the crash) is further support of causal connection in this case.

The Arbitrator relies on the opinions and testimony of Dr. Oken, *supra*, who confirmed a diagnosis of fibromyaligia, iliopsoas tendonitis, myofascial pain to the neck and shoulder as well as the hips, sacroiliac joint dysfunction, pelvic floor dysfunction, anxiety and insomnia. Dr. Oken testified that Petitioner's medical condition and permanent work restrictions consisting of no lifting, pushing or pulling over ten pounds, alternate sitting and standing every 30 minutes, and a 20-hour work week are related to the motor vehicle collision of October 2, 2008. According to the doctor, Petitioner would need ongoing medical treatment for her myofascial pain, including trigger point injections, four to six times per year. According to his testimony fibromyaligia is not a curative disease and is considered a permanent condition. Dr. Oken testified that the treatment provided by him and Marianjoy was reasonable and necessary and customary treatment within his field of medicine, and that all such treatment was related to the October 2, 2008 work accident (Id. at 37).

The Arbitrator has also reviewed and considered the Reports of Drs. Levin, Bello and Candido. With respect to Petitioner's diagnosis, Dr. Levin opined that Petitioner has "an underlying autoimmune illness with a secondary myofascial pain syndrome involving her cervical and lumbar areas and her left shoulder. The Arbitrator finds that Dr. Levin provided a causal connection for all medical treatment from the date of the crash until his report of February 11, 2011, and in fact, recommended that Petitioner engage in the program at Marianjoy with Dr. Oken. Despite his diagnosis of an underlying autoimmune deficiency and myofascial pain syndrome rather than fibromyaligia, Dr. Levin squarely puts Petitioner, her conditions of ill-being and medical treatment into the hands of Dr. Oken and Marianjoy.

Dr. Bello opined that there is no autoimmune deficiency and sustains the diagnosis of fibromyalgia.

Dr. Candido prepared a voluminous Report and answered narratively to nearly every question on cross-examination. The Arbitrator finds that Dr. Candido did diagnose Petitioner with fibromyalgia and opined that all of her medical treatment from the date of the crash to present

was reasonable, necessary and customary. Dr. Candido disagreed with Dr. Oken only as to causation and the extent of work restrictions. On the issue of causation and Dr. Candido, the Arbitrator refers to the doctor's own testimony wherein he states that he has never found causal connection between an event or trauma and the development of fibromyalgia, and the following colloquy:

Q: Here is what I am getting at. Your opinion as you sit here on October 9, 2014 is you do not believe there is sufficient research or medical evidence in any case to show that fibromyalgia is caused by trauma. Would you agree with that? *(Emphasis Added)*

A: Yes.

Q: So no matter what medical records, evidence, facts, evidence depositions, whatever counsel had sent you as relates to Ms. Sauer, that would be your opinion, true.

A: True, because I know the literature as well as or better than many of these people, if not all of them. So yes. (38-39)

In Ms. Sauer's case, while there may be some disagreement in the medical profession as to the etiology of fibromyalgia, that fact does not compel the conclusion that claimant failed to prove a causal connection between her work accident and her current condition. Rather, the Arbitrator finds that the evidence in the record relating to the specific nature of Petitioner's job duties and responsibilities, the change in her health after the car crash and the medical evidence and testimony of Dr. Oken coupled with certain opinions contained in Respondents medical evidence support a finding of causal connection.

The Arbitrator notes that the Commission has upheld causal connection findings of fibromyalgia by several other Arbitrators in the following cases: *Friesen v. Time Definite Services, Inc.*, No. 07 WC 38397, 13 I.W.C.C. 0078 (2013); and *Walker v. Prairie Hills Elementary*, No. 01 WC 49803, 08 I.W.C.C. 1153 (2008)

Accordingly, the Arbitrator finds Petitioner has sustained her burden with respect to the work accident and her condition of ill being for which she received and currently receives medical care, as well as her current state of impairment and permanent work restrictions.

IN SUPPORT of the Arbitrator's Decision regarding "J" (Medical), the Arbitrator makes the following findings and conclusions:

The Arbitrator notes that Petitioner's Exhibit List (Px 1) and the medical bills (Px 16-55) were admitted into evidence with the objection only on the basis of liability. A review of the records (Px 2-14) provide that Petitioner was within the appropriate line of doctors. Petitioner testified that the submitted bills were paid either by Respondent or by her private group health insurance or self-pay, with several possible outstanding balances. Based upon Arbitrator's Exhibit 1, the evidence presented, including Petitioner's credible testimony, the Arbitrator's review of the medical records and bills, the fact that causation has been decided, (Dr. Oken) as well as Respondent's failure to produce any evidence through its multiple Medical Examiners that Petitioner's treatment and bills were unreasonable or unnecessary, the Arbitrator finds the bills

submitted in (PX 1 and Px 16-55) to be reasonable, necessary, customary and causally related to the accident, and the bills to be reasonable in amount and orders Respondent to pay said bills in full as set forth below to Petitioner by per Fee Schedule.

(16) CENTRAL DuPAGE HOSPITAL		
10/02/2008 (5648398)	$ 651.00	Balance $ 238.79
(17) CENTRAL DuPAGE HOSPITAL		
05/09/2012 - 05/31/2012 (20409102)	$ 885.50	Balance $ 00.00
(18) CENTRAL DuPAGE HOSPITAL		
06/07/2013 - 06/30/20012 (20408793)	$ 1,444.25	Balance $ 00.00
(19) CENTRAL DuPAGE HOSPITAL		
06/20/2012 (20506358)	$ 471.25	Balance $ 00.00
(20) CENTRAL DuPAGE HOSPITAL		
07/09/2012 - 07/31/2012 (20449861)	$ 1,217.25	Balance $ 00.00
(21) CENTRAL DuPAGE HOSPITAL		
08/14/2012 - 08/31/2012 (20571973)	$ 1,023.00	
Balance $ 00.00		
(22) CENTRAL DuPAGE HOSPITAL		
09/19/2012 - 09/30/2012 (20632988)	$ 542.25	Balance $ 00.00
(23) CENTRAL DuPAGE HOSPITAL		
10/03/2012 - 10/31/2012 (20714660)	$ 798.00	Balance $ 00.00
(24) CENTRAL DuPAGE HOSPITAL		
11/12/2012 - 11/30/2012 (20849513)	$ 399.00	Balance $ 00.00
(25) CENTRAL DuPAGE HOSPITAL		
10/30/2013 (21870368)	$ 979.50	Balance $ 00.00
(26) WINFIELD RADIOLOGY CONSULTANTS		
06/20/2012 - 10/30/13 (2320)	$ 236.00	Balance $ 00.00
(27) WEST CHICAGO FAMILY CHIROPRACTIC		
10/10/2008 - 02/05/2009	$ 4,981.00	Balance $ 00.00
(28) WEST CHICAGO FAMILY CHIROPRACTIC		
07/27/2010 - 08/21/2010	$ 1,829.00	Balance $ 00.00
(29) WEST CHICAGO FAMILY CHIROPRACTIC		
01/03/2011 - 01/05/2011	$ 312.00*	Balance $ 00.00
(30) WEST CHICAGO FAMILY CHIROPRACTIC		
10/14/2013 - 11/13/2013 (766)	$ 1,055.00	Balance $ 00.00
(31) DUPAGE MEDICAL GROUP-GLEN ELLYN CLINIC		
11/11/2008 - 09/10/2010 (285127132)	$ 5,259.00	Balance $ 207.00
(32) DIAGNOSTIC IMAGING		
12/17/2008 - 06/16/2014	$ 5,475.00	Balance $ 207.00
(33) SUBURBAN ORTHOPAEDICS		
02/09/2009 - 02/26/2010 (SAUEL000)	$ 6,182.84	Balance $ 1,558.00
(34) SUBURBAN ORTHOPAEDICS		
11/22/2010 - 12/31/2011 (1320)	$ 1,491.00	Balance $ 1,268.00
(35) NEURODIAGNOSTIC ASSOCIATES OF ILLINOIS		
03/02/2009 (SAUEL576)	$ 2,279.00	Balance $ 2,279.00
(36) NORTHWESTERN MEDICAL FACULTY FOUNDATION		
05/01/2009 - 04/12/2013	$ 3,633.00	Balance $ 00.00

(37) THE WAY TO OPTIMAL HEALTH			
05/07/2009 - 07/06/2009		$ 1,075.90	Balance $ 00.00
(38) WINDY CITY ANESTHESIA			
02/26/2010	(6873)	$ 1,803.00	Balance $ 1,200.00
(39) MARIANJOY MEDICAL GROUP-REHAB MEDICINE CLINIC			
11/16/2010 - 02/27/2014	(X00000463236)	$ 8,489.10	Balance $ 00.00
(40) MARIANJOY REHABILITATION HOSPITAL-WHEATON			
12/03/2010 - 01/31/2011	(M00000110683)	$ 2,441.00	Balance $ 00.00
(41) MARIANJOY REHABILITATION HOSPITAL-WHEATON			
04/25/2011 - 05/31/2011	(O00000011926)	$ 9,066.00	Balance $ 00.00
(42) MARIANJOY REHABILITATION HOSPITAL-WHEATON			
06/02/2011 - 02/23/2012	(O00000012275)	$ 3,167.00	Balance $ 00.00
(43) OPEN ADVANCED MRI			
04/14/2011	(01572156)	$ 1,210.00	Balance $ 00.00
(44) MIDWEST ORTHOPAEDICS AT RUSH			
05/10/2013 - 01/20/2014	(255438)	$ 1,977.60	Balance $ 00.00
(45) WALGREENS			
11/23/2010		$ 2.29	Balance $ 00.00
(46) WALGREENS			
01/05/2011		$ 2.42	Balance $ 00.00
(47) WALGREENS			
02/09/2011		$ 3.94	Balance $ 00.00
(48) WALGREENS			
02/17/2011		$ 130.00	Balance $ 00.00
(49) VILLAGE HERBALIST			
09/11/2010		$ 38.92	Balance $ 00.00
(50) VILLAGE HERBALIST			
10/09/2010		$ 269.70	Balance $ 00.00
(51) VILLAGE HERBALIST			
10/21/2010		$ 174.09	Balance $ 00.00
(52) VILLAGE HERBALIST			
11/13/2010		$ 173.80	Balance $ 00.00
(53) VILLAGE HERBALIST			
11/20/2010		$ 36.88	Balance $ 00.00
(54) VILLAGE HERBALIST			
12/27/2010		$ 68.17	
Balance $ 00.00			
(55) MEDICAL BENEFITS			
10/02/2008 - 02/23/2012		$ 31,991.77	Balance $31,991.77
Total:		**$103,265.42**	

IN SUPPORT of the Arbitrator's Decision regarding "K" (TTD/TPD/MAINTENANCE), the Arbitrator makes the following findings and conclusions:

The Arbitrator finds that Petitioner has failed to prove by a preponderance of the credible evidence that she is entitled to temporary benefits. Petitioner claims that she was temporarily and totally disabled from February 11, 2011 – October 29, 2012, and May 2, 2013 – December 9, 2014 (representing a total of 121 weeks). She also claims that she was temporarily and partially disabled from October 30, 2012 – May 1, 2013, and again from December 10, 2014 – May 26, 2015 (representing a total of 23 6/7 weeks).

Petitioner testified that she continued to work her regular duties after the motor vehicle accident. She further testified that no doctor had kept her off of work completely, but only had recommended that she reduce her work hours – first by 50%, which she refused, and then by 20%. Petitioner testified that she voluntarily resigned from her job with Respondent, and conceded that Respondent was accommodating any issues that she had in performing her job duties. Petitioner's voluntary resignation is tantamount to refusing to work within the restrictions that Respondent was in full compliance with. Accordingly, Petitioner's request for temporary benefits are denied.

IN SUPPORT of the Arbitrator's decision regarding "L" (Nature and Extent), the Arbitrator makes the following findings and conclusions:

Based upon the medical evidence, vocational reports, Petitioner's credible testimony, and the evidence deposition of Dr. Oken (Px 14) including his findings, conclusions and opinions as cited above; and with specific weight being afforded to Petitioner's complaints of pain, current findings and conclusions, the Arbitrator finds by a totality of the evidence that Petitioner in the case at bar is partially incapacitated from pursuing her usual and customary line if employment within the meaning of Section 8(d)(1) of the Act.

Section 8(d)(1) of the Act provides, in part, for an award of 2/3rds of the difference between what she would be earning at the time of Arbitration in her usual and customary employment (Average Weekly Wage Stipulated to in Arbitrator's Exhibit No. 1) and "the average amount of which she is earning or is able to earn in some suitable employment or business after the accident." Part-time versus full-time is not set forth, only "suitable employment." Even business earnings may be used regardless of hours. As held in *United Airlines v. IWCC,* 991 N.E.2d 458, the Act is to be liberally interpreted to effectuate its main purpose: providing financial protection for injured workers. 991 N.E.2d at 458. The Court went on to hold: the statute does not provide for a varying amount to be paid out at various future dates. Rather, as the statute states, the award must be based upon the average amount of the claimant's wages at the time of the accident and the average amount which the claimant is able to earn in some suitable employment after the accident.

There are two ways by which the Arbitrator can calculate current earning capacity of the employee. The first is by the average of what she is actually making, in this case is $750.00 per week. This is the preferred way, but if the employment is not suitable, or if there is no

employment, then the calculation can be based on what the Petitioner is able to earn in some suitable employment or business after the accident. The *United Airlines* case also held that a wage differential award must be calculated as of the date of the Arbitration hearing. So, too, in *Forest City Erectors v. Industrial Commission,* 264 Ill. App.3d 436, 636 N.E.2d 969 (1994), the Court held that the Commission acted appropriately in refusing evidence that the claimant's present wages would increase, as that was a matter of speculation which was properly disregarded.

In this case, Petitioner has satisfied both elements set forth above in proving an 8(d)(1) award. 1) She is currently working pursuant to a consulting contract at the rate of $3,000.00 per month; and 2) Both Petitioner and Respondent submitted Vocational Assessment Reports setting forth the wages and/or suitable employment that Petitioner, with her medical restrictions, is capable of earning. Since Petitioner obtained gainful employment from December, 2014 to the date of hearing, and further considering that she had previously obtained one or more consulting jobs within her industry, the need for the Vocational Reports in unnecessary but still instructive.

Petitioner submitted Exhibit 56, which included the contract under which she is working currently, as well as copies of checks and proof of deposits consistent with her testimony. The Contract calls for potential commissions, bonuses or other increases in compensation; however, at the time of hearing in May 2015, no such increases had been achieved.

Petitioner testified as to the reasons that she resigned her employment with Respondent. The Arbitrator notes that Petitioner's testimony was honest and credible and that the decision to walk away from a career such as Petitioner's was not an easy decision.

A claimant's voluntary decision to remove himself from the work force does not preclude a wage differential award. *Copperweld Tubing Products Co. v. Illinois Workers' Compensation Comm's,* 402 Ill. App. 3d 630, 634, 931 N.E.2d 762 (2010). Instead, a wage differential award is determined by comparing the claimant's prior earning capacity to the amount he "is earning or is able to earn in some suitable employment or business accident." 820 ILCS 305/8(d)(1) (West 2008); See *Copperweld Tubing Products,* 402 Ill. App. 3d at 634.

The evidence contained in the record shows the efforts made by Petitioner to find suitable, post-accident employment. As such, the Arbitrator finds that Petitioner is partially incapacitated from her usual and customary employment within the meaning of Section 8(d)(1) of the Act.

Based on the evidence contained in the record, the Arbitrator concludes that Petitioner is entitled to weekly benefits of $912.56 pursuant to Act. The Arbitrator finds, based on careful consideration of the record as a whole, that Petitioner reached MMI on December 3, 2014, the day she was released from chiropractic care from West Chicago Family Chiropractic Treatment. Petitioner's wage differential award is to begin on that date.

IN SUPPORT of the Arbitrator's Decision regarding Section 5(b) Subrogation, the Arbitrator makes the following findings and conclusions:

On Arbitrator's Exhibit No. 1, the Respondent raised the issue of 5(b) credits. The parties stipulated that Petitioner received an award with respect to a third-party claim involving the auto accident at issue, that at the arbitration hearing, an amount of $23,997.75 had been paid back to the Respondent leaving a zero lien at present.

Documents reflecting the settlement were provided to Respondent but not made part of the Record in this case. Without such documents, and no testimony or evidence presented (absent the stipulation) this Arbitrator, cannot issue a finding under Section 5(b).

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

NATHANIEL SALZIGER,

Petitioner,

vs. NO: 12 WC 25711

PEPSI BEVERAGES COMPANY,

17IWCC0109

Respondent.

DECISION AND OPINION ON REVIEW UNDER SECTIONS 8(a), 19(h), 19(L), 19(K) and 16 OF THE WORKERS' COMPENSATION ACT

Timely Petitions for Review under Sections 8(a) and 19(h) and a contemporaneous petition for penalties and attorney fees having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical benefits, TTD, prospective medical care, penalties, and attorney fees, and being advised of the facts and law, grants the 8(a) and 19(h) petitions as set forth below and denies the penalties and fees petition.

The evidence adduced at the arbitration hearing on September 2, 2014 showed that Petitioner was a truck driver for Respondent Pepsi when he sustained a back injury on June 25, 2012. Petitioner had two microdiscectomies performed at L5-S1 by Dr.Graf. Petitioner was placed on permanent "medium" work restrictions by Dr. Graf and was unable to perform the work as a truck driver at Respondent. Petitioner subsequently was employed by Medela Corporation. In his employment at Respondent, Petitioner earned an average weekly wage of $1,119.30. At Medela, Petitioner earned $560.00 per week. Petitioner declined a lumbar fusion recommended by Dr. Graf prior to the arbitration hearing. Similarly, Petitioner declined pain management recommended by Respondent's Section 12 examiner, Dr. Butler. The arbitrator found that Petitioner had sustained an impairment of his earning capacity and awarded wage

differential benefits of $380.00 per week beginning September 2, 2014 and until age 67, as provided in Section 8(d)1 of the Act. Neither party appealed the Arbitrator's decision.

On July 12, 2016, Petitioner filed petitions pursuant to Section 8(a), 19(h), 19(L), 19(K) and 16. On August 24, 2016, Commissioner Stephen Mathis held a hearing on the petitions. The evidence adduced at the hearing shows that Petitioner developed increasing lumbar symptoms over time and returned to Dr. Graf for further treatment in September 2015. Petitioner underwent a course of physical therapy, 2 ESI injections, and now is reliant upon daily dosages of Hydrocodone. Dr. Graf has again recommended a single level fusion. Dr. Graf attributes Petitioner's continuing escalation of back and leg pain to a complete loss of disc height at L5-S1 and compression of the L5 nerve root bilaterally. Petitioner has been unable to work per Dr. Graf since August 12, 2016.

On October 28, 2015 Dr. Butler examined Petitioner at Respondent's request. Dr. Butler opined that Petitioner's MRI scan does not show severe neurological compression and degeneration is stable. Dr. Butler recommended that the Petitioner should continue with conservative therapy before contemplating surgical care.

Petitioner testified that the conservative treatment has not relieved his pain and that he is not able to work or participate in family life or activities of daily living. Petitioner further testified that he is requesting anterior decompression and fusion at the L5-S1 level be performed by Dr. Graf.

The Commission adopts the opinions of Dr. Graf and awards prospective medical care in the form of the surgical fusion recommended by Dr. Graf and all reasonable and necessary medical and rehabilitative expenses associated therewith pursuant to Section 8(a) and 8.2 of the Act. Further, the Commission awards TTD benefits commencing August 12, 2016 through August 24, 2016.

The Commission denies penalties and fees. Respondent reasonably relied upon the opinion of their Section 12 examiner Dr. Butler.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall provide prospective medical care in the form of the surgical fusion recommended by Dr. Graf and all reasonable and necessary medical and rehabilitative expenses associated therewith pursuant to Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED that Respondent pay to Petitioner temporary total disability benefits in the amount of $746.20 per week for 2 weeks commencing August 12, 2016 through August 24, 2016 pursuant to Sections 19(h) and 8(b) 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 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: FEB 16 2017
d- 12-22-16
SM/msb
44

Stephen J. Mathis

Mario Basurto

David L. Gore

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Marianne Nave,

Petitioner,

vs.

NO: 14 WC 31556

Dr. M. L. Mehra,

17IWCC0110

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b)/8(a) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection (CC), temporary total disability (TTD), medical expenses, prospective medical care, and permanent partial disability (causal connection only) and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 was a 52 year old employee of Respondent, who described her job as receptionist/office associate. Petitioner did insurance, and billing. As she was the only one in the office, she did everything. Petitioner still works for the same doctor but in

2000 it was a private practice, now the practice is under different ownership. On the date of accident, April 5, 2000, Petitioner testified she was trying to go from one room to another to answer the phone and the chair broke. Petitioner stated that she had grabbed under the desk to try to break her fall and she jammed her arm down and twisted her back and pulled her shoulder. She testified that within a couple days her arm swelled up and everything was hurting. She grabbed the desk with her left and tried to break her fall with her right arm. Petitioner stated she initially sought treatment with her boss, Dr. Mehra (Respondent) and then she had to see an orthopedic specialist, Dr. Ludwig, on referral from Dr. Mehra. Petitioner first was seen by Dr. Mack (on referral) for her cervical spine and then to Dr. Ludwig for her shoulder. Petitioner testified the doctor just offered therapy for her lumbar spine. Petitioner testified that Dr. Mack performed cervical fusion at C5-6 in March 2002. She continued with cervical problems after surgery and the doctor also gave her injections to her low back. Petitioner stated that after the neck surgery she still has a lot of numbness in her arm. Petitioner stated that her mid to upper back (thoracic) is cold all the time even after the months of therapy. After the cervical surgery she saw a Dr. Feinberg in St. Louis for injections. She believed it was WC that sent her to Dr. Feinberg. She ultimately sought treatment with Dr. Kennedy in 2005 for her continued neck complaints. In September 2005 Dr. Kennedy ordered a CT myelogram; she was still treating with Feinberg at that time. Petitioner testified that she returned to Dr. Kennedy in April 2006 and he recommended surgery. He did a C6-7 discectomy May 2006 and released her September 2006. She returned to Dr. Kennedy in April 2008 regarding her lumbar spine. Petitioner testified, regarding her lower back that she reported the low back complaints to Dr. Mack and he injected her a few times; (steroid, and trigger point injections). Petitioner testified her complaints had been consistent and persistent over the years and those had been reported to the doctors. She had seen Dr. Feinberg for injections, between the Kennedy neck surgeries, regarding her low back. Petitioner testified that Dr. Kennedy recommended back surgery which was done in June 2008. Petitioner testified to having continuing problems after surgery and to treating with Dr. Feinberg for her neck and low back. Petitioner stated that she returned to Dr. Kennedy in May 2014 and underwent another CT myelogram. Petitioner indicated that Dr. Kennedy was aware that she had continued treating with Dr. Feinberg between those visits. Petitioner testified when she had returned to Dr. Kennedy in 2014 she was barely able to lift her arm or use keyboards. Petitioner was aware that based on results of the myelogram, Dr. Kennedy was recommending a decompression and fusion at C4-5. Petitioner testified that she wanted to proceed with that procedure, but Dr. Kennedy would not accept her insurance now.

The Commission finds that Petitioner's testimony is unrebutted and supported in the evidence that she sustained a cervical and right shoulder injury, both of which required surgical intervention. Evidence supports Petitioner's testimony of the ongoing cervical issues and need for the 2nd cervical fusion level and further to her need for the surgery recommended by Dr. Kennedy. Dr. Kennedy opined a causal connection to Petitioner's lumbar condition and is

recommending another cervical surgery he opines is causally related to the original injury. Dr. Kennedy opined that but for the cervical surgeries there would likely not have been the stress on the adjacent levels which caused him to recommend another surgery. There is no indication that any subsequent falls had broken the causal chain by further aggravating the cervical condition and now need for surgery. Respondent's §12 examiner, Dr. De Grange, opined a causal connection to the shoulder injury and to the 1st cervical surgery and recovery. Dr. De Grange opined that upon recovery from the 1st cervical surgery, Petitioner was at maximum medical improvement (MMI) and thereafter there was no further causal connection; he also opined no causal connection regarding any lumbar injury or need for surgery. The doctor's agreed that a fusion at a cervical level presents added stress to other adjacent levels and that is evidenced between the 1st and 2nd cervical surgeries and to the currently recommended surgery; but for the initial cervical injury and treatment, Petitioner may not have needed the initial surgeries-(or at least not at that time, but with natural degeneration) or the now recommended surgery. There is evidence and testimony to support a causal relationship regarding the shoulder condition of ill-being and the ongoing cervical condition of ill-being to find Petitioner met the burden of proving that causal connection. The back condition/injury, however, even with Dr. Kennedy's causal connection opinion, is hard to accept, and find a causal connection, given the length of time elapsing before any back complaints appeared in medical records even sporadically and then years before any real treatment was directed towards the back. It is difficult to find that Petitioner simply waited for the neck and shoulder issues to resolve before voicing any real concerns and subjective complaints regarding her back. Petitioner had the shoulder and initial cervical surgeries not too far apart and had received care to both within close proximity after the accident. If Petitioner had voiced real back complaints, the doctors likely would have at least tried some conservative care. When she did initially note back pain, diagnostics revealed nothing significant and it was not until diagnostics years later, when she noted more back pain, that showed degenerative changes, osteophytes. Dr. De Grange's opinion that those would be from natural degeneration and not from an accident years before seems more likely and is supported in the evidence with no complaints or back treatment for so many years. Petitioner clearly had a degenerative condition that would likely have worsened over time given her age. Medical records also indicated that many years after the accident Petitioner voiced real back complaints that came about in the recent past which again more likely would appear to support a natural deterioration rather than from the May 2000 accident. The evidence and testimony supports a finding of causal connection regarding the cervical and shoulder current conditions of ill-being, but, evidence and testimony supports a finding that Petitioner failed to meet the burden to prove a causal connection to her lumbar condition of ill-being. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence regarding the cervical/shoulder conditions, but contrary regarding the lumbar condition, The Commission, therefore, affirms and adopts the Arbitrator's finding as to causal connection regarding Petitioner's cervical and shoulder conditions; however, the Commission reverses the decision of the Arbitrator to find no causal connection regarding her low back condition.

The Commission finds that Respondent does not address the issue of temporary total disability (TTD) other than via causal connection, the issue is therefore deemed as waived and considered with the causal connection issue noted above. Regardless, The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to total temporary disability; all related lost time paid to date.

The Commission finds with the above of an ongoing causal connection regarding the cervical condition leads to affirm and adopt the Arbitrators award of medical expenses and prospective medical as recommended by Dr. Kennedy. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to medical expenses and prospective medical care.

The Commission finds that Respondent does not address permanent partial disability (PPD) other than via causal connection, the issue is therefore deemed as waived and considered with the causal connection issue above. Accordingly, permanent partial disability is to be assessed at a future hearing for that determination. Regardless, the Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to Permanent disability to be determined, with causal connection found regarding her cervical and shoulder conditions of ill-being and not her lumbar condition.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay for reasonable and necessary and related medical expenses under §8(a) of the Act, and for the prospective medical treatment as recommended by Dr. Kennedy.

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.

17IWCC0110

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: FEB 17 2017
o-1/5/17
DLG/jsf
045

David S. Gore
David Gore

Stephen J. Mathis
Stephen Mathis

Mario Basurto

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

NAVE, MARIANNE
Employee/Petitioner

Case# **14WC031556**

17IWCC0110

DR M L MEHRA
Employer/Respondent

On 6/14/2016, 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 0.40% 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:

4463 GALANTI LAW OFFICE
LESLIE N COLLINS
PO BOX 99
E ALTON, IL 62024

0264 HEYL ROYSTER VOELKER & ALLEN
JESSICA BELL
300 HAMILTON PO BOX 6199
PEORIA, IL 61601

17IWCC0110

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Marianne Nave
Employee/Petitioner

v.

Dr. M.L. Mehra
Employer/Respondent

Case # **14** WC **31556**

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 **Molly Dearing and the Honorable Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **9/28/2015 and 3/29/2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **4/5/2000**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$29,178.24**; the average weekly wage was **$561.12**.

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

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

Respondent shall be given a credit of **$8,663.99** for TTD, **$0** for TPD, **$0** for maintenance, and **$242,017.76** for other benefits, for a total credit of **$250,681.75**.

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

ORDER

The Arbitrator awards prospective medical treatment as recommended by Dr. Kennedy.

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

6/4/16
Date

ICArbDec19(b)

JUN 14 2016

17IWCC0110

This case was originally tried on September 28, 2015 in Springfield, Illinois before Arbitrator Dearing. Proofs were not closed at that time because Respondent wanted to Subpoena records from Dr. Mehra's office. Respondent remitted a Subpoena to Dr. Mehra's office and there were no records available. This case was subsequently set for hearing on March 29, 2016, before the Honorable Edward Lee. Both parties went on record on this date and Petitioner was recalled to testify on said date. Proofs were closed on March 29, 2016.

The issues presented for trial in this case are causal connection relating to the cervical fusion which is presently being recommended by Dr. David Kennedy together with causation relating to the lumbar fusion which Petitioner has already undergone. Respondent is not disputing the causation of the prior cervical fusion that Petitioner had in 2002.

Petitioner, Marianne Nave, testified at the hearing she was employed by the Respondent, Dr. M.L. Mehra in April of 2000. Petitioner testified she had worked for Respondent since 1974. Petitioner testified that in 2000 she did the insurance, office work and billing for the doctor. Petitioner was the only employee of Respondent on 2000. Petitioner testified that on April 5, 2000, she was attempting to go from room to room to answer a phone. Petitioner testified that the chair she was in broke and she grabbed underneath the desk to try to break her fall. When doing so, Petitioner jammed her right arm while grabbing the desk with her left arm. Petitioner testified she also twisted her back and pulled her shoulder.

Petitioner testified at the initial hearing in September of 2015 that she initially treated with her boss, Dr. Mehra. Petitioner testified Dr. Mehra gave her some therapy to do. Petitioner further testified that Dr. Mehra never submitted any billing for his services to her health insurance.

Dr. Mehra referred Petitioner to Dr. Mack for treatment of her neck and lumbar spine. Petitioner testified she told Dr. Mehra about her lumbar complaints. Petitioner testified that she first saw Dr. Mack and then she was referred to Dr. Ludwig for treatment relating to her shoulder.

Dr. Mack treated Petitioner for her cervical spine. Petitioner had diagnostic studies performed which showed a disc lesion which involved the nerve root at the C6 level. Dr. Mack performed an interior cervical fusion at C5-6 on March 6, 2002. Dr. Mack noted lumbar complaints in his April 3, 2001, office note.

Subsequent to this surgery, Petitioner continued to complain of pain into her right shoulder. Eventually, Petitioner was diagnosed with a full thickness tendon tear which was repaired by Dr. Ludwig. When Petitioner returned to see Dr. Mack on January 27, 2004, she reported continued pain into her neck, right shoulder and right arm. At this visit, she still had numbness and tingling at her third, fourth and fifth fingers. Dr. Mack's impression was that of radicular pain probable at C6-C7. Dr. Mack ordered an MRI. The MRI revealed a cervical fusion at C5-6, minimal left sided foraminal narrowing at levels C6-C7. Dr. Mack recommended a nerve root injection. Petitioner returned to see Dr. Mack again on April 13, 2004. At this time, Petitioner complained of both hands being numb, right worse than left. Petitioner also

complained of pain in the shoulders, more on the right than left, together with spasms on the right side of her face. Petitioner also complained of some pain in the mid and low back, which was thought to be from the neck, per Dr. Mack's note of April 13, 2004. On June 8, 2004, Petitioner returned to see Dr. Mack at which time she complained of pain into her neck and both of her arms. Petitioner further complained of pain in her thoracic and right shoulder region. Petitioner complained of pain in the lumbar region with spasm, especially at night. Dr. Mack referred Petitioner for therapy. In September of 2004, Petitioner was given work restrictions of no lifting over 25lbs and no prolong or repetitive overhead activity. Petitioner continued to have complaints regarding her neck. Petitioner saw Dr. Mack on March 15, 2005 with continued complaints of her neck and hands. Dr. Mack referred Petitioner for another MRI which was performed on March 21, 2005. This MRI revealed a small central disc protrusion at C6-7 with mild flattening of the left cord, mild proximal forminal narrowing on the left.

Petitioner was sent to Dr. Kennedy on May 12, 2005. On physical exam, Dr. Kennedy noted tenderness to the right shoulder together with sensory loss on the 4th and 5th digits in the right hand. Dr. Kennedy referred Petitioner to Dr. Feinberg and also recommended a CT myelogram.

Petitioner saw Dr. Feinberg on June 14, 2005. Dr. Feinberg noted a positive spurling maneuver at the right C6-7 with tenderness at C6-7 with radiating pain into the right and upper extremity. Petitioner returned to see Dr. Kennedy on September 6, 2005, at which time he recommended a CT myelogram. The CT myelogram was performed on October 31, 2005. Petitioner returned to see Dr. Kennedy on April 11, 2006. The CT myelogram revealed degenerative disc disease adjacent to her fusion from 2002. It was Dr. Kennedy's opinion that this was casually related to her surgery from 2002. Dr. Kennedy recommended surgery at this time. On May 17, 2006, Dr. Kennedy performed a cervical discectomy and fusion at C5-6 and C6-C7 assisted by Dr. Raskus. Petitioner was placed at MMI regarding her cervical spine on September 26, 2006 by Dr. Kennedy.

Petitioner returned to see Dr. Kennedy on April 23, 2008 with regard to her lumbar spine. Petitioner gave history to Dr. Kennedy of lower lumbar pain since her original injury of April 5, 2000. Dr. Kennedy noted that in his notes from 2004, Petitioner described lumbar pain. Petitioner did have injections performed by Dr. Feinberg with no improvement. Petitioner testified she had foot weakness on the left side back in 2007. However, it had improved. Dr. Kennedy reviewed a lumbar myelogram from February 25, 2008, which demonstrated significant stenosis from L3-L5. Dr. Kennedy recommended surgery on this date.

On June 13, 2008, Dr. Kennedy and Dr. Robson performed L3-L4-5 laminectomy, facetectomy and foraminotomy bilateral together with a screw fixation at L3-4, 5 with bone morphogenetic protein and mosaic performed by Dr. Robson. Petitioner returned to see Dr. Kennedy on July 9, 2008. She described some aggravating pain on the right side more since pre-operation. Dr. Kennedy contributed this to nerve irritation which was present prior to the operation. Petitioner was being held off work and showed signs of improvement. Petitioner returned to see Dr. Kennedy on October 2, 2008. Petitioner was complaining of having spasms in her lower lumbar area and twitches in her lower leg muscles. Dr. Kennedy recommended that she go see Dr. Feinberg for injections.

On January 20, 2009, Petitioner returned to see Dr. Kennedy. Dr. Kennedy noted that there could be a slight loosen around the screws but there actually appeared to be some good posterorlateral bone noted as well. Clinically, Petitioner was doing well. Petitioner retuned to see Dr. Kennedy on July 28, 2009. Dr. Kennedy noted occasional pain and weakness in her foot. It was Dr. Kennedy's opinion that Petitioner would benefit from an ankle foot orthotic. On March 2, 2010, when Petitioner returned to see Dr. Kennedy, Dr. Kennedy noted an aggravation following a cough. Dr. Kennedy noted local tenderness in the right paraspinous. Petitioner was also going to treat with Dr. Feinberg on that date for injections. Dr. Kennedy ordered a foot orthotic brace for Petitioner.

On September 9, 2010, Petitioner returned to see Dr. Kennedy. Dr. Kennedy noted intermittent pain at the base of the cervical spine and lower lumbar area. He further noted some occasional pain in the legs. Dr. Kennedy noted reduced range of motion in the cervical and lumbar spine. Dr. Kennedy placed Petitioner at maximum medical improvement on this date and released Petitioner to work without restrictions.

Petitioner continued to treat with Dr. Feinberg after being released at MMI by Dr. Kennedy for her cervical condition and lumbar condition. Specifically, Dr. Feinberg continued to administer injections to Petitioner on a regular basis. In his note dated January 7, 2013, Dr. Feinberg specifically said, "The patient is at maximum medical improvement in terms of both her cervical and lumbar spine assuming that patient will have progression of both problems. This can be predicted. The patient is basically being treated now for flare ups that are related to juxtafusional stenosis at C4-C5 level in the cervical spine and the patient has ongoing degenerative process in the lumbar spine, most marked at L5-S1. The patient may require surgery in the cervical spine. I do not believe is at a surgical point at L5-S1. However, further evaluation with Dr. Kennedy and myself is ongoing." PX 7 at 45. This was prior to any accidents reported to Dr. Feinberg for which Petitioner was asked about at trial in cross-examination.

Petitioner returned to see Dr. Kennedy on May 29, 2014. Petitioner complained of increasing pain at the base of her cervical spine. It was associated with radiating pain in the right arm and fingertips and the upper cervical area and into the jaw. Dr. Kennedy noted Petitioner had injections with Dr. Feinberg as recent as April 2014, with no improvement. Dr. Kennedy reviewed a CT Myelogram which demonstrated significant degenerative changes at C3-4, C4-5 with listhesis of C4 on C5. There was some underfilling of the nerve roots more notable on the left than right. Dr. Kennedy's impression was that of segmental instability at C4-5. Dr. Kennedy recommended a decompression and fusion.

Dr. Kennedy testified in an evidence deposition on March 25, 2015. Dr. Kennedy testified that the need for the surgery proposed at C4-5 was related to her original accident in 2000. Dr. Kennedy related the need for the surgery to the stress the original fusion at C5-C6 on the adjacent level, C4-5. Dr. Kennedy testified that the accident described to Dr. Feinberg in 2013 could have aggravated the underlying condition; however, he still believed that the need for surgery was related to the original work accident in 2000.

Petitioner saw Dr. DeGrange for an Independent Medical Examination. Petitioner gave a history of her alleged accident and injuries. Dr. DeGrange noted that the Petitioner sustained an injury to the cervical spine resulting in the cervical discectomy and fusion at C5 C6 and rotator cuff repair. However, Dr. DeGrange noted that any further diagnoses and/or treatment were not related to the Petitioner's alleged accident.

Regarding the lumbar spine, Dr. DeGrange opined that the Petitioner's complaints, and treatment, were related to her underlying degenerative condition and as a result of the normal degenerative process. Regarding the lumbar fusion, Dr. DeGrange noted that it was not related to the 2000 work accident. Dr. DeGrange admitted that an acute accident can aggravate a pre-existing condition.

Regarding the Petitioner's cervical condition, Dr. DeGrange did agree with the original diagnosis and surgery performed at C5 C6. However, Dr. DeGrange noted the Petitioner needed no further cervical treatment as of the date of his IME and further specifically addressed the proposed cervical fusion, indicating it was not necessary or related to the alleged work accident.

Petitioner testified she is desirous of having the procedure performed that Dr. Kennedy is recommending.

Based on the foregoing, the Arbitrator makes the following conclusions:

1. Petitioner's current condition of ill-being relating to her cervical spine is causally related to her work accident on April 5, 2000. Dr. Kennedy performed a fusion at C5-6 in 2006. Petitioner continued to treat for complications at this and adjacent levels subsequent to being placed at MMI and released from Dr. Kennedy. Dr. Feinberg treated Petitioner and noted that a future surgery was likely.

2. The need for Petitioner's lumbar surgery in 2008 was causally related to her work accident on April 5, 2000. Petitioner testified she had complaints of low back pain beginning with the date of accident and continuing until she sought treatment from Dr. Mack. Petitioner testified she was treated by her boss, Dr. Mehra, Respondent in this matter although there were no treating records for the same. The surgery performed by Dr. Kennedy in 2008 was both reasonable and necessary.

3. Respondent shall be responsible for and pay the reasonable and necessary medical expenses associated with the proposed treatment recommended by Dr. Kennedy.

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

William Lloyd, Sr.,

Petitioner,

vs.

NO: 11 WC 22877

City of Chicago,

17IWCC0111

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 temporary total disability-(TTD)-nature and extent only, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Petitioner was a 64 year old (currently 69) employee of Respondent, who described his job on the date of the accident as a traffic aide. In his position he was paid hourly and had no benefits; he was assigned to O'Hare Airport, Terminal 5. His job involved moving traffic and writing parking tickets for the City of Chicago. Petitioner testified that he had no restrictions or limitations on the date of the accident, was on no pain medications and was in general good health at that time. Petitioner stated that at the time he could be assigned to any terminal at O'Hare. On the date of accident, May 7, 2011 (about 1:00pm), Petitioner testified he was in vestibule B, Terminal 5 and a cab was blocking the crosswalk where travelers would cross with their luggage to the middle island to get to picked up and load their luggage. Petitioner stated he told the cabbie he had to move as he could not be blocking the crosswalk. Petitioner stated there was no way for the cab to back-up. The guy in front threw his car into reverse to move to get around so the cab

could move. Petitioner stated he was struck when he had his back to the car and he was hit by the rear of the cab (bumper and trunk) and knocked onto the hood and then to the ground; landing on his right side. The cab backed into Petitioner. Petitioner stated that the cab that hit him pulled out, but Chicago police were there immediately and stopped him. The vehicle had hit his left side and had knocked him forward onto the hood of the car. The Chicago police investigated the accident and Petitioner reported the accident to his supervisor; Anthony Ballard. Petitioner stated that after the accident he was shaken up. Petitioner stated the supervisor asked if he wanted to go to the hospital and Petitioner said no, he still had hours left on his shift. At the time Petitioner stated that he had minor pain in his lower left side, right shoulder and left leg and the left middle of his back. He had not injured those body parts again since the accident.

- Petitioner sought medical treatment at the emergency room at Presence Resurrection Hospital, May 9, 2011. Petitioner testified at that time he had spasms in his back and with severe pain in the lumbar region. Petitioner followed up at MercyWorks for a while as Respondent sent him there for the same complaints. Petitioner had a lumbar MRI about June 1, 2011. While at Resurrection Petitioner stated that he received physical therapy. Petitioner had an EMG at the Neuro Center on July 7, 2011; he did not recall the results. Petitioner first saw Dr. Yapor, a surgeon, at Resurrection on July 12, 2011. The doctor put Petitioner into therapy (at ATI) and into pain management with Dr. Konowitz at Pain Management, Morton Grove. Petitioner stated that Dr. Konowitz had given him two shots to his lower spine and Hydrocodone, heavy narcotic medicine, for the pain. Petitioner testified that the therapy Dr. Yapor sent him to did not help, nor did the injections to the back. Petitioner continued to treat with different doctors through 2012 and 2013.

- Petitioner saw Dr. Graf, and Dr. Julie Wehner for Respondent's §12 examination. Petitioner's primary care doctor at that time was Dr. Bolmey at Gottlieb Hospital. Petitioner treated with Dr. Yapor and others in 2013 and 2014. Petitioner had no back surgery until he underwent a lumbar fusion performed by Dr. Yapor and Dr. Benson Yang at Resurrection Hospital. Petitioner had incurred medical bills from the various providers. Petitioner stated that after the fusion surgery, Dr. Yapor sent him for therapy at ATI in Norridge, three times per week for 1-1.5 hours each day. Petitioner stated that the therapy was mainly stretching, walking the treadmill and walking around; there was no bending, at all, and no lifting over 5 pounds. Petitioner ultimately had a functional capacity evaluation (FCE) at ATI in Forest Park. Petitioner indicated that therapy and FCE was provided between July 8, 2015 and September 3, 2015. At the time of hearing Petitioner had been released from care from Dr. Yapor and had no further appointments. Petitioner testified that he takes Tramadol, 4-6 times per day, as needed, as prescribed by Dr. Bolmey, his primary care physician. Petitioner testified that he takes the medicine first thing in the morning. Petitioner stated that he was currently working at Home Depot; after 2-3 hours of walking around he starts getting spasms and he takes a pill. Petitioner indicated that at Home Depot he can sit with the pain to take the stress off his back. Petitioner testified that he works in the hardware department with nuts and bolts and tools. Petitioner stated that he likes working there as it gets him out of the house and he enjoys helping people. Petitioner indicated that he was on 40 hours per week but he cut himself back to 32 hours as his back was hurting so much.

- Petitioner testified that he had not slept a full night since surgery. He stated he may sleep an hour and if he gets spasms he gets up and walks around and then tries to lay back down, but he is up again in an hour. He indicated his social activities have been cut in half; he is no longer in charge of a charitable organization (Teamsters Motorcycle Association) that conducted fundraisers to provide gifts for kids at LaRabida Children's Hospital. He sold his motorcycle because of his left leg. He was afraid to ride anymore. Petitioner stated his leg is weak and it feels like he is going to fall. Petitioner agreed he resigned from Respondent April 12, 2012. Petitioner stated at that time he went to his supervisor, Noreen Cooney, with his papers to return to full-duty work. Petitioner asked to return to O'Hare and she told Petitioner he would be by Wrigley Field (Cubs park), Addison and Clark. Petitioner stated he told her that he did not think he could do it and she told him to quit. Petitioner stated for his safety and safety of others at the ballpark, he thought it best to resign. Petitioner testified that he was never offered the job back at O'Hare where he had been originally; though he had requested that, it was denied. Petitioner did not recall any prior back injuries or back treatment prior to this accident.

The Commission finds that, as Respondent noted in their brief, there was no stipulation as to the period of lost time, contrary to what the Arbitrator indicated in the decision. The Commission, herein, corrects the clerical error, that indicated that "the Respondent agreed that Petitioner was entitled to temporary total disability benefits..." and strikes that portion of the Arbitrator's decision. The Commission notes that the emergency room notes for May 9, 2011 noted the history of the mechanism of injury, but discharge notes did not indicate a work status either way. Mercy works, May 11, 2011, noted the history of accident and Petitioners symptoms and they provided a restricted work release. Petitioner had the FCE January 5, 2012 indicating Petitioner at the level to return to his duties as a traffic control person. Dr. Konowitz further noted that Petitioner was at maximum medical improvement (MMI) as of January 18, 2012 and able to return to work per the FCE. Petitioner did ultimately receive an off work note from his primary care doctor March 28, 2012. Petitioner subsequently, voluntarily, resigned from Respondent April 12, 2012 as Respondent wanted Petitioner around Wrigley Field rather than O'Hare, and Petitioner did not think he could handle that. There was no indication in the evidence that the Wrigley Field traffic position required a higher physical demand level. There is no indication or testimony that Petitioner attempted to return to Respondent when released in January 2012 or evidence that Petitioner attempted to obtain alternative employment elsewhere. The evidence and testimony finds Petitioner failed to meet the burden of proving entitlement to temporary total disability before May 11, 2011 or after his release to light work and finding at MMI January 18, 2012. Petitioner met the burden of proving entitlement to temporary total disability benefits from May 11, 2011 through January 18, 2012 (36-1/7 weeks) at $253.00 (minimum rate) per week under §8(b) of the Act (total TTD $9,144.14). The Commission, herein, modifies the Arbitrator's decision as to the period of lost time. The Commission further finds Respondent entitled to receive credit for TTD paid of $8,579.00 for net TTD benefits due Petitioner of $565.14.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $253.00 per week for a period of 36-1/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent is entitled to receive

credit for TTD paid of $8,579.00 for net TTD benefits due Petitioner of $565.14. The portion of the Arbitrator's decision erroneously indicating the parties had agreed to the period of lost time is, herein, stricken from the Arbitrator's decision.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $253.00 per week for a period of 40 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the 8% loss of use of Petitioner's person as a whole.

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

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

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

DATED:
o-1/19/17
DLG/jsf
045

FEB 17 2017

David Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LLOYD SR, WILLIAM G
Employee/Petitioner

Case# **11WC022877**

CITY OF CHICAGO OEMC
Employer/Respondent

17IWCC0111

On 1/4/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.55% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2089 BUDIN LAW OFFICES
JOHN J BUDIN
ONE N LASALLE ST SUITE 2165
CHICAGO, IL 60602

0113 CITY OF CHICAGO
MICHELLE BRYANT
30 N LASALLE ST 8TH FL
CHICAGO, IL 60602

☐	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

ARBITRATION DECISION

WILLIAM G. LLOYD, SR.
Employee/Petitioner

Case #11 WC 22877

v.

17IWCC0111

CITY OF CHICAGO, OEMC
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on November 16, 2015. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

A. ☐ Was the respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☐ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to the respondent?

F. ☒ Is the petitioner's present condition of ill-being causally related to the injury?

G. ☐ What were the petitioner's earnings?

H. ☐ What was the petitioner's age at the time of the accident?

I. ☐ What was the petitioner's marital status at the time of the accident?

J. ☒ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☒ What temporary benefits are due: ☐ TPD ☐ Maintenance ☒ TTD?

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

M. ☐ Should penalties or fees be imposed upon the respondent?

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On May 7, 2011, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed 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 $18,886.40; the average weekly wage was $363.20.
- At the time of injury, the petitioner was 64 years of age, married with no children under 18.
- The parties agreed that the petitioner received all reasonable and necessary medical services.
- The parties agreed that the respondent paid the appropriate amount for all the related, reasonable and necessary medical services provided to the petitioner.
- The petitioner agreed that the respondent paid $8,579.03 in temporary total disability benefits.
- The respondent agreed that the petitioner is entitled to temporary total disability benefits for 48-4/7 weeks, from May 9, 2011, through April 12, 2012.

ORDER:

- The respondent shall pay the petitioner the sum of $253.00/week for a further period of 40 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused

the permanent partial disability to petitioner to the extent of 8% loss of use of the man as a whole.

- The respondent shall pay the petitioner compensation that has accrued from May 7, 2011, through November 16, 2015, and shall pay the remainder of the award, if any, in weekly payments.

- The medical care rendered the petitioner for his lumbar spine through January 18, 2012, was reasonable and necessary and is awarded. The medical care rendered the petitioner for his lumbar spine after January 18, 2012, and for his cervical spine was not reasonable or necessary and 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.

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

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

Robert E. Williams

Signature of Arbitrator

December 30, 2015

Date

JAN 4 - 2016

FINDINGS OF FACTS:

On May 7, 2011, the petitioner, a traffic aide at O'Hare airport, was struck by a cab, knocked on the hood of another vehicle and fell to the ground. He sought emergency care at Resurrection Hospital on May 9th for back and left hip/leg pain. X-rays revealed moderate narrowing at L4/5 and L5-S1 and spurring at multiple levels. He followed up with Dr. Soler at MercyWorks for right arm and shoulder pain, left knee pain, left leg numbness and back pain with radiation down the back of his leg. The diagnosis was sciatica and shoulder pain. He was treated conservatively with activity restrictions. An MRI on June 1st revealed herniated discs at L4/L5 and L5-S1. On June 8th, the petitioner saw Dr. Wehner, who noted moderate distress, a mildly antalgic gait, a mildly positive straight leg raise and 5/5 motor strength. She opined that the MRI revealed an L5-S1 right central disc herniation and an L4-5 broad based central disc herniation. Her diagnosis was a left L4 radiculopathy without any specific image of a compressive lesion. She prescribed a Medrol Dosepak and Lyrica. The petitioner followed up with Dr. Wehner on June 20th and reported no relief with the medication and worsening symptoms. The doctor noted no acute distress, a normal gait and a negative straight leg raise.

The petitioner requested to see Dr. Wesley Yapor on June 17th. An EMG/NCV study on July 11th was consistent with a severe left L5 radiculopathy. Dr. Yapor reported to Dr. Carlos Bolmey on July 12th that he found a negative straight leg raise sign, symmetrical and no pathological reflexes, a full lumbar range of motion, a normal gait, intact strength and a decreased sensation following the anterior lateral aspect of the shin and ankle and slightly on the dorsum of his foot. Dr. Yapor opined that the MRI revealed small herniations at L4-5 and L5-S1 and mild foraminal stenosis but nothing that could

relate to the petitioner's severe symptoms. He further opined that the EMG showed irritation of all the nerve roots in the left lower extremity, suggestive of a lumbar plexus injury but without correlating symptoms. The doctor recommended physical therapy and light-duty work with limited two-hour sitting and standing. Dr. Wehner saw the petitioner on July 18th and noted that his left leg pain was consistent with the L4 and L5 nerve root neurologic distribution and the EMG but opined that there was no intraspinal cause and suggested the possibility of an intraabdominal pathology pressing on his lumbar plexus. The petitioner received physical therapy from July 18th through August 11th. A CT scan of the petitioner's abdomen and pelvis on July 27th was normal. Dr. Yapor's neurological examination on August 18th was unchanged. The petitioner was referred for pain management to Dr. Howard Konowitz. On September 7th, the petitioner saw Dr. Konowitz chiefly for left low back and buttock pain and left leg numbness and tingling. The petitioner had lumbar epidural and gluteal medius injections and left L5-S1 nerve blocks.

A functional capacity evaluation on January 5, 2012, revealed the petitioner's ability to return to his traffic control position. On January 18th, Dr. Konowitz noted that the petitioner was at MMI and could return to work per the FCE. On March 28th, the petitioner received an off-work slip from Dr. Bolmey. The petitioner resigned from the respondent on April 12, 2012.

The petitioner began working 40 hours per week in the hardware department at Home Depot in May 2014. His duties require lifting, bending and walking. He currently works 32 hours per week. The petitioner returned to Dr. Yapor on July 15, 2014, and reported back pain since his discharge two years earlier. No significant midline

tenderness was noted and the straight leg raise tests were negative. Dr. Yapor opined on July 24th that the MRI on July 25th showed advanced disc disease at all levels, worse at L4-S1, collapsed disc spaces and a lesion at L1. An NM Bone scan of his lumbar spine on August 12th was negative for abnormal activity. He followed up with the same complaints on August 21st. On October 30, 2014, the petitioner was evaluated by Dr. Jesse Butler at the request of the respondent. Dr. Butler opined that the petitioner was at MMI as of the discharge on January 18, 2012, and that current treatment recommendations were not related to his May 7, 2011, injury.

On March 31, 2015, the petitioner reported continued back pain to Dr. Yapor and new symptoms of numbness in his right thumb, index and ring finger and occasional neck pain. Dr. Yapor opined on April 2nd that MRIs on April 1st showed disc disease in the mid cervical levels of moderate severity and L4-S1 advanced disc disease less so at L3. An EMG/NCV test of his upper extremities on April 2, 2015, was abnormal with evidence of bilateral median mononeuropathy across his wrists and bilateral ulnar neuropathy across his elbows. On April 13, 2015, the petitioner had a posterior lumbar interbody fusion at L4-L5 and L5-S1 and a L4 and L5 laminectomy by Dr. Yapor. He reported a relief of his radicular symptoms on April 28th. The petitioner was discharged from rehab on April 27th and physical therapy on September 3rd.

The petitioner had prior problems with his spine. Around September 2, 2005, the petitioner sustained injuries to his cervical, lumbar and thoracic spine. Dr. Kern Singh diagnosed a left L4-5 foraminal stenosis with radiculopathy and recommended an L4-5 microforaminotomy surgery. The petitioner's claim #06 WC 46568 was settled for 12.5% loss of a person.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner for his lumbar spine through January 18, 2012, was reasonable and necessary and is awarded. The medical care rendered the petitioner for his lumbar spine after January 18, 2012, and for his cervical spine was not reasonable or necessary and is denied. A functional capacity evaluation on January 5, 2012, revealed that the petitioner could perform the duties of a traffic controller. On January 18, 2012, Dr. Konowitz released the petitioner to work per the FCE.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that the current condition of ill-being with his lumbar spine through January 18, 2012, is causally related to the work injury. The petitioner failed to prove that his lumbar spine condition after his discharge from medical care and release to work on January 18, 2012, and his cervical spine condition were casually related to his work injury on May 7, 2011.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

There is no AMA impairment rating or evidence concerning the impact of the petitioner's injury in regard to his occupation, age or future earning capacity, as delineated in Section 8.1(b)(i) through (iv) of the Act, nor can any effect be reasonably inferred from the evidence. Regarding Section 8.1(b)(v), the petitioner currently complains of a difficulty sleeping due to spasms every other hour and continued left leg pain. His left leg is weak and he is afraid of falling. His social life has been affected and is he afraid to ride a motorcycle. The petitioner reported no radicular symptoms at his last medical care on April 28, 2015. The respondent shall pay the petitioner the sum of

$253.00/week for a further period of 40 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 8% loss of use of the man as a whole.

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 ON REMAND FROM THE APPELLATE COURT	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kevin Rafferty,

Petitioner,

vs.

NO: 06 WC 05568

City of Chicago,

17IWCC0112

Respondent.

DECISION AND ORDER ON REMAND FROM THE APPELLATE COURT

This matter had previously been heard and the Decision of Arbitrator Williams had been filed May 21, 2009. The Arbitrator found that Petitioner sustained accidental injuries arising out of and in the course of his employment with Respondent; that Petitioner established a causal connection between these accidental work related injuries and his condition of ill-being; that Petitioner is entitled to an award of 42-3/7 weeks of temporary total disability benefits (2/20/07-12/13/07) at a rate of $681.24 per week under §8(b) of the Act ($28,904.04 total TTD); that Petitioner is entitled to an award of 40% loss of use of Petitioner's right arm under §8(e)(10) of the Act (94 weeks at $571.96 per week =$53,764.24 total PPD). Penalties were denied.

- The matter was presented to the Commission on Petitioner's Review. On review the Commission vacated the permanent partial disability (PPD) award and ordered vocational rehabilitation testing and for Respondent to provide a rehabilitation plan. The Commission remanded the matter back to the Arbitrator for such order. The Arbitrator, thereafter, found there was no new evidence and reinstated his initial award. Petitioner motioned under §19(f) requesting the decision be recalled, corrected and reissued. A hearing was held before Commissioner Gore April 30, 2010 with Petitioner claiming a clerical error in remanding for vocational rehabilitation testing without ordering maintenance from maximum medical improvement (MMI) to present. The Commission

17IWCC0112

found no clerical error and denied the motion. Petitioner brought the matter before the Circuit Court who initially found no jurisdiction and remanded the matter back to the Commission August 3, 2010. An initial hearing on remand was heard August 19, 2011 before the Commission. The matter came before the Commission again August 2, 2012 wherein the Commission again affirmed their prior decision. The matter again came before the Circuit Court June 3, 2013 who retained jurisdiction and remanded the matter back to the Commission for clarification of specific evidence as why the Commission removed the order that Respondent provide appropriate vocational rehabilitation testing and for Respondent to submit a rehab plan.

The Commission notes that at the initial hearing before the Arbitrator, Petitioner failed to prove entitlement to permanent and total disability (PTD). On Review the Commission indicated Petitioner failed to establish permanent and total disability indicating Mr. Belmonte did not find Petitioner to be permanently and totally disabled, but had recommended vocational rehabilitation testing to access Petitioner's vocational rehabilitation potential and therein, with that evidence having been presented, the Commission ordered the vocational testing, vacated the permanency (PPD) award and remanded the matter to the Arbitrator for such action. The Arbitrator subsequently found no new evidence for such action and reinstated his prior award. The Petitioner, at the August 19, 2011 Commission hearing, acquiesced to Respondent's position that no new evidence was to be presented to the Arbitrator and essentially refused the Commission order for the vocational rehabilitation testing and Respondent vocational rehabilitation plan. At that hearing, Petitioner essentially indicated he did not believe the Commission's remand order required the taking of additional evidence (i.e., vocational rehabilitation testing and Respondent's rehabilitation plan) and Petitioner did not seek to enforce that Commission order. Petitioner in their Statement of Exceptions filed December 19, 2011 then did request the testing contrary to their prior assertions. Petitioner agreed at hearing with Respondent's position that no additional evidence was required and therefore rejected the vocational rehabilitation testing and rehabilitation plan order. The Commission thereafter reinstated the Decision of the Arbitrator to affirm the PPD award of 40% loss MAW based on the evidence that had been presented as Petitioner had acquiesced that no additional evidence was to be presented.

Thereafter, Petitioner appealed to the Appellate Court. The Appellate Court reviewed both Commission decisions and the Circuit Court decision. The Appellate Court indicated the Commission appeared to understand the Arbitrator's and the party's uncertainty of the initial order as to further evidence. The Appellate Court indicated the 2nd Commission order indicated that claimant seemed to argue no additional evidence was required on the subject and the Commission declared as claimant provided no further evidence then the initial Arbitrator's PPD award was reinstated. The Appellate Court stated the proper course would have been for the Commission to clarify the terms of the April 7, 2010 order remanding to the Arbitrator and authorizing the taking of new evidence as deemed appropriate as to the issue of suitability of vocational rehabilitation. The Appellate Court stated that the Circuit Court ordered such clarification in their June 13, 2013 remand order. The Appellate Court indicated that the Commission simply declared that as the claimant provided no further evidence they had no

choice but to reinstate the Arbitrator's award. The Appellate Court stated that rather than clarify the issue, the February 20, 2014 order compounded the confusion and error when the Commission arrived at the conclusion that the claimant acquiesced to the City's position that the April 7, 2010 order disallowed the taking of further evidence regarding vocational rehabilitation and that claimant refused the mandate on remand therefore waiving their opportunity to offer evidence on the issue. The Appellate Court indicated that a review of the hearing of April 7, 2010 revealed no acquiescence or waiver by either party as to admitting the appropriate evidence regarding vocational rehabilitation, rather the Arbitrator and the parties were uncertain of what the language of the order contemplated on the issue of additional evidence; ultimately both erroneously agreeing that such evidence was barred. The Appellate Court stated that there was no 'refusal' of the Commission's April 7, 2010 order, only a misinterpretation of what the order contemplated. The Appellate Court found that the Commission erred in its October 1, 2012 and February 20, 2014 orders by failing to enforce and clarify its April 7, 2010 order before determining whether Petitioner was entitled to PPD or TTD benefits. ((As such, they did not address whether Petitioner was entitled to odd-lot PTD)). The Appellate Court reversed the Circuit Court's February 20, 2014 order. The Appellate Court reinstated the Commission's April 7, 2010 order directing the Arbitrator to order the City to obtain vocational testing and to submit a vocational rehabilitation plan, remanding the matter to the Commission with such instructions to introduce the additional rehabilitation evidence.

The Commission finds that based on the Appellate Court instructions, The Commission herein, reinstates their April 7, 2010 order. The Commission further, herein, orders the Respondent to authorize and pay for the vocational rehabilitation testing and provide a rehabilitation plan and remands the matter to the Arbitrator to allow that NEW evidence be admitted to determine Petitioner's suitability for vocational rehabilitation.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent authorize and pay for vocational rehabilitation testing and provide a rehabilitation plan and, herein, remands the matter to the Arbitrator to allow that the NEW evidence be admitted at that time to determine Petitioner's suitability for vocational rehabilitation.

DATED: FEB 17 2017
o-1/19/17
DLG/jsf
045

David Gore

Stephen Mathis

Mario Basurto

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

Sarah Louise Carr,

Petitioner,

17IWCC0113

vs. NO: 10 WC 8748

Daystar Care Center et al,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §§19(b)/8(a) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of 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 March 28, 2016, is hereby affirmed and adopted.

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

17IWCC0113

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 $13,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 17 2017
o2/1/17
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

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

17IWCC0113

CARR, SARAH LOUISE
Employee/Petitioner

Case# **10WC008748**

DAYSTAR CARE CENTER ET AL
Employer/Respondent

On 3/28/2016, 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 0.44% 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:

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

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

17IWCC0113

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
CORRECTED ARBITRATION DECISION
19(b)/8(a)

SARAH LOUISE CARR
Employee/Petitioner

v.

DAYSTAR CARE CENTER, ET. AL.
Employer/Respondent

Case # 10 WC 08748

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **COLLINSVILLE**, on **January 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. ☐ 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, **October 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 **$18,591.00**; the average weekly wage was **$357.52.**

On the date of accident, Petitioner was **47** years of age, ***married*** with **1** dependent child.

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

Respondent shall be given a credit of $ ***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

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $245.33, the minimum rate allowable under the Act, per week for 54-3/7 weeks, commencing JANUARY 13, 2015 through JANUARY 28, 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.

Signature of Arbitrator

March 28, 2016
Date

MAR 28 2016

STATEMENT OF FACTS

Petitioner brought this case before the Arbitrator based upon a 19(b) request for hearing on TTD, with Respondent disputing an ongoing causal relationship with regard to TTD after January 13, 2015.

The matter was originally tried on a 19(b) hearing request on April 15, 2014 before Arbitrator Lindsay, at which time Petitioner was seeking TTD and medical treatment. In a decision rendered on June 16, 2014 (Arbitrator's Exhibit 2), Arbitrator Lindsay awarded TTD from June 26, 2012 through April 15, 2014, and payment for medical expenses incurred to date, but denied Petitioner's request for prospective medical care. On review the Commission affirmed the award, which was also affirmed on appeal to the Circuit Court. The matter was then remanded back to the Arbitrator.

Based on the information in the Request for Hearing form (Arbitrator's Exhibit 1), the parties stipulated that TTD benefits have been paid through January 13, 2015. The issue at the January 28, 2016 was TTD from January 13, 2015 to the date of hearing.

The Petitioner testified that, since the previous 19(b) hearing held on this matter on April 15, 2014, she has had no further medical treatment. She also testified that she has not sought employment in any way since that time. With regard to weight loss, the Petitioner testified that she has lost weight since the 2014 hearing date, but that her weight has fluctuated up and down. There was no testimony as to her specific current weight.

Her weight is relevant in that, according to the prior final 19(b) decision, the only treatment that had been recommended to Petitioner was weight loss. According to the decision, which is the only evidence the Arbitrator has to rely on in this matter, the Petitioner's lumbar spine problems and the sequelae from same are causally related to the October 3, 2009 accident. The prior decision relied significantly on Respondent's Section 12 examining physician, Dr. Coyle, who initially examined Petitioner on November 22, 2011. This was subsequent to a May 12, 2011 Functional Capacity Evaluation (FCE) that had been ordered by Dr. Fonn, the surgeon who performed September 20, 2010 lumbar fusion at L4/5 and L5/S1. [The Arbitrator notes that the surgical recommendation was for L4/5 and L5/S1 fusion; as the operative report was not specifically noted in the Arbitrator's decision, and was not offered or admitted into evidence, the Arbitrator assumes that the fusion surgery took place at these levels].

It appears that following the November 22, 2011 exam, Dr. Coyne indicated that he disagreed with the fusion surgery Dr. Fonn had already performed. He opined that Petitioner's condition was substantially worse after her surgery, including neurogenic bladder and difficulty walking, and that her symptoms were secondary to the work accident. He further opined that Petitioner at that time was not capable of employment in any reasonable capacity, and that she needed to lose at least 100 pounds (she was 312 pounds at the time) before he would consider performing a revision surgery that might help to improve her condition.

When he reexamined Petitioner on June 20, 2012, Dr. Coyne noted Petitioner's weight remained unchanged. He did not believe Petitioner was at maximum medical improvement pending weight reduction and imaging studies, and he believed she remained incapacitated for work. The Arbitrator notes that the Arbitrator's decision following the prior April 15, 2014 hearing indicated that the record of evidence at that time reflected no further evidence of medical care or treatment to Petitioner after the June 20, 2012 visit to Dr. Coyle.

According to the June 11, 2014 Arbitrator's decision, the May 12, 2011 FCE indicated Petitioner was capable of working at a sedentary physical demand level, but was unable to tolerate an eight hour workday due to severe limitations in functional tolerances. It was noted that some parts of the testing could not be completed due to poor aerobic capacity and endurance, dependency on cardiac medication, dyspnea and high blood pressure.

Finally, the Arbitrator notes that the prior Section 19(b) decision on arbitration reflects that Petitioner has multiple problems, beyond chronic low back symptoms into her legs, which impact her condition. These include: diabetes, anxiety, obesity, fatigue, myocardial infarction, neurogenic bladder, fluid retention, high blood pressure, renal lesion/cyst, possible bilateral carpal tunnel syndrome.

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 ongoing condition remains causally related to the October 3, 2009 accident. The basis for this is that the prior June, 2014 arbitration decision found that there was a causal relationship, which was affirmed on appeal, and no evidence had been presented to indicate that this causal connection ended prior to January 28, 2016. Neither party submitted evidence which would support the termination of a causal relationship.

The Respondent's dispute appears to be based on the Petitioner's failure to lose weight as instructed by Dr. Coyne. The Arbitrator acknowledges that this is a valid argument. The Arbitrator also finds that the Petitioner appears to lost minimal weight, and it appears that effort in this regard may be lacking to some extent. Further, it appears she has not sought any medical treatment since the June 20, 2012 visit to Dr. Coyne.

On the issue of prospective medical, Arbitrator Lindsay stated:

> "It is clear from Dr. Coyle's reports that Petitioner is not at maximum medical improvement and needs to lose a substantial amount of weight before any further treatment recommendations can be seriously considered. Dr. Coyle has recommended a supervised structured weight loss program with a kinetic physical therapy program and a physiatry consultation. However, Petitioner did not ask for any of this to be awarded and to simply award a generic "weight loss program" seems speculative and, perhaps, counter-productive given Petitioner's many medical conditions that need to be factored in along with her previous attempts to lose weight through a variety of different methods. Accordingly, the Arbitrator does not award any prospective medical care at this time." (Arbitrator's exhibit 1, page 16).

While there was some vague testimony from Petitioner in terms of an inability to obtain further treatment due to Respondent not authorizing same, there was no testimony as to exactly what treatment Petitioner is claiming that Respondent disputed and refused to authorize. Additionally, the parties did not make prospective medical treatment an issue at hearing, so, again, it is unclear what treatment Petitioner claims has not been authorized. Instead, it appears that, barring weight loss, Petitioner may be at maximum medical improvement. That is currently a premature determination based on the evidence presented, and is for medical personnel to determine. The best approach to resolve this issue is for the Respondent to authorize a visit to Dr. Coyne to determine Petitioner's current status, given ongoing causation has been found by this Arbitrator.

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:

Given the finding that of the Arbitrator that Petitioner's lumbar condition remains causally connected to the October 3, 2009 accident, and there has been no evidence presented indicating the Petitioner has reached MMI, the Arbitrator finds Petitioner is entitled to TTD from January 13, 2015 to the present, January 28, 2016.

The Petitioner's FCE indicated significant restrictions of sedentary duty for less than an eight hour day. The Arbitrator has not reviewed the FCE report, but also notes Petitioner testified that she is required to sit and stand as needed. Further, Dr. Coyne, Respondent's examining physician, as of June 20, 2012, opined that Petitioner remained unable to work.

That said, this does not take away from the fact that the Petitioner cannot simply do nothing and continue to collect TTD benefits. Should this matter go to another 19(b) hearing, it would be expected that the Petitioner will have determined if further treatment is needed or if she has reached MMI. A failure to do so could result in the Arbitrator determining the issue of MMI at that time. Evidence simply was not presented at this hearing that would allow the Arbitrator to reasonably make such determination in this decision.

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

Kristin Fincham f/k/a,
Kristin Shepley,
Petitioner,

vs. NO: 14 WC 38465

17IWCC0114

Aldi, Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of 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 January 4, 2016 is hereby affirmed and adopted.

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

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

17IWCC0114

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $17,600.00. 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: FEB 21 2017

Joshua D. Luskin

o-01/31/17
jdl/wj
68

Charles J. DeVriendt

DISSENT

I respectfully dissent from the Decision of the majority. I would have found that Petitioner did not sustain her burden of proving that her current condition left carpal tunnel syndrome was caused work activities, reversed the Decision of the Arbitrator, and denied compensation.

Petitioner was employed as a cashier at a grocery store. Her treating surgeon, Dr. Rhodes is board certified in orthopedic surgery and sports medicine. He opined that Petitioner's work as a cashier caused or aggravated her carpal tunnel syndrome because her work was repetitive, the exposure was "borderline," and she had no other non-occupational risk factors such as obesity, diabetes, thyroid dysfunction, or recent pregnancy. He based his opinion on Petitioner's history to him as well as his personal understanding of the job duties of a cashier. He did not review a job description or a video of a cashier's job activities.

Dr. Fakhouri, examined Petitioner pursuant to Section 12 of the Act. He is a board certified orthopedic surgeon with a certification in hand surgery and fellowship in hand/arm microsurgery in 1992. He has since limited his practice to treatment of the hand and arm. Dr. Fakhouri reviewed Petitioner's medical records, reviewed a description of her job, and viewed a video of the job activities of Respondent's cashiers. He opined that Petitioner's carpal tunnel syndrome was not caused by her work activities. Dr. Fakhouri based that opinion on the fact that Petitioner's work activities did not involve the use of vibratory tools or repetitive forceful grasping, which is normally associated with the development of carpal tunnel syndrome. He also noted that carpal tunnel syndrome is one of the most common conditions for a woman of Petitioner's age and that the condition is often idiopathic in nature.

In finding Petitioner proved accident and causation, the Arbitrator found the opinion testimony of Dr. Rhodes more persuasive than Dr. Fakhouri. By affirming and adopting the Decision of the Arbitrator, the majority is confirming that assessment, an assessment with which I disagree. In my opinion Dr. Fakhouri's conclusions were more persuasive than Dr. Rhodes. His expertise was more specifically related to hand surgery, he had a much better understanding of Petitioner's specific work activities, and I agree with his opinion about the importance of vibration and repetitive forceful gripping as a principle cause of carpal tunnel syndrome.

Based on the opinion of Dr. Fakhouri, I would have found that Petitioner did not sustain her burden of proving an accident and a causal connection between her work activities and her carpal tunnel syndrome, reversed the Decision of the Arbitrator, and denied compensation. For these reasons, I respectfully dissent.

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FINCHAM, KRISTIN F/K/A SHEPLEY, KRISTIN Case# **14WC038465**
Employee/Petitioner

ALDI INC
Employer/Respondent

17IWCC0114

On 1/4/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.55% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
SEAN OSWALD
3100 N KNOXVILLE AVE
PEORIA, IL 61603

2674 BRADY CONNOLLY & MASUDA PC
NOAH P HAMANN
211 LANDMARK DE SUITE C-2
NORMAL, IL 61761

STATE OF ILLINOIS)
) SS.
COUNTY OF MCLEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

KRISTIN FINCHAM, f/k/a KRISTIN SHEPLEY
Employee/Petitioner

v.

ALDI, INC.
Employer/Respondent

Case # 14 WC 38465

17IWCC0114

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Bloomington, Illinois**, on **November 24, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS 17IWCC0114

On **5/1/2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 **$7,616.73**; the average weekly wage was **$346.22**.

On the date of accident, Petitioner was **33** 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 **$6,288.36** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$5,625.15** for medical benefits paid, for a total credit of **$11,913.51**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $330.00/week for 43-3/7 weeks, commencing July 7, 2014 through May 6, 2015, as provided in section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $330.00/week for 28.5 weeks, because the injuries sustained caused 15% loss of use of the left hand (carpal tunnel) under Section 8(e) of the Act.

Respondent shall pay reasonable and necessary medical services as laid out in Petitioner's exhibit #12. Respondent is responsible only for the services related to the left hand and those bills are to be paid pursuant to fee schedule.

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

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

Signature of Arbitrator

12/30/2015
Date

ICArbDec p. 2

JAN 4 - 2016

FINDINGS OF FACTS

Petitioner testified that she primarily worked as a cashier for Respondent. Petitioner provided that she worked between 7-1/2 and 8-1/2 hours most days and estimated that 90% to 95% of her time was spent as a cashier. The remaining 5% to 10% of her day was spent cleaning the cash register areas and two bathrooms.

Petitioner testified regarding her job duties. She conveyed that she sits on an adjustable stool at a cash register station. It is adjustable to place her at a comfortable height to access the conveyor belt and register at the station. Customers approach her station and place grocery items on a conveyer belt that is machine operated. The conveyer belt brings grocery items towards her from left to right. Petitioner stated that she helps guide the items down the conveyer belt to her scanner with her left hand. She guides the items with varying strength and force depending on the weight of the items. For instance, items that do not weigh much can be moved along with an open palm, whereas heavier items such as boxes or cases of soda or water have to be pushed or lifted with force.

Petitioner testified that her scanner has a raised lip that is not flush with the conveyer belt. She estimated that the lip is a few centimeters high. She testified that canned goods do not slide over the lip and they have to be picked up with the left hand in order to be scanned. Once items are scanned, she moves them into a shopping cart that is positioned off to her right side. Petitioner testified that she was trained to push the items into the cart with her left hand and catch them with her right hand "so that they don't slam into the shopping cart." She testified that heavy items required her to lift with both hands.

Petitioner testified that she was required to scan 40 items per minute, but that she had difficulty meeting this quota. She testified that she scanned approximately 35 items per minute. Petitioner provided that she was threatened by a shift manager that if she did not increase her scanning rate, she would be terminated. Petitioner testified that the grocery store was very busy and that she often had multiple customers waiting in line, which required her to constantly scan. Petitioner indicated that each transaction was different and some customers required a lot of scanning, while others did not. Petitioner also testified that on occasion she had to manually type commands into a keyboard. She testified that she is right-hand dominant and she would predominantly type with her right hand. Petitioner introduced a job description that she authored and was marked as Petitioner's Exhibit 2. Respondent also offered a written job analysis marked as Respondent's Exhibit 3 as well as a video job analysis marked as Respondent's Exhibit 4. The video job analysis was viewed by the Arbitrator during the arbitration proceeding. The last two minutes of the video are the most pertinent as it depicted cashiering. Petitioner testified that largely the job analysis video is accurate with regards to the physical makeup of her work station and how the scanner operates. Petitioner however testified that the speed of the transactions depicted in the video are much slower than the speed she performed her duties.

Petitioner testified that in February 2014, after the holiday season, she began experiencing hand problems. She provided that her hand symptoms got progressively worse and as a result she sought treatment on May 6, 2014 at Advocate Medical Group's Department of Occupational Health where she saw Dr. Thomas Sutter. Records submitted show Petitioner complained of pain located in the left deQuervain's area. She reported the onset of nine weeks prior and noticed that it was made worse by "using it" and that it improved with rest. After an examination and obtaining an x-ray, which was unremarkable, Dr. Sutter diagnosed left wrist tenosynovitis. Occupational therapy was ordered and Petitioner was placed on restrictions of right-handed work only. (PX3) Petitioner testified that her restrictions were accommodated.

Following a course of occupational therapy at Advocate Bromenn Occupational Therapy Services, Petitioner returned to Dr. Sutter on July 1, 2014. The doctor noted that Petitioner had been in occupational therapy with no improvement. It was noted Petitioner had pain in the left palm and numbness of all five (5) fingers. Dr. Sutter referred Petitioner to orthopedic hand specialist Dr. Jerome Oakey at McLean County Orthopedics. Petitioner's restrictions were also continued. (PX3) Petitioner testified that her accommodations were accommodated through July 6, 2014. She has not worked for Respondent since.

Petitioner initially presented to Dr. Oakey July 17, 2014 with complaints of left wrist pain with associated tingling in the thumb, index and middle finger. The doctor recorded that Petitioner's symptoms had been present for several months without any specific provocative event other than repetitive gripping she does working at Aldi. Dr. Oakey felt that clinically there was evidence of both carpal tunnel syndrome and potential dorsal ganglion cyst. Dr. Oakey returned Petitioner to restricted work and recommended an MRI and an EMG. (PX5)

The MRI was performed on July 30, 2014. The impression was limited to motion. However, findings suggested stress along the dorsal capsule at the radial aspect. It was negative for any ganglion cyst or osseous abnormalities. The EMG when performed on August 13, 2014 was deemed as within normal limits. (PX5)

Petitioner continued with Dr. Oakey. On September 15, 2014, Dr. Oakey recommended a steroid injection which was carried out on that visit. The injection was to Petitioner's left CMC joint. Dr. Oakey noted that carpal boss was one of the potential diagnoses. He stated the injection was both diagnostic and potentially therapeutic. The doctor added that if her pathology was coming from the carpal boss, "I can see where that would be aggravated by the work she describes doing." Petitioner's restrictions were continued and she was to follow-up in two months. (PX5) Petitioner testified that she did not follow with Dr. Oakey after the September 2014 visit. She indicated that she "didn't like the treatment" as she had "pools of blood all over [her] hand."

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Anton J. Fakhouri on October 28, 2014. In his report, dated same, the doctor noted that he performed an examination and reviewed Petitioner's medical documentation. He also noted that he was provided with a cashier job description which he reviewed. Dr. Fakhouri diagnosed left carpal tunnel syndrome. The doctor opined that her condition was not work related as "this is idiopathic carpal tunnel syndrome." Dr. Fakhouri suggested a thyroid profile to rule out an associated condition. The doctor also recommended a comfortable splint and a cortisone injection of the carpal tunnel. He indicated that if one or two cortisone injections were not successful, then surgery was a consideration. (RX1)

Petitioner testified that she next sought treatment with Dr. Blair Rhode. Records submitted show she saw Dr. Rhode on November 5, 2014. Dr. Rhode noted Petitioner presented for consultation of left wrist pain which were secondary to an injury while at work. Dr. Rhode recorded, "…she worked as the lead cashier at Aldi. She spent 7.5 hours per day at the register. She is required to push with her left hand and catch with her right. She would be required to lift cases of pop. She specifically describes the motion of lifting pop as an aggravating motion secondary to the fact that they had to grab the top and lift the cans to prevent it from becoming caught on the conveyor edge. She would then be required to quickly place these items into the cart. She states that she was required to scan 40 items per minute in order to maintain her job…" The doctor added that she had been in her position since September 2013 and that her symptoms developed in May 2014. An examination of the left wrist showed evidence of mild thenar atrophy. There was a positive Phalen's test. The cubital tunnel sign was positive for producing parasthesias in the ulnar distribution. Tinels sign was positive for producing parasthesias in the medial nerve. An examination of the right wrist revealed positive Tinels sign for producing parasthesias in the medial nerve. After performing an examination, Dr. Rhode felt Petitioner demonstrated evidence of left wrist carpal tunnel syndrome secondary to her exposure as a cashier. A repeat EMG was recommended. (PX6)

The EMG study was performed by Dr. Edward Trudeau on November 21, 2014. The study was positive for moderately severe left carpal tunnel syndrome. The doctor noted there was no current evidence of median neuropathy at the right wrist. (PX8)

Petitioner returned to Dr. Rhode on December 3, 2014. Dr. Rhode recommended surgery. The surgery was carried out on December 23, 2014 in the form of a left open carpal tunnel release. (PX6, PX7)

Postoperatively, returned to Dr. Rhode on January 5, 2015. Dr. Rhode recorded that Petitioner had some resolve of her left wrist symptoms. The doctor also noted Petitioner reported noticing increased symptoms in her right hand in the last few months, specifically at night. Dr. Rhode noted Petitioner was doing well postoperatively and felt she would benefit from a course of physical therapy. The doctor also provided her with a brace to wear nightly for her right wrist. (PX6)

Petitioner participated in physical therapy at McLean County Orthopedics per the orders of Dr. Rhode. (PX5) On her return visit to Dr. Rhode on January 28, 2015, the doctor continued to note Petitioner's progress postoperatively. The doctor also noted that Petitioner continued to report right-side symptomatology. As a result, Petitioner received a right wrist carpal tunnel steroid injection. (PX6)

On March 9, 2015, Dr. Rhode recorded Petitioner was having slower than expected improvement as she had significant weakness in the left hand. Dr. Rhode felt that some of this could be residual damage to the medial nerve that Petitioner was complaining of and would take time to heal and improve. Dr. Rhode continued to document Petitioner was also complaining of right-sided symptomatology with nocturnal symptoms. (PX6)

Petitioner continued under the care of Dr. Rhode. By May 6, 2015, Dr. Rhode felt Petitioner was stable relative to her left wrist. Because Petitioner was continuing to complain of right sided symptomatology, Dr. Rhode ordered a repeat EMG/NCV. He also released her to full duty relative to her left hand. (PX6)

Dr. Trudeau performed the prescribed EMG/NCV on May 26, 2015. Dr. Trudeau's interpretation of same was mild to moderately severe right carpal tunnel syndrome. (PX9) On June 6, 2015, Dr. Rhode recommended Petitioner undergo right carpal tunnel surgery. (PX6)

At Respondent's request, Dr. Fakhouri authored an addendum report dated July 20, 2015. (RX2) In his report, the doctor noted that he was provided with the written job analysis and the video job analysis marked as Respondent's Exhibits 3 and 4. Dr. Fakhouri wrote that his review of same did not change his original opinion, stating, "I believe that her carpal tunnel syndrome is idiopathic and it is not related to her work activities."

Dr. Blair Rhode testified via deposition in this matter. Dr. Rhode testified that Petitioner first presented on November 5, 2014 with complaints of a work related left wrist injury which started to develop in May 2014. Dr. Rhode stated Petitioner provided that she worked for Aldi; she spent 7.5 hours per day at the register; she is required to push with her left hand and catch with her right; she would be required to lift cases of pop; she specifically described the motion of lifting pop as an aggravating motion secondary to the fact that they had to grab the top and lift the cans to prevent it from becoming caught on the conveyor edge; she would then be required to quickly place these items into the cart; she was required to scan 40 items per minute in order to maintain her job; and she had been in her position since September 2013. (PX10, pp.5-6)

Dr. Rhode testified that after performing an examination, he felt Petitioner demonstrated evidence of left wrist carpal tunnel syndrome secondary to her exposure as a cashier. Dr. Rhode stated, "It was my feeling that the patient described a highly repetitive motion which included components of her job that she felt was causative." The doctor noted Petitioner's past medical history was negative for diabetes or thyroid dysfunction. She was not pregnant and her BMI was less than 30. (PX10, pp.10-11, 24)

Dr. Rhode testified that he ordered a repeat EMG which when completed was positive for carpal tunnel syndrome at the left wrist with no evidence of median neuropathy at the right wrist. (PX10, p.14) Dr. Rhode stated that inasmuch as Petitioner had previously failed conservative measures, surgery was recommended and carried out on December 23, 2014. (PX10, p.17)

Dr. Rhode's testimony shows that Petitioner continued treating for her left wrist through May 6, 2015. At that time he advanced her to full duty for the left wrist. Dr. Rhode testified that during that period, Petitioner was seen at his office on January 5, 2015 wherein Petitioner complained of increasing symptomatology in the right hand, especially at night. Petitioner was placed in a splint for the right hand. Dr. Rhode subsequently ordered a EMG of the right wrist. At the time of the deposition, the EMG results were not available. Dr. Rhode however testified that he believed Petitioner was a candidate for right carpal tunnel release. (PX10, pp.18-23) Dr. Rhode stated that the fact that Petitioner did not complain that her right hand symptoms got worse until she stopped working, same would support that Petitioner's right hand condition is not work related. He added that because she did not complain of right hand symptoms until after the left hand surgery, same would support a non-causal relationship. (PX10, pp.36-37) Lastly, the doctor stated that he did not view the job analysis video and that he relied largely on Petitioner's description of her job duties. (PX10, pp.43-44)

Dr. Anton Fakhouri testified via deposition in this matter. Dr. Fakhouri testified that he performed a Section 12 examination of Petitioner on October 28, 2014 and subsequently reviewed a written job analysis as well as a video depicting Petitioner's duties as a cashier. The doctor stated that after obtaining a history, reviewing records and performing an examination, he diagnosed Petitioner with left carpal tunnel syndrome. He testified that Petitioner's diagnosis was not related to her work activities. The doctor explained, "..because we know that carpal tunnel syndrome is one of the most common conditions for women in her age group and often times it's idiopathic…The duties that were described both on paper as well as the duties that I saw on video, they do not cause carpal tunnel syndrome" The doctor added, "The duties that we hear about as it relates to a job are more with activities such as vibratory tools, jackhammers and so forth and so on." (RX5, pp.12-13)

On cross-examination, Dr. Fakhouri was asked about his opinions regarding aggravation. When asked if he did not think that there was an increase in her symptoms as a result of her work activities, the doctor replied, "No, I can't say about her symptoms. Symptoms are subjective…so in my opinion, the activities that I saw don't necessarily increase the symptomatology as long as she wears a carpal tunnel splint." Dr. Fakhouri stated that his opinion was not based solely on the video he saw. He indicated it was a combination of talking to Petitioner, his review of the records, his experience and the understanding of the literature. The doctor added that "…jobs like described by [Petitioner] are not a risk for developing carpal tunnel syndrome…" (RX5, pp.19-20) In response to a hypothetical question, the doctor stated it was possible that flexing at a rate of forty times per minute throughout an entire workday and then spread out over weeks could potentially be a factor that could contribute to the development of carpal tunnel syndrome. He further explained that it was more grasping-type activities and it depended on force, not just simply bending and extending the wrist without any force. (RX5, pp25-26)

Ms. Dee Bressner testified on behalf of Respondent in this matter. Ms. Bressner testified that she works as the store manager at the location where Petitioner worked. She was Petitioner's supervisor and she has worked for Aldi for more than 20 years. Ms. Bressner provided that she has worked and continues to work as a cashier. She testified that the written job analysis and video job analysis offered by Respondent as Exhibits 3 and 4 are accurate.

Ms. Bressner testified that she "can't say" that Petitioner's description regarding how she performs her cashier duty was inaccurate. She agreed that the registers have a "lip" and that some registers have more of a "lip" than others. Ms. Bressner testified that employees are trained to push items with their left hand, scan the

item, and then use the right hand to place same into shopping carts. Ms. Bressner testified that an employee can swipe items without grasping the item. She conceded that heavier items require grasping and lifting. Lastly, Ms. Bressner, testified that scanning 40 items per minute was the target goal at the time of the accident but that it has been subsequently changed to 1200 per hour or the equivalent of 20 per minute.

Respondent offered Petitioner's time cards as Respondent's Exhibit 6. The time cards span from the September 10, 2013 date of hire through the May 1, 2014 manifestation date. When her total hours are averaged over that 33 week period of time, she worked approximately 30 hours per week.

Petitioner testified that she has not treated with Dr. Rhode, or any providers, since June of 2015.

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 repetitive trauma claims, the issues of accident and causation are intertwined to the point where they need to be analyzed together.

The alleged repetitive trauma was the repeated scanning of items while working as a cashier at Aldi Foods. Petitioner testified that she had to repetitively grasp and lift items over a small lip and then slide them across scanning them running her arm repeatedly. Petitioner spent 95% of her time as a cashier. No testimony was offered by Respondent's witness to contradict the assertion that she spent 95% of her time cashiering. Petitioner's unrebutted testimony demonstrated that the nightly reviews that she received indicated that during the duration of her shift she scanned 34 to 35 items per minute and that she was encouraged to try to make the goal of 40 items per minute. Respondent's witness, Ms. Dee Bressner, the store's general manager, testified that 40 items per minute was the target goal at the time of the accident but that it has been subsequently changed to 1200 per hour or the equivalent of 20 items per minute, thus cutting the goal in half. Ms. Bressner did not dispute Petitioner's claim that she had scanned or had been scanning an average of 34 to 35 items per minute during the course of her work days. Assuming 34 items per minute and assuming 7 1/2 hour shifts and 95% of the time scanning that would have been an average of 14,535 items scanned per day. It is uncontested by Ms. Bressner, or the video, that the scanning was done almost exclusively with the left hand with some lifting and/or catching of items done with the right hand. Petitioner testified that she was right-hand dominant that her work injury was related to her left hand.

While there was some dispute as to how much grasping is done with the items, it was agreed that some items would fall over the lip and might need to be picked up. Petitioner's unrebutted testimony was that she did repeatedly grasp those items and that it required her to use a moderate amount of force to grasp each item. Respondent's witness did not dispute that this was the way in which Petitioner performed her job. Given that there were no disputes arising out of the way in which Petitioner performed her job duties or with regard to the number of repetitions which she performed them and given the fact that she was performing in excess of 14,000 repetitions per shift for a period of approximately 8 months before her condition arose to the point that she sought medical treatment, the Arbitrator finds that this constitutes an accident of repetitive trauma as defined by the Worker's Compensation Act.

As noted above, closely linked to the issue of accident in any repetitive trauma claim is the question of causation. Given the undisputed testimony of Petitioner, it is clear that Dr. Rhode's opinion was better informed with regard to what Petitioner actually did. The testimony of Dr. Rhode is further supplemented by the medical records from McLean County Orthopedics in which Dr. Oakey sought authorization from workers compensation to proceed forward with the opinions. A reasonable assumption can be made since Dr. Oakey sought authorization from workers compensation before proceeding forward with further treatment that he believed the

condition was a work-related condition. On September 15, 2014, Dr. Oakey recommended a steroid injection which was carried out on that visit. The injection was to Petitioner's left CMC joint. Dr. Oakey noted that carpal boss was one of the potential diagnoses. He stated the injection was both diagnostic and potentially therapeutic. The doctor added that if her pathology was coming from the carpal boss, "I can see where that would be aggravated by the work she describes doing."

Dr. Rhode testified that he believed that Petitioner's condition of ill-being in her left upper extremity was causally related to the work activity. He testified to an understanding of the job duties performed and had viewed Petitioner's Exhibit 2.

In contrast to the opinion of Dr. Rhode, Dr. Fakhouri opined Petitioner's left wrist diagnosis was not related to her work activities. The doctor explained, "..because we know that carpal tunnel syndrome is one of the most common conditions for women in her age group and often times it's idiopathic…The duties that were described both on paper as well as the duties that I saw on video, they do not cause carpal tunnel syndrome." The doctor added, that although it was possible that flexing at a rate of forty times per minute throughout an entire workday and then spread out over weeks could potentially be a factor that could contribute to the development of carpal tunnel syndrome, he further explained that it was more grasping-type activities and it depended on force, not just simply bending and extending the wrist without any force. Curiously, when the doctor was asked if he did not think there was an increase in Petitioner's symptoms as a result of her work activities, the doctor replied, "No, I can't say about her symptoms. Symptoms are subjective…so in my opinion, the activities that I saw don't necessarily increase the symptomatology as long as she wears a carpal tunnel splint." This statement implies a potential relationship between Petitioner's job activities and her left carpal tunnel syndrome diagnosis. Also, Dr. Fakhouri's opinion, in part, was based upon the job analysis description. A review of analysis does not show the number of repetitions required to be performed by Petitioner in the course of her employment. Additionally, Dr. Fakhouri's opinions were based upon the video of the job. There was uncontested testimony that the video did not display the pace at which the job is performed and therefore is not illustrative of the actual job being performed by Petitioner.

Based on the above, the Arbitrator is not persuaded by the opinion of Dr. Fakhori and instead relies on the opinion of Dr. Rhode. As such the Arbitrator finds that that a causal relationship exists between Petitioner's job duties as a cashier and the condition of ill being in her left wrist. The Arbitrator notes that it's unclear if Petitioner is claiming that her right wrist condition of ill-being is causally related to her employment with Respondent. Nevertheless, relying on the opinion of Dr. Rhode, the Arbitrator would find that she failed to prove a causal relationship between said extremity and her employment with Respondent. Dr. Rhode specifically stated that because Petitioner did not complain that her right hand symptoms got worse until she stopped working and she did not complain of right hand symptoms until after the left hand surgery, same would support a non-causal relationship.

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, the Arbitrator finds as follows:

Having found the requisite accident and causal relationship to Petitioner's left hand, the Arbitrator awards the medical bills as set forth by Petitioner's Exhibit 12. The Arbitrator notes Respondent is responsible only for the services related to the left hand and those bills are to be paid pursuant to fee schedule. Respondent is entitled a credit for payments made.

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

Petitioner was placed in an accommodated position from May 21, 2014 through July 6, 2014. She was paid temporary total disability benefits from July 7, 2014 through November 3, 2014. Thereafter benefits were stopped following a Section 12 opinion from Dr. Anton Fakhouri. Petitioner began treating with Dr. Rhode on November 5, 2014. Petitioner continued treating for her left wrist through May 6, 2015, at which time Dr. Rhode advanced her to full duty for the left wrist.

Based on the above and having found that Petitioner's left carpal tunnel syndrome is causally related to her employment with Respondent, the Arbitrator finds that Petitioner was temporarily totally disabled from July 7, 2014 through May 6, 2015.

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

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 most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment"; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; (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. 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)

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains no impairment rating and therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner was employed as a cashier at the time of the accident. She was ultimately advanced to full duty work regarding her left wrist/hand. The Arbitrator gives some weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 33 years old at the time of the accident. Because of the length of time Petitioner will live with her permanent disabilities, the Arbitrator gives some weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that no evidence was presented to show the impact on Petitioner's future earnings capacity. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that when Petitioner last saw Dr. Rhode on June 6, 2015, the doctor recorded that Petitioner was stable relative to her left wrist. An examination showed pain was elicited over the palm during palpation. At arbitration, Petitioner testified that the surgery provided some relief although she still has "issues." Petitioner's testimony is consistent with the treating records. The Arbitrator therefore gives some weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 15% loss of use of the left hand pursuant to §8(e) 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

David Van De Warker,
Petitioner,
vs.

NO: 14 WC 21124

Vactor Manufacturing,
Respondent,

17IWCC0115

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 care, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 8, 2015, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $2,400.00. 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: FEB 24 2017
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DLG/mw
045

David L. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

VAN DE WARKER, DAVID
Employee/Petitioner

Case# **14WC021124**

VACTOR MANUFACTURING
Employer/Respondent

17IWCC0115

On 10/8/2015, 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 0.06% 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:

0190 LAW OFFICES OF PETER FERRACUTI
TRAVIS DUNN
110 E MAIN ST
OTTAWA, IL 61350

1120 BRADSY CONNOLLY & MASUDA
MARK VIZZA
10 S LASALLE ST SUITE 900
CHICAGO, IL 60602

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

DAVID VAN DE WARKER
Employee/Petitioner

v.

VACTOR MANUFACTURING
Employer/Respondent

Case # 14 WC 21124

Consolidated cases: N/A

17IWCC0115

An *Application for Adjustment 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 **Kankakee**, on **September 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. ☐ 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 the date of accident, **3/26/2013**, 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 **$27,465.64**; the average weekly wage was **$773.68**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **no** dependent children.

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

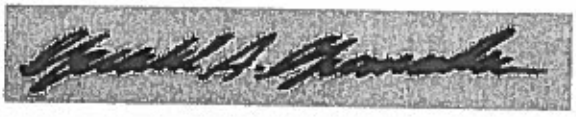
Respondent is entitled to a credit of **$9,880.24** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $464.20/week for 5 weeks, because the injuries sustained caused the 1% 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

10/6/15
Date

OCT 8 2015

17IWCC0115

FINDINGS OF FACT

This case involves a petitioner alleging injuries to his left arm sustained while working for the Respondent on March 26, 2013. (See. Arb. Exh. 2) At hearing, the issues in dispute were the following: 1) causation, 2) average weekly wage, 3) medical expenses and 4) nature and extent. (Scc Arb. Exh. 1)

The petitioner testified that in March 2013 he worked at respondent for 24 years. He was a welder. On March 26, 2013 he was pulling an air hose attached to a grinder when it jerked and pulled his shoulder. He felt a snap in his shoulder. It started aching. The Petitioner testified he reported this to his supervisor, Art Zimmerman. He was able to continue working that day. He was sent to see Dr. Garg the next day or the day after that. He was released to full duty by Dr. Garg. He still had an aching. The pain varied and got worse. He was prescribed physical therapy and a home exercise program.

In August 2013 he went to McLean Orthopedics. He believes his arm got worse before he went to McLean. Dr. Norris at McLean Orthopedics tried an injection. His shoulder did not improve with the injection. In January 2014 he underwent an MRI and Dr. Norris performed surgery in February 2014. He felt better after the surgery. After the surgery he retired.

The Petitioner testified he worked full duty from the time of the injury until he went off work for the surgery on February 14, 2014. The Petitioner testified he used to golf before the injury but no longer golfs. He testified that he owns a thrift store and works at the thrift store. Between the time of the accident and the surgery, he worked at the thrift store and sometimes he would have to move objects at the thrift store.

The Petitioner testified that he did his job standing up and welded objects on a table that was approximately waist height. He testified that when he was pulling the air hose, he was pulling at approximately shoulder level. After the accident he had no problem performing his regular duties. He didn't miss any time from work between the date of the accident and the date of his surgery. The Petitioner testified he was seen by Dr. Lieber for a Section 12 examination. He testified that Dr. Podzamsky is his family doctor and he treated with Dr. Podzamsky in September and December of 2013, but not for his shoulder.

Dr. Joseph Norris testified through deposition. He testified he is a board certified orthopedic surgeon who specializes in sports medicine and arthroscopy. He testified that he first saw the Petitioner on August 12, 2013. At that time, the patient was complaining of left shoulder pain and thought he strained his shoulder while at work. He was complaining of weakness, popping and clicking. The doctor felt there was a problem with the biceps tendon and subacromial impingement. He injected the biceps tendon in the subacromial space. He recommended home exercise program and physical therapy. He next saw the petitioner January 28, 2014 and the patient stated he had no relief from the injections. The doctor recommended an MRI which was done that showed the full thickness tear of the supraspinatus, SLAP tear, which is a tear of the superior labrum. He recommended subacromial decompression, rotator cuff repair and biceps tendonotomy. That surgery was performed on February 14, 2014. The patient saw the doctor on April 28, 2014 and was complaining of some persistent discomfort, but its motion was progressing. The doctor injected the biceps groove at that time.

On June 2, 2014 the patient was doing excellent and he was back to his former activities. Dr. Norris' records indicate that the date of onset was March 27, 2013 when the patient strained his shoulder at work. The fact that the patient continued to work for five months afterwards would not affect his decision regarding causal connection. What would be of interest to him was whether or not the Petitioner had any symptoms or

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complaints before the accident and what his symptoms were between the date of the accident and the first time he saw him. Certain tests were performed by Dr. Norris which were negative, but those are only accurate 60% of the time.

Lawrence Lieber, M.D. testified through deposition. He testified that he specializes in orthopedic surgery and did a fellowship in sports medicine, as well as in arthritis and total joint replacement surgery. As part of his practice, he normally operates on the shoulder and the arm. He performed an independent medical evaluation of petitioner. He took a history from the petitioner. He was given a history of the work-related injury on March 26, 2013. The petitioner stated he was pulling an air hose with a grinder attached, the hose snapped, and he felt pain and a pop in his left shoulder. The petitioner told the doctor he was pulling the air hose at chest level and his arm was jarred with the activity. He told the doctor he had no further treatment until approximately five months later when he saw Dr. Norris in August. He had an injection and eventually surgical intervention by Dr. Norris. At the time Dr. Lieber saw the petitioner, he had no discomfort in his shoulder and no swelling and no stiffness or difficulty with overhead activities. He did complain of occasional weakness in his left shoulder, as well as pain at night. The petitioner indicated that his employment was that of a welder which required him to stand, bend, push, pull heavy objects, lift up to 100 pounds on a consistent basis, as well as overhead. His examination of the petitioner showed he was doing quite well concerning functional abilities in his left shoulder and he did show stiffness at the extremes in motion, but otherwise had a basically normal exam. Dr. Lieber testified he reviewed the medical records of St. Mary's Hospital and Dr. Norris. After his examination of the patient and his review of the medical records, it was his opinion that the patient was status post arthroscopy subacromial decompression rotator cuff repair, AC joint resection and biceps tendonotomy of the left shoulder. Based upon his review of the records, the history and his physical examination, he found that there was no relationship between the March 2013 work activity and the patient's present left shoulder complaints and surgical intervention that was performed in February 2014. He felt there was no objective evidence that the isolated rotator cuff repair and subsequent surgery had any relation to the March 2013 work event.

Dr. Lieber felt the mechanism of injury did not appear to have been significant enough to cause a rotator cuff tear. His opinion was based on the lack of treatment, other than initial evaluation in the Emergency Room, for up to five months due to the lack of significant symptoms about the left shoulder. He also testified that the MRI showed evidence of pre-existing degenerative abnormalities of the shoulder that showed no evidence of any acute injury that would be associated with the March 2013 event.

Regarding the mechanism of injury, Dr. Lieber felt that since the patient told him he was pulling the air hose at chest level, he didn't feel the force across the arm and just jarring in that manner would not have been significant enough to cause the damage that was present during the operative report. As to the lack of treatment, Dr. Lieber noted this was significant because if the rotator cuff tear and SLAP tear were in direct association with the March 2013 event, then those conditions would have caused significant pain, swelling, dysfunction and disability that would not have allowed the petitioner to carry on his activities in most of all daily living, and certainly his work activities would have been affected. The fact that the petitioner worked five months after the event supported his opinion. It is his testimony that nothing that was found in Dr. Norris' operative report would be related to the incident in March 2013.

The records of St. Mary's Hospital from 8/20/13 show that the patient injured himself on March 27, 2013 when pulling a hose. The patient reports aching a few months prior to the injury.

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CONCLUSIONS OF LAW

1. With regard to the issue of causation, the Arbitrator finds that the Petitioner's current condition of ill-being is in part due to the undisputed March 27, 2013 work accident. Specifically, the Arbitrator finds that as a result of his work accident, the Petitioner sustained a strain to his left arm. Furthermore, the Arbitrator finds that the surgery performed by Dr. Norris on March 14, 2014 is not related to any accident arising out of and in the course of the Petitioner's employment with the Respondent. These findings are supported by the Petitioner's testimony and the medical evidence. The Petitioner testified that when the accident occurred, he was pulling the air hose at shoulder level or slightly below. He told Dr. Lieber that he was pulling the air hose at chest level. Dr. Lieber's opinion (Respondent's Exhibit 5) was that pulling an air hose at chest level would not cause or aggravate a rotator cuff tear. (Respondent's Exhibit 5) Both Dr. Norris and Dr. Lieber testified that if the patient had complaints prior to this incident, it would show that the accident on March 26, 2013 did not cause or contribute to the Petitioner's rotator cuff injury. Respondent's Exhibit 3 shows that the Petitioner was having aching in the shoulder a few months prior to the injury. The Petitioner testified he was able to work his full job from the date of the incident through the date of the surgery, March 14, 2014. Dr. Lieber testified that the patient told him he did pulling and lifting up to 100 pounds and did overhead work. It was Dr. Lieber's opinion that if the patient had a torn rotator cuff, he would not be able to do these activities. (Respondent's Exhibit 5) Dr. Norris testified that people have a different threshold of pain, but Dr. Norris did not address the issue of whether or not the Petitioner would have been physically capable of doing those activities with a torn rotator cuff. Based on these facts, the Arbitrator finds persuasive the opinions of Dr. Lieber and concludes that the Petitioner sustained a strain to his shoulder on the alleged accident date.

2. Regarding the issue of average weekly wage, the Arbitrator concludes that the Petitioner's average weekly wage at the time of his accident was $773.68. On this issue, the only evidence presented was Respondent's Exhibit 7 which were wage records for the year preceding the accident. Those records show that the Petitioner's average weekly wage was $773.68. The Petitioner offered no documentary evidence or testimony regarding the average weekly wage.

3. With regard to the issue of medical expenses, the Arbitrator finds that the Petitioner's medical treatment was not all related to his condition. The Arbitrator finds that the bill from Oak Lawn Radiology Imaging for a date of service March 28, 2013, a bill from St. Mary's Hospital from March 28, 2013 and April 4, 2013 to be related to the accident arising out of and in the course of Petitioner's employment with Respondent on March 26, 2013. Those bills show a zero balance as they were paid by the Respondent. The remaining bills contained in Petitioner's Exhibit 1 are not related to the accident arising out of and in the course of the Petitioner's employment with the Respondent and therefore are not the responsibility of the Respondent.

4. 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. Per 820 ILCS 305/8.1b(b), the criteria to be considered are as follows: (i) the reported level of impairment pursuant to subsection (a) [AMA "Guides to the Evaluation of Permanent Impairment"]; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. Applying this standard to this claim, the Arbitrator first notes the following:

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(i) no permanent partial disability impairment report and/or opinion was submitted into evidence, therefore the Arbitrator gives no weight to this factor;

(ii) petitioner was employed as a welder at the time of the accident, retired from this employment for reasons not related to this injury, and because the Petitioner no longer works as a welder, the Arbitrator gives little weight to this factor;

(iii) the petitioner was 59 years of age at the time of the accident and because of the petitioner's subsequent retirement, the Arbitrator gives some weight to this factor;

(iv) no evidence was presented regarding petitioner's future earning capacity as he had retired following this injury, and therefore the Arbitrator gives no weight to this factor; and

(v) there was some evidence of disability corroborated by the treating medical records, which show the Petitioner sustained a sprain to his left shoulder, after which the petitioner was released to return to work full duty and has made an excellent recovery – all of which the Arbitrator gives greater weight in factoring the petitioner's permanent partial disability.

Based on the above, the Arbitrator finds that the petitioner sustained permanent partial disability to the extent of 1% loss of use of man as a whole pursuant to 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

Robert Armes,
Petitioner,

vs.

NO: 08 WC 17563

Monterey Coal Company,
Respondent,

17IWCC0116

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of occupational disease, permanent partial disability 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 31, 2016, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $13,200.00. 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: FEB 24 2017
o020917
DLG/mw
045

David L. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ARMES, ROBERT
Employee/Petitioner

Case# **08WC017563**

MONTEREY COAL COMPANY
Employer/Respondent

17IWCC0116

On 5/31/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Robert Armes
Employee/Petitioner

v.

Monterey Coal Company
Employer/Respondent

Case # 08 WC 17563

Consolidated cases: N/A

17IWCC0116

An *Application for Adjustment 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 **4/15/16**. 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. ☐ 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 **12/03/07**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner was last exposed to the coal dust and fumes arising out of and in the course of employment.

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

In the year preceding the last date of exposure, Petitioner earned an average weekly wage of $**871.92.**

On the last date of exposure, Petitioner was **53** years of age, ***married*** with **0** dependent children.

ORDER

Petitioner suffers from occupationally related asthma.

Petitioner is permanently partially disabled to the extent of 5 % Person As A Whole.

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

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

D. Dylan McCarty

Signature of Arbitrator

5/23/2016

Date

MAY 31 2016

FINDINGS OF FACT 17IWCC0116

Petitioner was born on December 2, 1954. He graduated from Raymond-Lincolnwood High School and received a journeyman certificate from a trade school, Midwest Tech. He worked 30 years as an underground coal miner. He was exposed to coal dust and silica dust. He was also exposed to roof bolting glue fumes when they had it. He was also exposed to diesel fumes and smoke from belt fires. His last day working at the mine was December 3, 2007. He was working for Respondent. At that time, his job classification was a pumper. He fueled machines and also cleaned out the Johnny on the Spots underground. He did breathe coal dust on that day. At the time he last worked, the machines he drove had no suspension and they beat him to death. He recalls some surgery done on his shoulder but is not sure. He was having difficulty breathing at that time. He did not seek other coal mine employment. After leaving mining, Petitioner indicated he tried to find some small jobs. He had the option to go to school so he did go to welding school in Springfield. He then opened a welding shop for about two years. He did not have much business. Last fall he started working for a local farmer driving a truck to the elevator and back. He makes $12.00 an hour doing that. He also does some cleaning at the KC Hall in Raymond after a reception. He makes $200.00 for that. This year he has had three and in a normal year he has six.

Petitioner started his coal mine employment on August 21, 1978 for Respondent. He stayed with Respondent his whole career. He started out as an inside laborer. Basically that was doing everything away from the face area. He remembers shoveling belts a lot. There is a lot of dust on the belts. Utility work is at the face. This involves hanging curtains to direct airflow and rock dusting. As a utility man you do anything they tell you to do. At times he might run a roof bolter and at times, a scoop. Roof bolting involves drilling into the ceiling so there could be a lot of rock dust. After starting out as an inside laborer, he got a utility job for about 10 years. He was at the north portal until they closed it and moved everything back to the main portal. When they did that, he was back to the inside laborer classification. He indicated everything was involved with that classification. He could be doing outby dusting, rock dusting or pod dusting. Eventually he became a pod duster. This involves shooting dust as you drive along. Petitioner noted exposure to both the diesel fumes and the rock dust. Petitioner never used roof bolting glue pins, but was around them. His last job classification was a pumper. That involved fueling up the diesel machinery underground. This would be everything away from the face. Additionally, he would go in and pump out the Johnny on the Spot toilets and clean them and then fill them back up. When fueling the diesel machines, he was exposed to diesel fumes. He first noticed breathing problems when he was about 49 years old. His breathing became more labored. The problems for a while got worse and then they plateaued because he started taking several different medications. Presently, he can walk up to about a quarter mile and then he starts getting labored. He has an emergency inhaler if he needs it. After two flights of stairs, he gets winded.

Petitioner is on medications of Advair 500 and Spiriva. He also has Ventolin as the emergency inhaler. Petitioner indicated that certain things he cannot do very long because of his breathing. With regard to the four acres he has to mow, the trimming is done with a push mower. He is out of breath doing it after 15 to 20 minutes. Any kind of work causes problems. He has started back up at a gym in Hillsboro. Petitioner noted that with high humidity he has to stay inside. His grandkids are getting too big to pick up and carry. Petitioner indicated he never smoked cigarettes. He does have high blood pressure and Type II diabetes. The first time he had blood clots was when he was in his 20's. He had blood clots again when he turned 49. He was told his lungs were full of blood clots. He is now on Coumadin. Petitioner indicated that he retired about four weeks before the mine actually closed. Since then he has had both of his knees replaced. He thought probably in 2013.

Dr. Paul examined Petitioner on July 16, 2008. Dr. Paul indicated that Petitioner had a pulmonary embolism five years prior to the examination, which is a clot coming from the legs and lodging in the lungs. This causes decreased blood flow to the lungs. The history was that Petitioner's asthma began five years prior to Dr. Paul's examination. That did not have anything to do with the pulmonary embolism. Dr. Paul diagnosed coal workers'

pneumoconiosis. Dr. Paul also diagnosed asthma. He noted that there are exposures in the coal mine environment that can cause or aggravate occupational asthma. The doctor testified that Petitioner's asthma could be related to the exposures in the coal mine environment. With asthma, there is no way to know for sure what caused it. With regard to the pulmonary function study, Dr. Paul indicated that there was a moderate restriction. With regard to obstruction, Dr. Paul indicated that it was an estimate and it might be mild. With a diagnosis of asthma, the obstructive defect could be worse some days and less on other days. Dr. Paul indicated that Petitioner could not have any further exposure to coal mine dust without endangering his health. He agreed that further exposure to coal dust would put Petitioner at risk for disease progression, but that such progression would not be guaranteed. Dr. Paul felt Petitioner had clinically significant pulmonary impairment caused by coal workers' pneumoconiosis and asthma. He also had physiologically significant pulmonary impairment from coal dust exposure. Dr. Paul felt that some days Petitioner could do light work and some days he would have to be sedentary. Dr. Paul agreed that with asthma, a pulmonary function study on one particular day would not necessarily be the worst or best the person could do. Dr. Paul indicated that he did not diagnose emphysema or chronic bronchitis.

Dr. Paul found wheezes on his physical examination of Petitioner's chest. He indicated that this finding might not be there if he examined Petitioner a month later. The doctor indicated that Petitioner is obese. At the time of a pulmonary embolism, Dr. Paul indicated that Petitioner would have shortness of breath. Once the clot is cleared, the patient is ok. However, he may be at risk for more clots. Dr. Paul indicated that the computer indicated on the pulmonary function test form that there was poor test performance. Dr. Paul indicated that the test was not performed poorly.

Dr. Henkle first saw Petitioner in 2003 on referral from Dr. Epplin. That had to do with pulmonary embolisms. He has seen him intermittently since. Dr. Henkle felt that Petitioner has asthma and that this was caused in part or aggravated and made worse by coal mine exposures. Further exposure would present a risk to Petitioner's health. Dr. Henkle also indicated that Petitioner has an obstructive ventilatory defect which was caused in part or aggravated and made worse by coal mine exposures. He would also be at risk with further exposure for a worsening of his obstructive defect. Dr. Henkle indicated that Petitioner had restrictive pulmonary disease but did not know the cause or any risk factor. He was more focused on Petitioner's obstructive problem because that was more important than any restrictions. Dr. Henkle indicated that Petitioner's asthma lung function abnormalities do not fully reverse with bronchodilators so that he may have COPD. He thought it was certainly possible that COPD might have been caused in part or aggravated in part by mining. There would be a risk with regard to the COPD to return to a coal mine environment. With regard to coal workers' pneumoconiosis, the doctor indicated that he had not seen radiographic evidence. Dr. Henkle felt that Petitioner probably did not have the pulmonary capacity to perform the manual labor of a coal miner.

Dr. Henkle agreed that his office note of November 6, 2012 indicated that Petitioner was a former smoker. Other places it indicates that he never smoked but the doctor did not know for sure. Dr. Henkle did not believe Petitioner had any residuals from the 2003 pulmonary embolism. The decreases seen on the pulmonary function study are not related to the pulmonary embolism. Dr. Henkle indicated that GERD can certainly cause respiratory symptoms that mimic asthma or COPD. Dr. Henkle felt that Petitioner was overweight and that it could cause him to feel short of breath with activity. In February of 2012, Dr. Henkle saw Petitioner with worsening shortness of breath and paroxysmal cough. The doctor thought this was largely related to asthma but wondered if reflux was contributing to the respiratory symptoms. Dr. Henkle indicated that welding with certain substances or in a poorly ventilated area can cause problems. With proper ventilation, there are not a lot of respiratory problems. Dr. Henkle indicated that the restrictive disease could be related to his weight. With some seasonal symptoms and rhinitis, Dr. Henkle indicated Petitioner could have allergies. This could affect his asthma and cause it to worsen.

In January of 2007, Dr. Henkle indicated that Petitioner was complaining of shortness of breath with activity and it sounded like general fatigue and weakness rather than true dyspnea. In February of 2007, the doctor indicated that the respiratory symptoms were due to general debility related to his back pain. The multiple pulmonary function studies done in conjunction with Dr. Henkle's treatment were fairly similar. He noted a total lung capacity of 77% which would be a mild lung restriction or borderline for lung restriction. 80% would be considered the low end of normal. The doctor said that some people go a little lower for normal. The doctor agreed that most of the pulmonary function results would put him in the mild category. He agreed that it is possible that Petitioner could perform the duties of a coal miner even with a mild to moderate reduction. The doctor indicated that Petitioner was a coal miner for many years. Dr. Henkle found a note indicating that there was a positive Methacholine test. This was part of the reason for the diagnosis of asthma.

Petitioner was evaluated by Dr. Tuteur for Respondent on October 23, 2009. Petitioner provided a history to Dr. Tuteur of pleurisy shortly after undergoing surgery on a knee. Following this, he had intermittent bouts of wheezing and chest tightness, which would be exacerbated when exposed to dust and tobacco smoke. At its worst, wheezing, cough, expectoration and chest tightness develop. He was able to continue working in the coal mine industry. Petitioner reported that in the mid-1990's he was prescribed Advair and Albuterol. He also reported the pulmonary emboli developing in 2003. Petitioner described shortness of breath and paroxysmal cough when he assumed the supine position. Dr. Tuteur noted a long history of heartburn and gastroesophageal reflux (GERD). Dr. Tuteur noted that the material in the stomach when standing or sitting has gravity on the side of keeping the material in the stomach. However, if one is supine, gravity is not a factor so that the reflux occurs. This can be aspirated in part into the lungs causing cough and shortness of breath. Dr. Tuteur agreed with Dr. Henkle that GERD can cause respiratory symptoms which mimic asthma or COPD. Dr. Tuteur felt Petitioner was about 70 pounds too heavy. With any activity and an extra 70 pounds, this would produce more symptoms and may limit the distance one could walk.

Dr. Tuteur indicated that Petitioner performed exercise during the course of the examination and that the oxygen saturation level was normal during that exercise. The FEV1 was measured before and after the exercise and it was stable. In some persons with bronchial reactivity or asthma, a fall of FEV1 occurs after exercise. The arterial blood gas study was normal both at rest and with exercise. The pulmonary function study revealed a restrictive ventilatory defect but this was not because of a pulmonary parenchymal problem. Dr. Tuteur indicated that maybe the overweight status contributed and maybe the history of pleurisy contributed. He noted there was no interstitial lung disease responsible for the reduction of the total lung capacity. On physical examination, Dr. Tuteur found a prolonged expiratory phase and some scattered wheezing. The spirometric portion of the pulmonary function study revealed some air flow obstruction. With a bronchodilator, there was significant improvement of the FEV1. The x-ray films did not reveal any evidence of coal workers' pneumoconiosis. The chest CT films showed no evidence of an interstitial process consistent with coal workers' pneumoconiosis. Dr. Tuteur noted an exaggerated narrowing of the tracheal lumen consistent with a condition called tracheo-bronchial collapse syndrome. With expiration, the airway will collapse and exaggerate obstruction. This would be due to Petitioner's recurrent GERD with aspiration. Additionally, the doctor noted the pleurisy and the granulomatous disease or fungal infection. Dr. Tuteur felt that the tracheo-bronchial collapse syndrome would be responsible for the airflow obstruction noted on the pulmonary function study. With the significant improvement after the administration of the bronchodilator, Dr. Tuteur indicated Petitioner may have some reversible airways disease in association with the inflammation caused by these factors. The physical examination findings also fit in with this syndrome.

Dr. Tuteur indicated he found no evidence to support a diagnosis of coal workers' pneumoconiosis. He did not find any evidence of an occupational lung disease. Dr. Tuteur indicated that if Petitioner could not perform the tasks of a coal miner at the time of his examination, it is not because of impairment of pulmonary function.

With regard to the medical records from Dr. Epplin, the Arbitrator notes that Petitioner seldom had any complaints with regard to breathing problems. The diagnoses of asthma and COPD appear in Dr. Epplin's records in the year 2005. Restrictive lung disease is mentioned for the first time in Dr. Epplin's records in early 2012. The medical records of Dr. Epplin also contain reports with regard to Petitioner's treatment for the pulmonary embolism which occurred in November of 2003. The Arbitrator notes that there are a number of office notes where Petitioner indicated he had no difficulty breathing and no shortness of breath. In May of 2010, Dr. Epplin performed a pre-operative physical before Petitioner was having surgery on both knees. At that time, Petitioner had no cough, no decreased exercise tolerance, no difficulty breathing, no dyspnea, no hemoptysis, and no sputum production. There was no shortness of breath and no exertional chest discomfort.

There are a number of films that have been taken of Petitioner's chest over the years. In January of 2012, films taken at St. Francis Hospital of Petitioner's chest were read as showing no acute findings. The history was decreased lung capacity. On January 24, 2012, Petitioner had a CT of the chest because of asthma, COPD, shortness of breath, and cough. There were no significant abnormalities seen. A follow up CT was done a month later on February 22, 2012. At that time, they ruled out a pulmonary embolism. There was no evidence of active pulmonary disease. On November 7, 2012, a CTA of the coronary arteries was done. This included at least a portion of the lungs and there were no significant findings of emphysema or bronchiectasis.

The Arbitrator notes a B-reading from Dr. Smith of films taken on 1/17/08, which the doctor found positive for CWP in a 1/1 profusion. Dr. Smith also reviewed films taken on 10/23/09 with the same interpretation. The films from 1/17/08 were read by Dr. Cohen as positive for CWP in a 1/0 profusion. The 10/23/09 were read by Dr. Alexander as positive for COPD in a 1/0 profusion. Dr. Smith also reviewed CT films taken on 10/23/09 and felt there were findings consistent with CWP in a 1/1 profusion.

Dr. Meyer reviewed films taken on 10/23/09 and found no evidence of coal workers' pneumoconiosis. Dr. Seaman reviewed the same films and found no evidence of coal workers' pneumoconiosis. The films from 10/23/09 were also reviewed by Dr. Shipley and Dr. Tarver. Both doctors found no evidence of coal workers' pneumoconiosis. Dr. Meyer reviewed the 10/23/09 CT film and found no evidence of coal workers' pneumoconiosis.

Petitioner was evaluated by June Blaine, a vocational rehabilitation specialist, on 1/14/14. She determined that Petitioner was employable in the labor market. She performed a labor market survey and looked at about nine different employers in and around the Carlinville area. This included some welding positions because he had been trained in that field in 2010. Blaine determined that Petitioner could find a position that paid up to $12.00 an hour. She noted that Petitioner had run his own business for a couple of years after he completed the welding program. With regard to the labor market survey, Blaine noted that Petitioner lived in Montgomery County and worked for the Respondent in Macoupin County. She did not include in her labor market survey Madison County which borders both Macoupin County and Montgomery County. She agreed that there was a greater population and more business entities in Madison County than Macoupin County or Montgomery County. She also did not look in Decatur or in Springfield.

CONCLUSIONS OF LAW

The Arbitrator notes that Petitioner indicated that he first noticed breathing problems when he was about 49 years old in 2003. That was when Petitioner had blood clots. At the time of such a pulmonary embolism, Dr. Paul indicated that it will result in shortness of breath. Dr. Henkle first started seeing Petitioner at that time.

Dr. Paul diagnosed coal workers' pneumoconiosis. On the other hand, Dr. Tuteur indicated that he saw no evidence of coal workers' pneumoconiosis on the chest x-ray films he reviewed or the chest CT films he reviewed. The Arbitrator notes that Dr. Henkle indicated that he had not seen radiographic evidence of coal

workers' pneumoconiosis. The Arbitrator further notes a number of B-readings of chest x-ray films and one B-reading of a CT film that were positive for CWP. There were an equal number of chest x-ray B-readings and a chest CT scan B-reading that were negative for coal workers' pneumoconiosis. The Arbitrator notes that the CT films and x-ray films found in Dr. Epplin's records do not suggest evidence of coal workers' pneumoconiosis. The Arbitrator also notes a letter dated April 3, 2002 from the Department of Health and Human Services advising Petitioner that he did not have evidence of pneumoconiosis.

The Arbitrator notes that Dr. Paul diagnosed asthma, but did not diagnose emphysema or chronic bronchitis. There is no mention of COPD. Dr. Henkle testified that Petitioner had asthma and said it was possible that Petitioner had COPD. Dr. Henkle testified that GERD can cause respiratory symptoms that mimic asthma or COPD. Dr. Tuteur agreed with that statement. Dr. Paul did not note any restrictive disease, but Dr. Henkle did. Dr. Henkle indicated that this could be related to Petitioner's weight. Dr. Tuteur found no evidence that an interstitial lung disease was responsible for the total lung capacity decrease which signaled the restrictive ventilatory defect. The doctor noted that the overweight status contributed and perhaps the history of pleurisy. Dr. Tuteur felt that the airflow obstruction noted on the pulmonary function study was due to Petitioner's recurrent GERD with aspiration. The doctor also noted the pleurisy and the granulomatous disease or fungal infection. The tracheo-bronchial collapse syndrome was responsible for the airflow obstruction. Dr. Tuteur indicated that the reversible airways shown on the pulmonary function study was also associated with the inflammation from the tracheo-bronchial collapse syndrome. He found no evidence of an occupational lung disease.

Based upon the above evidence, the Arbitrator does not believe the Petitioner has proven that he suffers from pneumoconiosis (CWP). As stated above, six B-Readers looked at chest X-Ray's done on October 23, 2009. An equal number of them saw no evidence of scarring of the Petitioner's lungs as those who did see such scarring. As Dr. Paul stated in his testimony, tissue reaction is a required part of the diagnosis. (PX 1 at 10)

The Arbitrator does feel, however, that the Petitioner has proven that he suffers from mild to moderate asthma which was aggravated by his work in the mine. Dr. Henkel's opinion, bolstered by the positive methacholine challenge on June 17, 2004, is persuasive. (PX 2 at 9, 25, 26) While it is true that the doctor said that the Petitioner's symptoms of shortness of breath could also have been the result of GERD or obesity, the condition certainly could have been multi-factorial.

On the issue of permanency, the Arbitrator notes that the asthmatic condition was not one which has required a lot of medical care. The Petitioner in his proposed decision points to a number of doctor visits between 2004 and 2012 to support his claim of disablement. However, a closer look at those visits does not show that they were actually related to shortness of breath. The Petitioner did see Dr. Henkel on March 24, 2004 for shortness of breath, and the doctor did indicate that his work exposure could trigger the condition. His later visit to Dr. Henkel on May 23, 2005 was also for shortness of breath, but the doctor clearly attributed it to his sleep apnea, a condition for which he would be surgically treated three months later. Dr. Epplin's notes support the theory that the sleep apnea was causing breathing symptoms at the time, as evidenced by his visits on May 19, July 18 and August 5 of the same year. Also, it appears that the pulmonary function studies the Petitioner had improved between 2004 and 2007. (PX 7, Dr. Henkel note-1-8-07) The Petitioner has continued to treat periodically for asthma since the mine was closed. Dr. Henkel saw him on February 7, 2012, at which time he again commented on the positive methacholine challenge seen earlier. (PX 7) However, Dr. Henkel does not believe the asthma would prevent the Petitioner from performing his coal mining work if such work were available. (PX 2 at 23)

Based upon the above evidence, the Arbitrator believes the Petitioner is entitled to permanency of 5 % Person As A Whole under 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 PEORIA)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeffrey Weaver,

Petitioner,

vs. NO. 14WC029603

UnityPoint Methodist Medical Center,

17IWCC0117

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses, causal connection, 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 June 7, 2016 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 the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

17IWCC0117

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: FEB 27 2017
SJM/sj
o-2/9/17
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WEAVER, JEFFREY
Employee/Petitioner

Case# **14WC029603**

UNITYPOINT METHODIST MEDICAL CENTER
Employer/Respondent

17IWCC0117

On 6/7/2016, 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 0.43% 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:

0192 CUSACK GILFILLAN & O'DAY
DANIEL P CUSACK
415 HAMILTON BLVD
PEORIA, IL 61602

5354 STEPHEN P KELLY
ATTORNEY AT LAW
2710 N KNOXVILLE AVE
PEORIA, IL 61694

17IWCC0117

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

JEFFREY WEAVER,
Employee/Petitioner

v.

UNITYPOINT METHODIST MEDICAL CENTER,
Employer/Respondent

Case # **14** WC **29603**

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 **Peoria**, on **5/17/16**. 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 **7/26/14**, 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 as it relates to his right shoulder ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$23,021.96**; the average weekly wage was **$442.72**.

On the date of accident, Petitioner was **25** 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 **$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

The Respondent shall pay Petitioner temporary total disability benefits of $295.15/week for 0 weeks, as provided in Section 8(b) of the Act. Petitioner has failed to prove by a preponderance of the credible evidence that he was temporarily totally disabled from8/6/14 to 1/15/15.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, for all treatment to petitioner's right shoulder from 7/26/14 through 10/13/14, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for all reasonable and necessary medical services to the right shoulder from 7/26/14 through 10/13/14 that have been paid pursuant to the Fee Schedule.

Respondent shall pay Petitioner permanent partial disability benefits of $265.63/week for 0 weeks, because the injuries sustained caused the 0% loss of his person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay to Petitioner penalties of **$0**, as provided in Sections 19(k) and 19(l) of the Act. The arbitrator finds the respondent's failure to pay temporary total disability benefits from 8/6/14-1/15/15 was not unreasonable or vexatious.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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

6/1/16
Date

ICArbDec p. 2

JUN 7 - 2016

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 25 year old CNA, sustained an accidental injury to his right shoulder and neck that arose out of and in the course of his employment by respondent on 7/26/14. On this day petitioner tripped over a call light electrical cord after getting a patient in bed. Petitioner testified that after he tripped on the cord, he started falling and caught himself before he fell to the ground. He testified that he had a little right arm pain at that time. Petitioner is left hand dominant.

Petitioner sought treatment on 7/26/14 at Unity Point Health. He provided a consistent history of the accident. He complained of right shoulder pain for the past 3 hours. He stated that it radiates up and down his right arm, and is worse with movement. Petitioner denied any previous injuries to his right arm. Petitioner was examined and assessed with right shoulder pain.

On 7/28/14 petitioner presented to IWIRC. He gave a consistent history of the accident. He rated his right shoulder pain at 3-4/10. He described his symptoms as a constant throbbing with intermittent pulling pain with movement. Petitioner was examined and assessed with a right shoulder strain. He was released to light duty with maximum lifting of 10 pounds and 20 pounds of lifting occasionally. On 7/30/14 petitioner returned complaining of worsened symptoms. He reported tingling and pain radiating down his arm and stated that his fingers were numb. He complained of pain when lifting anything. Petitioner was examined and again assessed with a right shoulder strain. Petitioner was given a Medrol Dose Pack and continued on light duty. On 8/4/14 he reported that his symptoms had improved a little. He stated that his swelling was better, but had intermittent throbbing. He was examined and assessed with a right shoulder strain that was slowly improving.

On 8/5/14 petitioner testified that it was a busy night in the emergency room and he was helping with surgical vitals and stacking shelves within his restrictions. While he was doing these activities he experienced pain radiating down his arm and into his neck from his shoulder. He testified that he had a swollen right hand.

On 8/5/14 petitioner presented to the emergency room at Unity Point Health. He complained of severe right shoulder and neck pain that radiates to the right leg. Petitioner reported that at the time of the injury he had not fallen to the ground, but rather caught himself on the recliner with his right arm. Petitioner was examined. Generalized tenderness was noted in the right shoulder, as well as slight swelling. Petitioner was diagnosed with right shoulder pain.

On 8/7/14 petitioner returned to IWIRC and reported that his symptoms were worse. He reported constant tightness, throbbing and aching sensations in the right shoulder. He reported that on Tuesday he had shooting sensations radiating to his neck, and down his right leg. He also reported swelling in the right wrist/hand.

Petitioner stated that his symptoms were worse when working. Petitioner stated that his face swelled on the right and felt hot. He also reported gait changes. It was noted that petitioner had a 5mm cyst growing on his pituitary, as was seen by MRI. Following an examination petitioner was assessed with a resolved right shoulder strain. PA Korf noted that she was unable to correlate the mechanism of injury with his current symptoms. Petitioner was released from care by IWIRC. He was taken off work until cleared by PCP for non-work related medical problems.

On 8/13/14 petitioner presented to Unity Point Clinic Family Medicine for follow-up of his right shoulder pain. He rated his pain at a 5-6/10, and stated that it was aggravated with overhead activities. He did not feel he could return to work. An examination revealed pain on flexion abduction external rotation. Am drop test was mildly positive on right. Cervical range of motion was within normal movements. Impingement test was positive. Dr. Dawalibi diagnosed right shoulder pain, probably related to a sprain/strain. Petitioner was referred to orthopedics for further evaluation.

Thereafter, petitioner sought legal representation. On 8/18/14 petitioner signed an Application for Adjustment of Claim, alleging injuries to his right, shoulder, right arm and right hand as a result of the injury on 7/26/14. This was filed on 9/2/14.

On 8/20/14 petitioner presented to Dr. Daniel Hoffman, a General Practitioner, at the direction of his attorney, Cusack. Petitioner reported that he hurt his right shoulder and cervical spine when he tripped on 7/26/14. He complained of pain in the right shoulder radiating down his arm. Petitioner reported that he was taken off work by the Methodist emergency room and had not been released by his primary care doctor to return to work. Petitioner was examined and assessed with a right shoulder strain, possible nerve compression and cervical strain. An MRI of the right shoulder was ordered, and a nerve study of the right arm was ordered. Petitioner was continued off work.

On 8/26/14 the petitioner underwent an MRI of the right shoulder. The impression was no acute fracture or rotator cuff; minimal fluid signal associated with the biceps tendon sheath that could be an asymptomatic finding or represent some tenosynovitis; and very small joint effusion.

Petitioner followed-up with Dr. Hoffman periodically from 9/3/14 through 1/15/15. Petitioner was authorized off work by Dr. Hoffman until 1/15/15. At that time he released petitioner on a trial basis.

On 10/6/14 petitioner's attorney sent letter to IRMS (Mika). He indicated that medical records with regards to petitioner's 7/26/14 injury were included. He claimed that the attached records show petitioner had been off of work since 8/6/14. Cusack claimed that petitioner had not received any TTD benefits, and asked

that respondent issue a check immediately. He further noted that petitioner's PCP Dr. Hoffman had referred petitioner to an orthopedic surgeon for evaluation, and wanted approval from respondent for the same. The records petitioner's attorney Cusack claims were attached to this letter were not included as part of his PX12.

On 10/13/14 petitioner was seen by Dr. Mark Markley for his right shoulder. He gave a history of tripping and catching himself with his arms extended in front of him. He rated his pain at a 5/10. He reported that his hand swelling and associated numbness and tingling had improved somewhat. Dr. Markley reviewed an outside MRI that showed scant effusion. There was no evidence of cuff or labral pathology. His impression was right rotator cuff strain, right shoulder acromioclavicular joint synovitis. Dr. Markley performed a corticosteroid injection into petitioner's right shoulder. Dr. Merkley gave petitioner no restrictions at waist level, and 20 pound restriction waist to chest level. He ordered some physical therapy for petitioner's right shoulder.

On 10/30/14 Cusack drafted another letter to respondent's attorney (Kelly). He stated that attached to his letter were a copy of petitioner's medical records with regard to his injury of 7/26/14 along with a copy of his 10/6/14 correspondence directed at IRMS. (The records were not included in PX12). Cusack claimed that the records show petitioner had been off since 8/6/14 and had not received any TTD benefits. He noted that petitioner had been referred to Dr. Markley, and paid for that visit out of pocket. Cusack noted that Dr. Markley recommended physical therapy, but petitioner was unable to pay out of pocket for this treatment.

On 11/6/14 petitioner underwent an MRI of the cervical spine. The impression was minimal diffuse disc bulge at C5-C6 of doubtful significance. No other disc bulge or protrusions were noted.

On 1/15/15 petitioner presented to Dr. Patrick O'Leary, at Midwest Orthopaedic Center, on the referral of Dr. Hoffman. Petitioner gave a history of hurting his right shoulder and neck when he tripped over a cord by a patient's bed at work on 7/26/14. He reported that he had to "kind of throw his arms out to catch himself". Dr. O'Leary noted that petitioner had undergone an MRI of the cervical spine and had injections into his right shoulder by Dr. Markley, that really helped him a lot. Petitioner identified the area of pain as the right trapezial, paracervical shoulder region on the right side. He rated his pain as a 4/10. Petitioner demonstrated full range of motion of his cervical spine. All petitioner had was some tenderness in the right trapezial region that was aggravated by a shoulder shrug. X-rays of the cervical spine showed mild spondylosis. He also reviewed the MRI of the cervical spine that showed no disk protrusions. He noted that a minimal disk bulge of doubtful significance was noted at C5-C6. Dr. O'Leary recommended physical therapy for petitioner's trapezius. He released petitioner on an as needed basis. He released petitioner with no work restrictions.

On 2/16/15 petitioner underwent an Initial Evaluation at Professional Therapy Service, Inc. Petitioner continued in physical therapy until 3/2/15. Petitioner had 5 visits.

On 10/1/15 petitioner amended his Application of Adjustment of Claim and added a new body part injured. Petitioner indicated that his neck was also injured as a result of the accident on 7/26/14.

On 10/27/15 petitioner filed a petition for penalties under Section 19(k) and 19(l) of the Act. He claims petitioner was injured on 7/26/15, and respondent has refused to pay medical expenses for treatment despite being furnished with copies of the medical bills. Petitioner claims that respondent has no medical opinion stating medical treatment is not necessary. Petitioner claims he was off work from 8/6/14 through 1/15/15. Petitioner claims respondent has refused to pay TTD benefits, which is in violation of Sections19(k) and 19(l).

On 12/16/15 the evidence deposition of Dr. Dru Hauter, who specializes in occupational medicine, was taken on behalf of the respondent. Dr. Hauter is from IWRIC in Peoria, the office where petitioner treated on four occasions. Dr. Hauter is the supervising physician at IWIRC and has physician assistants and nurse practitioners that work under him. Dr. Hauter testified that petitioner was seen by three of his physician assistants, and one nurse practitioner. Dr. Hauter testified that he did not personally examine petitioner. However, as supervising physician he reviews the notes of the visits, and is available for consult.

Dr. Hauter went over the notes of the four office visits and opined that a right shoulder strain was consistent with the mechanism of injury petitioner provided. He was of the opinion that a shoulder strain will typically resolve in 3-6 weeks. He opined that petitioner had reached MMI on 8/7/14 for his right shoulder strain and could return to unrestricted duty work. Dr. Hauter did not believe petitioner's complaints of pain going up the arm to the face area were related to this injury, and needed further follow-up with his primary care physician. He believed petitioner's treatment at IWIRC was reasonable and necessary. Dr. Hauter was of the opinion that Methodist had a light duty program. When petitioner was discharged from IWIRC on 8/7/14 he did not see any evidence of any permanent disability of petitioner as a result of his work injury.

On cross examination Dr. Hauter testified that he is a shareholder in the Integrated Work Injury network and is not a shareholder in the Illinois Work Injury Resource Center, which includes the Peoria facility where petitioner was seen. Dr. Hauter has a company called Hauter Medical that has a contract with IWIRC in Peoria. He testified that his clients are companies and not all his patients are clients. Dr. Hauter agreed that petitioner sustained a right shoulder strain that had resolved. Dr. Hauter testified that petitioner stopped being treated at IWIRC when his symptoms were no longer consistent with the documented injury. Petitioner was then sent back to his primary care physician.

On 4/19/16 the evidence deposition of Dr. O'Leary, an orthopedic spine surgeon, was taken on behalf of petitioner. Petitioner saw Dr. O'Leary to get his neck checked out. He noted that he saw petitioner once and he had a little bit of pain in the neck/shoulder region. He only noted a little bit of pain near the trapezius. He stated that petitioner's range of motion of the neck was normal and there were no neurological findings. Dr. O'Leary was of the opinion that petitioner's cervical MRI was pretty normal. Dr. O'Leary stated that he did not have petitioner off work. Dr. O'Leary was of the opinion that the mechanism of injury of 7/26/14 caused him to be symptomatic.

On cross examination Dr. O'Leary stated that his examination revealed no evidence of permanent disability. Dr. O'Leary was not certain whether petitioner fell to the floor or not on 7/26/14, or if had both hands stretched out or only one. Dr. O'Leary was of the opinion that whether or not petitioner fell to the ground or not, if he tried to brace himself from falling with an extremity that could essentially cause stress to the neck or shoulder region and precipitate symptoms. He also did not know of any preexisting problems with petitioner's right arm or cervical spine. He saw no signs of malingering. Dr. O'Leary did not know if petitioner had a neck injury, but noted that petitioner described pain in that region. Dr. O'Leary could not opine that petitioner injured his cervical spine at the time of the injury. Dr. O'Leary could not opine if petitioner's pain was either just innate related to a trapezial muscle strain or just something that might be connected to the shoulder. He did not believe it was related to the cervical spine. Dr. O'Leary testified that the MRI showed no nerve root compression and he did not think petitioner's pain was radicular.

At trial petitioner testified that he feel fines. He testified that he was in the same shape he was before the injury. He stated that he had no pain and nothing was bothering him. Petitioner testified that he was in a motor vehicle accident in April, 2014, after which he treated with his primary care physician, and his chiropractor Dr. Walker for about a month for his neck and left shoulder. Petitioner said his treatment included adjustments to his neck, and thoracic and lumbar spine. After that he got a full release. He thinks he only missed 2 days of work. Petitioner admitted that his first complaints of neck pain were on 8/7/14 and he felt the neck pain was radiating pain from his right shoulder.

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

Petitioner is alleging that his current condition of ill-being as it relates to his right arm and neck are causally related to the injury on 7/26/14. When petitioner first sought treatment for his injury on 7/26/14 he complained of right shoulder pain. He had no neck complaints. When he treated at IWIRC on 7/28/14, 7/30/14, and 8/4/14 he only reported complaints of right shoulder pain. He had no neck complaints. Petitioner's first

complaints of neck pain were not until 8/5/14 when he complained of severe right shoulder and neck pain. There was no diagnosis at that time with respect to the neck. He was only diagnosed with shoulder pain.

His complaints at IWIRC on 8/7/14 continued to be his right shoulder with pain radiating to the neck. At that time it was also noted that an MRI revealed a 5mm cyst growing on petitioner's pituitary gland. Petitioner was found at that time to have symptoms such as face swelling and hot feeling on his face, as well as gait changes, that did not correlate to the mechanism of injury. Petitioner was examined and assessed with a resolved right shoulder and released from care for the right shoulder. He was referred to his PCP for his non-work related medical issues.

Despite this release from care for the right shoulder by IWIRC petitioner continued to treat. On 8/13/14 Dr. Dawalibi diagnosed right shoulder pain, probably related to a sprain/strain. Petitioner told Dr. Dawalibi that he did not feel he could work. When he was not taken off work, he sought legal representation and was sent to Dr. Hoffman by his attorney on 8/20/14. Petitioner reported to Dr. Hoffman that he had shoulder and cervical injuries when he tripped on 7/26/14. The arbitrator finds this accident history inconsistent with the credible medical records to date. At no time prior to this date did petitioner allege that he injured his cervical spine on 7/26/14. The only test Hoffman ordered was an MRI of the right shoulder. No tests were ordered for the neck.

Even when petitioner filed his Application for Adjustment of Claim days later on 9/2/14 he did not allege any injury to the neck as a result of the accident on 7/26/14.

Petitioner saw Dr. Markley on 10/13/14 and complained of right shoulder pain. Dr. Markley assessed a right rotator cuff strain and right shoulder acromioclavicular joint synovitis. He performed an injection into petitioner's right shoulder. Petitioner reported that it really helped.

Petitioner then saw Dr. O'Leary on 1/15/15 for his cervical spine. He reported a little bit of pain in the neck/shoulder region. He noted that petitioner's cervical range of motion was normal and there were no neurological findings. He was also of the opinion that petitioner's cervical spine MRI was pretty normal . He could not opine as to whether or not petitioner had a neck injury as a result of the accident.

Dr. Hauter opined that a right shoulder strain was consistent with the mechanism of injury petitioner provided, and that a shoulder strain will typically resolve in 3-6 weeks. He opined petitioner reached maximum medical improvement on 8/7/14 for his right shoulder strain.

It was not until 10/1/15 that petitioner amended his Application for Adjustment of Claim and alleged that he sustained a neck injury as a result of the accident on 7/26/14.

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 he sustained a neck injury as a result of the accident on 7/26/14. Petitioner did not have neck complaints for weeks, and not even Dr. O'Leary, who treated him for his neck complaints, could opine that petitioner's neck complaints were related to the injury. Additionally, the arbitrator finds it significant that it was not until petitioner saw Dr. Hoffman, after seeking legal representation, that he reported for the first time that when he was injured on 7/26/14 that he injured his neck. The arbitrator also finds it significant that it was not until 10/1/15 that petitioner amended his Application for Adjustment of Claim and added a neck injury as a result of the accident on 7/26/14.The arbitrator also notes that petitioner had treatment to his neck just months before the injury. In April of 2014 petitioner was in a motor vehicle accident and sustained injuries to his neck for which he underwent chiropractic treatment for about a month before receiving a full release.

The arbitrator finds the petitioner injured his right shoulder as a result of the injury on 7/26/14. The arbitrator finds it significant that petitioner did not fall on his right arm and through 8/13/14, prior to seeking treatment with Dr. Hoffman, at the request of his attorney, petitioner was only diagnosed with a right shoulder strain. Even after petitioner sought legal representation and began seeing doctors at the request of his attorney, petitioner was never diagnosed with anything more than a strain, and some joint synovitis. Following the injection by Dr. Markley on 10/13/14 petitioner's right shoulder condition was improved.

Although Dr. Hauter opined that petitioner reached MMI for his right shoulder on 8/7/14, the arbitrator finds it significant that Dr. Hauter never examined petitioner and the records show that on 8/7/14 petitioner reported that his symptoms were worse. He reported constant tightness, throbbing, and aching sensations in the right shoulder.

Based on the above, the arbitrator finds the petitioner has proven by a preponderance of the credible evidence that he sustained an accidental injury to his right shoulder as result of the injury on 7/26/14 and that his current condition of ill-being as it relates to his right shoulder is causally connected to the injury on 7/26/14.

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

Having found the petitioner has failed to prove by a preponderance of the credible evidence that he sustained an injury to his cervical spine as a result of the injury on 7/26/14, the arbitrator find none of the medical services petitioner was provided for his cervical spine were reasonable and necessary.

With respect to petitioner's right shoulder the arbitrator finds all treatment to his right shoulder was reasonable and necessary through 10/13/14. Respondent shall pay all reasonable and necessary medical services for petitioner's right shoulder from 7/26/14 through 10/31/14 pursuant to Sections 8(a) and 8.2 of the Act.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner claims he is entitled to temporary total disability benefits from 8/6/14 through 1/15/15. Prior to 8/6/14 petitioner had been working light duty for respondent. On 8/7/15 petitioner was released from care by IWIRC. His off work authorization at that point was related to his non-work related medical problems.

On 8/13/14 when petitioner presented to Unity Point. Petitioner told Dr. Dawalibi that he wanted to be off work. Dr. Dawalibi would not take him off work. Days later petitioner sought legal representation, and was referred to Dr. Hoffman, a doctor his attorney selected for him. On 8/20/14 petitioner was taken off work by Dr. Hoffman, despite the fact that he only assessed a shoulder strain, which was the same as what all the prior doctors had authorized. For that reason, the arbitrator finds no credible medical evidence to support a finding that petitioner could not have continued working light duty for respondent, unless it was related to the cervical spine which is not related to petitioner's injury. Despite no further changes in petitioner's condition, Dr. Hoffman continued petitioner off work through 1/15/15.

The arbitrator finds it significant that even when Dr. Markley saw petitioner on 10/13/14 he also believed petitioner was a capable of light duty work, and petitioner had not proven by a preponderance of the credible evidence that he presented these restrictions to respondent, and they declined to accommodate them.

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 he was temporarily totally disabled from 8/6/14 through 1/15/15.

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains no impairment rating pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. Therefore, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a CNA at the time of the accident. He provided no credible evidence to support a finding that he is not currently able to perform this job. Therefore, the Arbitrator gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 25 years old at the time of the accident. Because petitioner has many years left of employment without any restrictions, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes there was no discussion regarding the impact of petitioner's future earnings capacity. Because of this, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that when petitioner last treated on 1/15/15 with Dr. O'Leary he reported an area of pain in the right trapezial, paracervical shoulder region on the right. Petitioner demonstrated some tenderness in the right trapezial region that was aggravated by a shoulder shrug. Petitioner was released with no work restrictions. Dr. O'Leary opined that petitioner had no evidence of permanent disability. At trial on 5/17/16 petitioner testified that he felt fine. He stated that he was in the same shape he was before the injury. He testified that he had no pain and nothing was bothering him.

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 0% loss of use of his person as a whole pursuant to §8(d)2 of the Act because the petitioner has no evidence of permanent disability.

M. SHOULD PENALTIES OR FEES BE IMPOSED UPON RESPONDENT?

On 10/27/15 petitioner filed a petition for penalties under Section 19(k) and 19(l) of the Act. He claims petitioner was injured on 7/26/15, and respondent has refused to pay medical expenses for treatment despite being furnished with copies of the medical bills. Petitioner claims that respondent has no medical opinion stating medical treatment is not necessary. Petitioner claims he was off work from 8/6/14 through 1/15/15. Petitioner claims respondent has refused to pay TTD benefits, which is in violation of Sections19(k) and 19(l).

Having found the petitioner is not entitled to temporary total disability benefits from 8/6/14 through 1/15/15, the arbitrator finds respondent's failure to pay temporary total disability benefits during this period was not unreasonable or vexatious.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner is not entitled to penalties pursuant to Sections 19(k) and 19(l) 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

Thomas Leverett,

Petitioner,

vs.

NO. 14WC022015

17IWCC0118

City of Harrisburg,

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 medical expenses, casual connection, choice of physicians and caregivers, 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 9, 2016 is hereby affirmed and adopted.

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

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

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

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: FEB 2 7 2017
SJM/sj
o-2/9/17
44

Stephen J. Mathis

David L. Gore

Mario Basurto

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

LEVERETT, THOMAS
Employee/Petitioner

Case# **14WC022015**

17IWCC0118

CITY OF HARRISBURG
Employer/Respondent

On 2/9/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.42% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0180 EVANS & DIXON LLC
MICHAEL A KARR
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

17IWCC0118

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

THOMAS LEVERETT
Employee/Petitioner

v.

CITY OF HARRISBURG
Employer/Respondent

Case # **14** WC **22015**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Herrin**, on **December 9, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] 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. [x] Other **Exceeding one's choice of physicians**

FINDINGS

On the date of accident, **June 2, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**78,505.07**; the average weekly wage was $**1,509.71**.

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 $ 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 its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay the medical bills found in Petitioner's Exhibit 6 subject to the Medical Fee Schedule pursuant to Section 8(a) of the Act and with Respondent receiving credit in the amount of $54,517.86 for medical bills previously paid.

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

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

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

Nancy Lindsay
Signature of Arbitrator

February 4, 2016
Date

ICArbDec19(b)

FEB 9 - 2016

FINDINGS OF FACT AND CONCLUSIONS OF LAW

At the time of Petitioner's 19(b) hearing, the issues in dispute centered on Petitioner's left knee injury. While Petitioner also claims injuries to his neck, left shoulder, and toe (see AX 2 and record) those issues were reserved for another hearing.

The Arbitrator finds:

Petitioner works as a police officer for the City of Harrisburg, Respondent herein.

On February 18, 2010 Petitioner underwent a left knee MRI after having slipped on ice a few days earlier. Both chronic and acute changes were noted. Petitioner had serious internal derangement with complete disruption of his ACL with "kissing bone bruises" involving the lateral femoral condyle as well as the proximal tibial condyles; an extensive cleavage tear involving the posterior horn of the medial meniscus; moderate joint effusion; far advanced Grade II tricompartmental osteoarthritis involving the anterior and medial compartments with multiple intra-articular loose bodies; and a focal spot of osteochondritis dissecans involving the mid portion of the lateral femoral condyle. Petitioner's lateral meniscus was noted to be intact. (RX 2)

On June 2, 2013, Petitioner, 49 years of age, was involved in an undisputed accident while making an arrest. At that time a suspect suddenly spun around and placed Petitioner in a choke hold. A fellow officer attempted to intervene and pushed Petitioner and the suspect through a doorway causing both to fall over a recliner and onto an end table and lamp before ending up on the floor. As the other officer pushed Petitioner and the suspect, Petitioner's knee twisted and popped. When Petitioner got up after the accident he noticed he was bleeding from both his face and knee and felt pain in all areas.

After the accident, Petitioner began treatment for his left knee at Primary Care in Harrisburg. At the time of his June 13, 2013 visit with Dr. Winkelman, Dr. Winkleman noted the work accident and took a history of the injured body parts of Petitioner. Petitioner's complaints included buckling of his left knee with pain, swelling and the sensation of "it pulling apart." Dr. Winkelman noted Petitioner's prior history of left knee surgery. His diagnosis included left knee internal derangement. Dr. Winkleman ordered an MRI of Petitioner's left knee and allowed Petitioner to continue working without limitation "for now." (PX 1)

Petitioner underwent the MRI on June 19, 2013, and it showed severe arthritic changes and an almost complete obliteration of Petitioner's medial meniscus. (PX 1)

On June 21, 2013, Petitioner returned to Dr. Winkleman reporting continued instability in his left knee. Dr. Winkleman felt a referral to a specialist was necessary and referred Petitioner to Dr. Wente at the Bonutti Clinic. (PX 1)

Petitioner presented to Dr. Wente at the Bonutti Clinic on July 8, 2013. Dr. Wente took a history from Petitioner regarding the work accident and noted his left knee pain. Dr. Wente compared the MRI of Petitioner's left knee from February 18, 2010 with the MRI of June 19, 2013. Dr. Wente felt that there were degenerative changes through the entire left knee and that Petitioner had advanced degenerative joint disease. Dr. Wente's plan of treatment was to offer medication and some injections to try and return Petitioner to his pre-accident level of physical activity. Dr. Wente felt that the only

thing that could be done surgically would be a total knee replacement. Dr. Wente also issued a prescription for medication and told Petitioner to return in four to six weeks.

Petitioner was examined at Primary Care on July 2, 2013 in follow up and his ongoing knee pain was noted. (PX 1, 14/51)

On July 31, 2013 Petitioner began treating with Dr. Bernardi for neck complaints stemming from the work accident. The doctor ultimately performed neck surgery on Petitioner in September of 2013. Petitioner was taken off work from the date of surgery through the end of the year. As of December 11, 2013 Dr. Bernardi felt Petitioner could return to work at the beginning of the year without any restrictions. It was anticipated Petitioner would be at maximum medical improvement with regard to his neck around February 1, 2014. (PX 3)

Petitioner was examined by Dr. Knight, his primary care physician, on December 27, 2013 for a release to return to work after his cervical fusion procedure. While Dr. Bernardi had released him, Petitioner advised the doctor that Respondent was also requesting a release from his primary care physician. Petitioner reported he was doing fine and was ready to return to work. No discussion or reference to Petitioner's left knee was made in the office note. (PX 1)

After recovering from his neck surgery Petitioner returned to work in January of 2014.

On June 2, 2014 Petitioner again presented to Primary Care Group where he was seen by Dr. Knight. Petitioner's primary complaint was left knee pain and, according to the office note, "The onset of the knee pain has been gradual and has been occurring in a persistent pattern for years (PT STATES THAT HE HAD AN INJURY ABOUT A YEAR AGO AND IS HAVING A FLARE UP IN THE LEFT KNEE. IT SWELLS AND AT TIMES HE IS UNABLE TO BEAR WEIGHT. USING ICE EVERY DAY TO BE ABLE TO WORK.) The course has been gradually worsening." (PX 1, 5/51) The knee pain was characterized as a dull aching in the entire knee. Petitioner noted difficulty arising from a chair and difficulty going up and down stairs. Petitioner's physical exam included generalized swelling of his left knee with decreased range of motion and painful movements. Tenderness on both the medial and lateral sides of Petitioner's knee was noted. An x-ray, MRI, and referral to an orthopedist, Dr. Bonutti, were ordered. Petitioenr was allowed to continue working full duty. (PX 1)

Petitioner's subsequent MRI, taken on June 9, 2014, revealed osteoarthritis, a tibial plateau fracture, a high grade tear of the ACL with scarring, a partial tear of the MCL with scarring, a radial tear of the posterior horn of the lateral meniscus with extrusion of the body and multiple loose bodies throughout the joint. (PX 4)

Petitioner signed his Application for Adjustment of Claim herein on June 23, 2014. (AX 2)

Upon the referral of his attorney, Petitioner then presented to Dr. J. T. Davis on June 25, 2014 at which time he gave Dr. Davis a history of his work accident and the knee problems he had been dealing with over the previous year. Petitioner informed Dr. Davis that he had been very active before the accident running several miles a week and walking several miles a day. Petitioner told the doctor that since his June of 2013 accident he had been experiencing significant difficulties in his knee with pain ("4/10") that he characterized as dull, sharp, aching, and throbbing and localized deep within his knee. Petitioner reported the pain was worse with steps and sudden stops. Additional complaints included swelling, a feeling of giving away, instability, fatigue, and radiating pain. Petitioner was taking anti-inflammatories and had done exercises. He was working full duty. On examination the doctor noted mild to moderate effusion, a lack of extension, patellofemoral crepitus and both medial and lateral joint line

tenderness. He reviewed both Petitioner's MRI and x-rays which revealed tri-compartmental osteoarthritis as well as a high grade ACL tear, evidence of prior meniscus issues and surgeries with some questionable tearing, degenerative in nature medially and a radial tear laterally. Dr. Davis diagnosed Petitioner with tri-compartmental osteoarthritis to the left knee with meniscus tearing both medially and laterally. They discussed various treatment modalities including injections, arthroscopic surgery, and a total knee replacement all of which were somewhat dependent upon Petitioner's desire to continue working as a police officer. Dr. Davis was of the opinion that Petitioner's accident was a direct cause for Petitioner's pain through an exacerbation of his underlying degenerative arthritic condition with possible contributions to meniscal tearing. "It is a new meniscal tearing versus exacerbation of underlying degenerative meniscal state." (PX 4)

On July 1, 2014 Petitioner was again seen at Primary Care Group for a small laceration sustained when a cabinet he was carrying dropped on his head. (PX 1)

Petitioner returned to see Dr. Davis on November 20, 2014 at which time the doctor recommended arthroscopic surgery, given the Supartz injection had not helped. (PX 4)

Petitioner underwent left knee surgery on March 19, 2015. The post-operative diagnoses were left knee medial meniscal tear; left knee arthritis; and left knee loose body with synovitis. Petitioner's procedures included a partial medial meniscectomy, a partial synovectomy, removal of loose bodies, extensive debridement of tibial and patellar osteophyte complexes as well as intra-articular adhesions, and a left knee injection. (PX 4)

Post-operatively, Dr. Davis ordered physical therapy. As of March 30, 2015 Dr. Davis was noting swelling in Petitioner's left knee along with discomfort. A venous Doppler, TED hose, Mobic, and physical therapy were ordered. Petitioner was advised against work. He was to return in one month at which time they would discuss injection therapy. The doctor cautioned that, ultimately, a knee replacement procedure might be necessary if he failed to respond to the arthroscopic procedure. (PX 4)

Petitioner's persistent pain complaints and feeling of instability were noted at the next visit of April 13, 2015. Modified work duties were given. (PX 4)

Petitioner then presented to Dr. Bonutti at Bonutti Clinic on June 30, 2015 at which time he gave a history of his work accident and persistent pain thereafter that had culminated in arthroscopic surgery in March of 2015 which Petitioner felt only made him worse. Petitioner reported that his leg felt like it wanted to buckle and give away and he was experiencing a constant aching and discomfort and the inability to squat, twist, or bend. Dr. Bonutti noted in his office note that the operative report had not mentioned the status of Petitioner's ACL. Treatment options were noted with Petitioner expressly desiring a total knee replacement. The consequences of the procedure in terms of lifestyle activity (ex. running) were discussed. Petitioner was given work restrictions. (PX 2)

At the request of Respondent, Petitioner underwent an examination pursuant to Section 12 of the Act on July 20, 2015 with Dr. Mirkin at Tesson Ferry Spine and Orthopedic Center. The examination included Petitioner's left shoulder, left knee and neck. After the exam, Dr. Mirkin issued a written report. (RX 1 – Res. Ex. 2) For purposes of this decision, Dr. Mirkin's exam and report will be limited to Petitioner's left knee. Petitioner was noted to deny any problems with his left knee before his work accident although the doctor noted Petitioner had undergone an MRI of his left knee in February of 2010 that showed an ACL tear and "significant abnormalities". Petitioner's chief complaint that day was left knee pain and the inability to run, an activity Petitioner was regularly engaged in prior to his accident. (RX 1 – Res. Ex. 2, p. 1)

Dr. Mirkin's report included a review of Petitioner's medical records and information supplied to him by Respondent's counsel. Based upon his review of the records, x-rays taken that day in his office, and his examination of Petitioner's left knee, Dr. Mirkin believed that Petitioner sustained an aggravation of his knee problem with the incident in question. (RX 1 – Res. Ex. 2, p. 4) He felt Petitioner had end stage osteoarthritis and would be a candidate for a total knee arthroplasty but he also needed to try and lose weight. He wrote, "I cannot dispute that the incident in question may have aggravated his symptomatology." He felt the need for treatment was his pre-existing degenerative arthritis which in natural history is to progress over time. (Id.)

Dr. Mirkin issued an addendum on September 24. 2015 noting that the 2010 MRI of Petitioner's left knee showed severe osteoarthritis, ACL insufficiency and meniscal pathology. He further stated that he felt the need for the knee replacement surgery was caused by the pathology that pre-existed the incident of June, 2013 as the nature of the condition was progressive and would have been accelerated by Petitioner's morbid obesity. (RX 1 – Res. Ex. 3, p. 1)

Petitioner underwent a total knee replacement on October 14, 2015 at St. Anthony's Memorial Hospital. Petitioner's post-operative diagnoses included osteoarthritis, contractures, severe patellar baja, Osgood-Schlatter lesion, and range of motion from only 10 to 80 degrees. Dr. Bonutti noted in his operative report that the procedure was complex and took twice as much surgical time. (PX 2)

Post-operatively, Petitioner underwent physical therapy at Joyner Therapy Services. As of October 27, 2015, Petitioner was using a cane for assistance when ambulating. He was doing home exercises and outpatient therapy. He was to return to see the doctor on January 19, 2016. (PX 2)

The deposition of Dr. Bonutti was taken on October 27, 2015. (PX 5) Dr. Bonutti testified that Petitioner told Dr. Wente on July 8, 2013 that he had undergone a knee arthroscopy ten years earlier and had done reasonably well thereafter. (PX 5, p. 6) He also testified that in light of Petitioner's earlier arthroscopic procedure, Petitioner had experienced some trauma or injuries in the past and he did have degenerative joint disease which the doctor, based upon Petitioner's history, was significantly exacerbated post-traumatically and then substantively worsened by another arthroscopic procedure. (PX 5, p. 9) Dr. Bonutti felt Petitioner's condition and need for surgery was due to the work accident. (PX 5, pp. 10-11)

Dr. Bonutti noted Dr. Davis didn't address Petitioner's ACL in his operative note. He, himself, suspected Petitioner injured it in 2013.

Dr. Bonutti acknowledged that he didn't review the 2010 MRI. He also testified that Dr. Wente believed that Petitioner had an injury to his ACL before June of 2013 or, at least, a partial injury. He saw nothing acute on the 2013 MRI. Dr. Bonutti believed that Petitioner had undergone a rapid progression of his degenerative condition I his knee after the surgery with Dr. Davis and that the condition would have progressed rapidly regardless of an injury to Petitioner's ACL.

Dr. Bonutti testified that he released Petitioner to return to work on July 18, 2013.

Dr. Mirkin's deposition was taken on November 13, 2015. (RX 1) Dr. Mirkin testified that Petitioner's endstage arthritis and chronic ACL deficienty was not caused by the June 2013 accident. He also testified that Petitioner needed a total knee replacement but he would have needed one eventually even if the work accident had not occurred. (RX 1, pp. 8-9)

On cross-examination Dr. Mirkin testified that he felt it "hard to believe" that Petitioner was fairly active prior to his work accident; however, he acknowledged that that is what Petitioner told him. (RX 1, p. 10)

Petitioner's case proceeded to trial on December 9, 2015. Petitioner was the sole witness at the hearing. The issues in dispute were causal connection, medical bills, and whether Petitioner had exceeded his choice of physicians.

Petitioner testified that he had no problems with his left knee before his accident. However, he acknowledged that he underwent an MRI of his left knee in 2010. Petitioner expressed uncertainty as to what the MRI was for but he assumed he must have been having some problems at the time and wanted his knee looked at. According to Petitioner, the problem then went away.

Petitioner testified that between 2010 and June 2, 2013, accident he had been regularly going to a local bike path to jog or walk about five miles. This was during the week days. On the nights that Petitioner worked he was allowed to go during his lunch hour to a local track and walk five miles. Petitioner testified that he was doing these workouts whenever he worked and he would do the bike path workout on the other days of the week. Petitioner testified that he was keeping track of his exercise with his wife and that at the time of the accident on June 2, 2013, he weighed 232 pounds.

Petitioner testified at trial that his knee symptoms did not improve with medication but he was also dealing with a neck injury from the work accident and decided to go through that treatment and surgical repair first. Medical records introduced into evidence corroborate Petitioner's testimony regarding his decision to proceed with neck surgery. Petitioner was released to return to work for his neck as of January 30, 2014.

Petitioner further testified that when he returned to work in January of 2014 he did so as a detective and not a patrolman. Petitioner described that his job duties as a detective were less physical than that of patrolman. Petitioner testified that after returning to work he was still taking medication for pain with his knee and that his pain in his knee never did subside from the time he had been treated at Bonutti Clinic. Petitioner testified that his knee ached, hurt, started to buckle and came out of socket.

Petitioner testified that he returned to Primary Care in Harrisburg and saw Dr. Knight on June 2, 2014, complaining about pain and discomfort in his knee. He told Dr. Knight that he had to ice his leg daily to get through the day.

Petitioner testified that he sought treatment with Dr. Davis in June of 2014 because he was on Naproxen and didn't want to have to drive two hours to Effingham to see Dr. Wente. Dr. Davis' office was in Marion. According to Petitioner, Dr. Davis gave him an option of undergoing an arthroscopy or a knee replacement and Petitioner wished to proceed more conservatively.

Petitioner testified that the surgery with Dr. Davis did not go well. After a short recovery and an attempt to get Petitioner's pain under control, Dr. Davis informed Petitioner that a knee replacement was his next step to fix his knee problem. Petitioner testified that he then wished to go back to Dr. Bonutti.

Petitioner testified that he underwent a total knee replacement on October 14, 2014 and that he is still recovering. He is currently undergoing therapy and doing great as he is walking up to four miles per day. Petitioner anticipates being released to light duty in January of 2016.

On cross-examination Petitioner was asked if he had an injury in 2010 when he slipped on ice and he replied, "Possibly." He agreed if that was stated in the history it would be correct he just didn't recall any further treatment after the MRI, however.

Petitioner denied that anyone had recommended a total knee replacement to him before June of 2013. He also acknowledged undergoing a prior left knee arthroscopic surgery for a meniscus tear but he didn't recall when. Following the surgery, Petitioner denied any further problems with his knee.

Petitioner also acknowledged that he tried walking for exercise after the 2014 accident but he couldn't do so due to the condition of his knee. He also acknowledged that he continued working full duty until he underwent his neck surgery. Petitioner testified that after Dr. Bernardi released him from care for his neck he tried getting back into physical activity (walking) because he had been gaining weight but that was when his knee "started failing" again. Petitioner explained that it would buckle once or twice a week and he even fell and hit his head once. He then resumed treatment. Petitioner denied having any problems working as a detective between January and June of 2014.

Petitioner was asked who referred him to Dr. Davis and he testified that he was told by "workmen's comp" that the "new knee pain" was going to be a different claim. Petitioner did not think that was right so he contacted an attorney who suggested he see Dr. Davis in Marion. Petitioner was familiar with Dr. Davis as he had treated his son. Additionally, Petitioner did not want to have to drive so far to see a doctor.

Petitioner acknowledged that Dr. Davis didn't take him off work from his detective duties. He further testified that the injections with Dr. Davis provided temporary relief and then his knee got worse. Petitioner was off work recovering from Dr. Davis' surgery and was released to light duty work in mid-April but was then taken off work completely in conjunction with the total knee replacement. Petitioner also testified that when Dr. Davis discussed a total knee replacement with him he said it would be up to Petitioner to choose who would perform the procedure. When asked about the referral to Dr. Bonutti and the fact that the doctor said Petitioner was a self-referral, Petitioner wouldn't disagree.

On further cross-examination Petitioner testified that he would disagree with Dr. Knight's June 2014 history of a flare-up as it was a continuing problem in his knee.

The Arbitrator concludes:

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

Petitioner's current condition of ill-being in his left knee is causally related to his undisputed accident of June 2, 2013. In so concluding the Arbitrator relies upon Petitioner's credible testimony, a chain of events, and the more persuasive opinions of Dr. Bonutti over those of Dr. Mirkin.

Petitioner's treatment to his left knee prior to the accident appears undisputed. Petitioner's treatment to his left knee injury after the accident through July 8, 2013 also appears undisputed. Respondent acknowledges that Petitioner sustained an accident but contends that Petitioner sustained a temporary aggravation of a pre-existing knee condition as a result of that accident which resolved by July 8, 2013.

Petitioner's testimony at trial and, as reflected in the history given to every physician who treated him after the work injury of June 2, 2013, was that he was very active physically prior to his

accident and, even more specifically, he had been running several miles a week and had been walking 5 to 10 miles a day, prior to his accident. Petitioner's testimony regarding this was unrebutted. While Dr. Mirkin found it hard to believe, no one else did and Petitioner was working full duty as a patrolman.

Dr. Mirkin, who evaluated Petitioner as an independent medical examiner doctor, opined that Petitioner had end-stage osteoarthritis for which he, too, recommended a total knee replacement. Dr. Mirkin opined that Petitioner's knee condition was multifactorial and while he wasn't asked about an aggravation theory when deposed, he did address it in his earlier report, noting that the work accident might have aggravated Petitioner's condition. While Dr. Mirkin opined that the need for a knee replacement was based on pathology that was present prior to Petitioner's work accident, he was not asked if the work accident accelerated the need for a total knee replacement.

The Arbitrator notes that Dr. Wente on July 8, 2013, suggested that the only surgical option for Petitioner was a total knee replacement. This opinion was given barely one month after the work accident and before any gap in treatment. No doctor had recommended a total knee replacement prior to Petitioner's work accident.

Dr. Davis also gave an opinion that the work injury sustained in June of 2013 was a direct cause for Petitioner's pain through an exacerbation of his underlying degenerative condition with possible contributions to meniscal tearing. He continued by stating that, "It is a new meniscal tearing versus exacerbation of underlying degenerative mensical tear."

After the arthroscopic procedure was a failure Petitioner was treated by Dr. Bonutti who recommended a total knee replacement. Dr. Bonutti opined that if Petitioner was as active as he had described to him in his history prior to the work accident then certainly the trauma from the work accident contributed to Petitioner's condition. Dr. Bonutti also opined that he was certain that the arthroscopic procedure that was performed by Dr. Davis contributed to Petitioner's rapid deterioration of his symptoms and his range of motion function. Dr. Mirkin did not address this possibility.

With regard to Petitioner's testimony, the Arbitrator finds it to be credible. Petitioner's testimony was unrebutted and he credibly explained how he was feeling and progressing during his one year gap in knee treatment. The Arbitrator recognizes that Petitioner was able to work full duty a significant amount; however, he credibly explained how he felt while working and also underwent a change in position within the police department that lessened the amount of time he was on his feet. In the end, he wasn't asymptomatic prior to June of 2014.

Based upon the foregoing, the Arbitrator finds ongoing causation, relying on the expert opinions of both Dr. Davis and Dr. Bonutti, and the credible testimony of Petitioner.

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 that all services to Petitioner's left knee based on the testimony of Dr. Davis, Dr. Bonutti and Dr. Mirkin were reasonable and necessary. The Arbitrator also finds that the need for the total knee replacement was causally connected to the work accident of June 2, 2013, and, therefore, the appropriate charges for that treatment is the responsibility of Respondent. Respondent shall pay the medical bills set forth in Petitioner's Exhibit 6 subject to the Medical Fee Schedule and Respondent shall receive credit in the amount of $54,517.86 for bills previously paid.

Issue O. Did Petitioner exceeding his choice of physicians?

Petitioner has not exceeded his choice of physicians as allowed under the Act.

Petitioner's family care for medical is taken care of through Primary Care of Harrisburg. Dr. Winkleman at Primary Care referred Petitioner to Dr. Wente at Bonutti Clinic on June 21, 2013.

Petitioner then sought treatment from Dr. Davis as his second choice.

After treating with Dr. Davis, Petitioner returned to the Bonutti Clinic where he was treated by Dr.Bonutti. Bonutti Clinic was Petitioner's first choice for care. Dr. Davis was Petitioner's second choice for care. That there was a gap in time and change in doctors at the Clinic doesn't make the resumption of care at Bonutti Clinic in 2014 a third choice. Given the circumstances in June of 2014 (including information being provided to him by "workmen's comp") Petitioner credibly explained why he went to Dr. Davis and how, later on, when Dr. Davis told him the choice of surgeons was ultimately his, he returned to Bonutti Clinic.

****

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

Aimee Spankroy,

Petitioner,

vs. NO. 10WC030872

Teresa Fister, Individually and
d/b/a Blue Pearl Stone Technologies, LLC.,

17IWCC0119

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, prospective medical care, notice, temporary disability, permanent disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 27, 2016 is hereby affirmed and adopted.

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

No bond 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: FEB 27 2017

SJM/sj
o-1/26/17
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SPANKROY, AIMEE Case# **10WC030872**
Employee/Petitioner

TERESA FISTER INDIVIDUALLY AND D/B/A BLUE OEARL STONE TECHNOLOGIES LLC
Employer/Respondent

17IWCC0119

On 1/27/2016, 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 0.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0659 BRILL & FISHEL PC
FRANCINE R FISHEL
180 N LASALLE ST SUITE 3700
CHICAGO, IL 60601

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

17IWCC0119

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

AIMEE SPANKROY,
Employee/Petitioner

Case # **10 WC 30872**

v.

Consolidated cases:

TERESA FISTER, INDIVIDUALLY AND D/B/A BLUE PEARL STONE TECHNOLOGIES, LLC,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **LYNETTE THOMPSON-SMITH**, Arbitrator of the Commission, in the city of **CHICAGO**, on **November 30, 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

17IWCC0117

FINDINGS

On 6/24/2010, 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 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 $**24,900.00**; the average weekly wage was $**480.00**.

On the date of accident, Petitioner was **21** 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 $0.00 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

Petitioner has not proven, by a preponderance of the evidence, that an accident occurred which arose out of and in the course of her employment by Respondent, therefore no benefits are awarded, pursuant to the Act.

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

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

FINDINGS OF FACT

Medical history prior to June 24, 2010

Aimee Spankroy, (the "Petitioner"), testified that she has received medical treatment to her back beginning in 2001, when she was in high school. She subsequently underwent an MRI of her lumbar spine on September 19, 2005; and was diagnosed at that time with a herniated disc at L5-S1. In October of 2005, Dr. Mather administered injections for back pain. In November of 2005, Dr. Mather performed an L4-L5; L5-S1 laminectomy. Post-operatively, Dr. Mather diagnosed Petitioner as having post-laminectomy syndrome in December of 2005. RX5

Petitioner was involved in an automobile accident on August 26, 2006, and seen in an emergency room following that accident. On January 8, 2007, Petitioner gave a history to Dr. Mather that she totaled her automobile a couple of months ago and now had low back pain radiating down her thighs. Petitioner underwent another MRI of the lumbar spine on May 11, 2007.

On April 9, 2010, Petitioner was examined by Dr. Mather, complaining of neck pain, right arm numbness, low back pain with symptoms worsening for the past few weeks, without a history of injury. At that time, she gave the doctor a history of getting a soft bed a few weeks ago and having similar symptoms as she did in April of 2007. On April 16, 2010, Dr. Mather examined Petitioner and said the MRI showed degenerative disc disease at L3-4, L4-5 and L5-S1, with a possible recurrent small herniation at L4-5, on the right side. On May 10, 2010, Dr. Mather performed an L5 nerve root block. On May 19, 2010, Petitioner called Dr. Mather complaining of increasing pain and stated she was unable to sit/stand for more than fifteen (15) minutes. On May 24, 2010, Petitioner underwent a myelogram of the lumbar spine and a CT of the lumbar spine. On May 27, 2010, Dr. Mather recommended surgery and on June 9, 2010, Dr. Mather performed an L4-5 microdiscectomy. RX5.

Petitioner testified that she was off work following her June 9, 2010, surgery until Monday, June 21, 2010. She testified that Dr. Mather released her to return to work at that time. The Arbitrator notes that the medical records from Dr. Mather do not document a release to return to work on June 21, 2010. Petitioner testified, on cross-examination, that she did not bring a doctor's note to Respondent when she returned to work on June 21, 2010. Tr. p. 43.

Petitioner's testimony regarding a June 24, 2010 accident

Petitioner testified that she was the office manager/sales person/book keeper for the respondent and that on June 24, 2010, she injured her back while showing a customer remnants of slabs of granite. She testified that she "felt extreme pain in my back and my leg gave out on me." She testified that this occurred in front of the customer and that she regained her balance and continued on with the sale in pain. Tr. p. 23.

Petitioner testified that she finished her workday on June 24, 2010 and called her doctor to make an appointment. The Arbitrator notes Dr. Mather's records do not reflect a June 24, 2010 telephone call from Petitioner, seeking an appointment.

Petitioner testified that she continued working for Respondent through July 2, 2010, and on that date, she met with Teresa Fister and told her that she hurt her back on June 24th, while servicing a customer by the name of Roche. Upon cross-examination, Petitioner was asked if she was absolutely certain her last day of work was July 2, 2010, and she responded, "No." She was asked on cross-examination, "On June 29, 2010, Teresa Fister sent you home and told you not to come back without a doctor's note, is that correct?" And she replied, "Yes." She was asked whether she made reference to the alleged June 24, 2010, work accident during the June 29, 2010, conversation with Teresa Fister and replied, "I do not know." Petitioner testified she did not remember whether she came to work on June 30, 2010 or had any conversations with Teresa Fister on that day. Tr. pp. 45-48.

Respondent's witness' testimony

Ms. Teresa Fister testified that she is the owner of Blue Pearl Stone Technologies, LLC. She rebutted Petitioner's testimony regarding her job title and duties and testified that Petitioner was an office assistant. Ms. Fister testified that in that capacity, Petitioner worked at a desk and answered the phone and helped her with sales when customers came in. She also testified that Petitioner's job did not entail lifting granite. Tr. pp. 66-67.

Ms. Fister further testified that when Petitioner returned to work on June 21, 2010, following her June 8, 2010 back surgery, she did not provide her with a doctor's note stating that she was cleared to return to work. Ms. Fister testified that on June 24, 2010, Petitioner did not report any work-related accident and that Petitioner told her she injured her back at home the evening before. Specifically, she testified that Petitioner came into work approximately 9:00 a.m. on June 24, 2010, looking very frazzled, pale and tired. She testified she asked Petitioner what was wrong and that Petitioner told her she had been up all night moving furniture out of her parents' flooded basement. She testified that Petitioner told her that her back really hurt from that activity. Ms. Fister gave Petitioner the option to stay at work and take it easy or to go home; and that the Petitioner decided to stay at work. Tr. pp. 70-75.

Ms. Fister stated that she observed Petitioner during the time she worked between June 24, 2010 and June 29, 2010, and that Petitioner was crying approximately three to four times a day. She testified that Petitioner was acting erratic and was sometimes very rude to customers. Ms. Fister testified that she heard Petitioner scream, "We shouldn't even do any work for this guy," and described Petitioner as being hysterical. Additionally, Ms. Fister testified that customers were complaining about Petitioner double scheduling appointments. Tr. p. 73.

On June 29, 2010, she had a conversation with Petitioner about her behavior and told Petitioner she should take some time off and that she wanted to see a doctor's release because she was worried about

her. She testified that she sent Petitioner home at that time and that during that conversation, the petitioner never mentioned any work-related accident. Tr. pp. 74-75.

June 29, 2010, was the last day Petitioner worked for Respondent. Ms. Fister testified that Petitioner came back to work the next day, i.e., June 30, 2010, but did not have a doctor's note therefore, she did not allow her to work. She met with Petitioner on the morning of June 30, 2010 and that Petitioner was acting nervous and was writing on a pad of paper during their conversation. She testified that Petitioner did not mention any injury at work to her on that day. That was the last time that she saw Petitioner, although she was under the impression Petitioner was going to come back to work. She subsequently telephoned Petitioner several times but she never returned her calls. Tr. pp. 77-78.

The first time Ms. Fister learned that Petitioner was alleging a work-related accident, was after she received an Application for Adjustment of Claim from Petitioner's attorney sometime between the date it was filed, i.e., July 2, 2010; and the date that she faxed it to her insurance carrier, i.e., July 22, 2010. She identified Respondent's Exhibit 1, as a copy of that Application for Adjustment of Claim. This was for case number 10 WC 25234, which alleged a June 29, 2009, lifting accident. Petitioner later testified that said case was dismissed, due to incorrect information on the application, filed by a previous attorney. Tr. pp. 78-82.

Petitioner's cross-examination

Petitioner was asked by Respondent's attorney, "Calling your attention to June 24, 2010, isn't it true that you told the owner of Blue Pearl, Teresa Fister, on that day that you re-injured your back the evening before on June 23, 2010, while lifting furniture in your parents' flooded basement?" Petitioner's response was, "I do not remember that at all." Tr. pp. 43-44.

Petitioner testified that she told Dr. Mather about the alleged June 24, 2010, work-related accident on July 1, 2010. The Arbitrator notes that the records from Dr. Mather on those dates or any other dates do not document a history of the alleged work-related accident. Dr. Mather testified at his deposition that his treatment notes do not indicate any type of lifting accident on June 24, 2010 PX2, p. 35; Tr. pp. 30-31.

The July 1, 2010, office note from Dr. Mather indicates that Petitioner was "Three weeks status post right L4-5 revision microdiscectomy. Complains of right leg pain; has not improved much since surgery; occasional numbness/tingling in right leg. Straight leg raising test on the right side at 60-70 degrees causing mild radiating down the right leg." The doctor's impression was post-laminectomy syndrome. The doctor prescribed a repeat MRI. RX5, p. 16.

Petitioner was asked if the records from Dr. Mather indicated that she made no report of any alleged June 24, 2010, work injury at that time, would she agree, and she responded yes. Petitioner was asked and admitted that it was true that she was assaulted and beaten by a woman on August 12,

2010, six days after her August 6, 2010 surgery; and that the beating caused her to go to an emergency room on August 12, 2010. Petitioner testified she called Dr. Mather's office on August 13, 2010, and said she "felt like she did before the surgery." Petitioner testified she had a revision laminectomy and lumbar fusion on May 10, 2011, and that the procedure was performed by Dr. Mather. Tr. pp. 50-53.

Medical history after June 24, 2010

On July 2, 2010, Petitioner underwent an MRI of the lumbar spine at Good Samaritan Hospital, which revealed findings compatible with post-surgical changes. RX5.

On July 29, 2010, Petitioner returned to Dr. Mather. The Arbitrator notes that there is no history of a June 24, 2010, work-related injury or any work-related injury. On that date, Petitioner told the doctor that she continued to have right leg pain and wished to proceed with the lateral foraminotomy.

On August 4, 2010, Dr. Mather performed a revision, right L5-S1 foraminotomy. The Arbitrator notes that two days after the surgery, on August 6, 2010, Petitioner signed the subject Application for Adjustment of Claim alleging a June 24, 2010, work-related accident. RX5. p. 13.

Respondent's IME

Petitioner was examined at Respondent's request by Dr. Singh on July 28, 2011. Dr. Singh diagnosed degenerative disc disease L4-5 and L5-S1, which is pre-existing; status post L4-5 and L5-S1 laminectomy and posterior spinal fusion with instrumentation and cervical muscular strain. The doctor found she did not sustain a work-related injury and that her condition was the result of pre-existing lumbar and cervical condition, which is unrelated to work injury.

Petitioner offered a purported copy of notes that she said she took during a final meeting with Teresa Fister. The Arbitrator notes the document contains a handwritten date and time of July 2 at 10:30 a.m. on the top of the page and that this ink appears to be different than the ink used on the rest of the text. Given Petitioner's testimony that she was not sure July 2, 2010 was the last day she worked, and Petitioner's other conflicting testimony throughout trial and lack of history of an alleged June 24, 2010 accident in the medical records of Dr. Mather, the Arbitrator does not find Petitioner's testimony to be reliable.

Respondent offered the notes identified by Teresa Fister as the notes she took after she was first made aware of an alleged June 29, 2009, accident as Respondent's Exhibit 3. These notes contain a fax transmission date of July 22, 2010, relative to a fax Ms. Fister testified she sent to her workers' compensation insurance carrier. The Arbitrator notes that this contemporaneous document is consistent with the testimony provided by Ms. Fister at trial, which the Arbitrator finds to be credible.

On rebuttal, Petitioner denied telling Ms. Fister that she hurt her back moving furniture from her parent's flooded basement and reiterated that she hurt her back at work.

17IWCC0119

CONCLUSIONS OF LAW

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

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 vs. 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 vs. 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 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 burden is on the petitioner to prove an accident "arose out of" and "in the course of" her employment with Respondent. Generally, an injury "arises out of " employment if, at the time of the occurrence, the employee was performing acts he was instructed by the employer to perform, those he might be reasonably expected to perform, or acts which he had a common law or statutory duty to perform. *Caterpillar Tractor Co. v. Industrial Comm'n,* 129 Ill.2d 52 (1989). The phrase "in the course of" refers to the time, place, and circumstances under which the accident occurred. *Orsini v. Industrial Comm'n,* 117 Ill2d. 38 (1987). Finally, an injury is received "in the course of" one's employment when it occurs within the period of employment, at a place the employee may reasonably be in the performance of his duties, and while he is fulfilling those duties or engaged in something incidental thereto. *Scheffler Greenhouses, Inc. v. Industrial Comm'n,* 66 Ill.2d 361 (1977).

Petitioner has failed to prove, by a preponderance of the evidence, that she sustained a June 24, 2010, accident that arose out of and in the course of her employment with Respondent. As the petitioner has not proven that an accident occurred, the additional disputed issues are moot and will not be addressed.

17IWCC0119

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
10WC30872
SIGNATURE PAGE

Signature of Arbitrator

January ~~27,~~ 2016
Date of Decision

JAN 27 2016

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

☒ 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

James Quick,

Petitioner,

17IWCC0120

vs.

NO: 12 WC 22982

State of Illinois, Murray 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 issue of medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission 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 18, 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.

DATED: FEB 2 7 2017
KWL/vf
O-2/6/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

17IWCC0120

QUICK, JAMES
Employee/Petitioner

Case# 12WC022982

STATE OF ILLINOIS MURRAY CENTER
Employer/Respondent

On 5/18/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.37% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 THOMAS C RICH PC
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0558 ASSISTANT ATTORNEY GENERAL
AARON L WRIGHT
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0498 STATE OF ILLINOIS
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1745 DEPT OF HUMAN SERVICES
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

MAY 18 2016

Ronald A. Peria
RONALD A. PERIA, 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
19(b)

17IWCC0120

James Quick
Employee/Petitioner

v.

State of Illinois, Murray Center
Employer/Respondent

Case # 12 WC 22982

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Collinsville**, on **August 19, 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? **(Cervical spine only)**
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? **(Cervical spine only)**
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, **May 4, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$39,987.48**; the average weekly wage was **$768.99**.

On the date of accident, Petitioner was **50** 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 **$all benefits paid** for TTD, $- for TPD, $- for maintenance, and $- for other benefits, for a total credit of **$all benefits paid**.

Respondent is entitled to a credit of **$any benefits paid through group** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $465,628.60, as set forth in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall also authorize and pay for prospective reasonable and necessary medical treatment as recommended by Dr. Gornet, including but not limited to surgery, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Michael K. Nowak, Arbitrator

5/13/16
Date

FINDINGS OF FACT

The Parties stipulated that Petitioner sustained accidental injuries arising out of and in the course of his employment with Respondent as a Mental Health Technician II on May 4, 2012, when, while Petitioner was changing a bed bound recipient, the recipient grabbed Petitioner's left arm. (T.9, 10). Petitioner believed the recipient was about to bite him and pulled away, but the recipient wrenched Petitioner forward by his arm and injured Petitioner's neck, left shoulder, and low back. (T.10). Respondent does not dispute causation with respect to Petitioner's low back or left shoulder, but disputes causation as to the neck. (AX1).

Petitioner testified credibly that following his injury, he immediately felt pain in his low back, neck and left shoulder. (T.10). Respondent sent Petitioner to St. Mary's Good Samaritan Work Safety Institute for treatment, where the primary focus was on the treatment of Petitioner's low back and left shoulder. (PX3). Although Respondent referred Petitioner to St. Mary's for care, it denied his treatment. (PX3). Handwritten notes made on June 5, 2012, state, "Back/shoulder sprain – not resolved. Unfortunately was denied by work comp. Feels he has to go to full duty." (PX3, 6/5/12). After Petitioner was forced to return to full duty, he derived little benefit from therapy. (PX3, 6/12/12).

After Respondent denied Petitioner's treatment, Petitioner saw Dr. Gornet on July 19, 2012 at the direction of his attorney. (T.11, 12; PX4, 7/19/12). Petitioner was an established patient with Dr. Gornet. Dr. Gornet had performed surgery on Petitioner's neck in 2007, and his last visit with Dr. Gornet relative to the earlier injury was October 5, 2009. (T.12; PX4, 7/19/12). Consistent with Dr. Gornet's record, Petitioner testified that he made a satisfactory recovery from his neck surgery and was discharged from care in 2009. (T.12, 13, 19). Petitioner testified that he was not under active care with any physician at the time of his May 2012 accident and that he was not experiencing any symptoms on his neck at the time of the May 2012 accident. (T.12, 13).

On July 19, 2012, just 2 months following the injury, Dr. Gornet noted Petitioner's complaints of neck pain along with his other conditions. (PX4, 7/19/12). Plain radiographs of Petitioner's cervical spine demonstrated some ankylosis of the segment at C5-6 posterior to the prosthesis. *Id.* Dr. Gornet believed that Petitioner suffered an aggravation of his previous neck condition versus a new injury. *Id.* He recommended conservative care and an MRI scan. *Id.* Dr. Gornet's review of Petitioner's MRI showed no significant adjacent level issues, but he noted that Petitioner's adjacent levels were "hard to visualize from the a C5-6 disc herniation secondary to artifact." *Id.* Since Petitioner's neck complaints were not as urgent as Petitioner's other symptoms, Dr. Gornet stated that that he "put this [Petitioner's neck] on hold." *Id.* Petitioner's low back and left shoulder took precedence, and Dr. Gornet referred Petitioner for lumbar injections at L4-5 and L5-S1. *Id.* Dr. Gornet referred Petitioner to Dr. Mall for evaluation of his left shoulder. (PX4, 1/24/13, 3/7/13). At the time of his initial visit on April 8, 2013, Dr. Mall noted tenderness to palpation at the cervical spine during physical examination. (PX8, 4/8/13). Dr. Mall, however, focused on the most pressing injury, the rotator cuff tear shown on MRI, as Dr. Mall believed this was the source of the majority of Petitioner's complaints. (PX8, 4/30/13).

As of June 17, 2013, Petitioner's neck care remained suspended, as Dr. Gornet acknowledged, "He also has some neck issues, but we have placed those on hold." (PX4, 6/17/13). Dr. Gornet again noted on September 19, 2013, that he was on standby for "working up his neck" due to a delay in approval for care for his lumbar spine. (PX4, 6/17/13). He stated, "We wait for approval for treatment, but he understands that a delay in care does affect his overall outcome." *Id.*

Petitioner ultimately required surgery on both his back and his left shoulder. Dr. Mall performed surgery on Petitioner's left shoulder on January 30, 2014. On June 25, 2014, Dr. Gornet addressed Petitioner's isthmic spondylolisthesis at L5-S1 with discogenic back pain through anterior decompression at L4-5 and L5-S1, anterior lumbar fusion at L5-S1 using cages, BMP and crushed cancellous allograft, and disc replacement at L4-5. (PX11). Petitioner testified that his low back symptoms improved following surgery; however, Petitioner's neck continued to be symptomatic. (T.13, 14). Dr. Mall noted on April 2, 2014, that Petitioner continued to have neck complaints. (PX8, 4/2/14). He stated, "I know that there are other issues with his lumbar spine and neck. Therefore, I will leave the work status for these up to his treating physician for this." *Id.*

Dr. Gornet continued to care for Petitioner's lumbar spine and reference Petitioner's neck care as being "on hold" on May 8, 2014, June 9, 2014, and again on October 6, 2014, after Petitioner's 3 and 6 week postoperative visits for his lumbar spine. (PX4, 5/8/14 through 10/6/14).

On December 8, 2014, Dr. Gornet turned his attention to Petitioner's cervical spine and recommended a CT myelogram to visualize the areas adjacent to Petitioner's prior C5-6 disc replacement. (PX4, 12/8/14). Petitioner's post myelogram CT demonstrated a left lateral recess broad based herniation at C4-5 resulting in left ventral cord flattening, left lateral recess stenosis, and left greater than right foraminal stenosis; a left foraminal broad based herniation at C7-T1 resulting in left foraminal stenosis; and a C6-7 circumferential disc bulge and right foraminal herniation resulting in severe foraminal stenosis. (PX9, 1/20/15).

On February 19, 2015, Respondent had Petitioner examined by Dr. Frank Petkovich with respect to Petitioner's cervical spine. (RX2). Respondent previously had Petitioner examined by Dr. Petkovich on January 16, 2014, for an opinion specifically regarding Petitioner's low back and left shoulder. (RX1). In his February 2015 report for Petitioner's *second* evaluation with respect to his cervical spine, Dr. Petkovich reported that Petitioner denied any injury to his cervical spine at the time of the incident. (RX2, p.2). However, the intake questionnaire for the January 16, 2014 examination listed Petitioner's "back/neck" as his chief complaint, listed the date of onset as the May 4, 2012 date of accident. (RX1). Petitioner further indicated that he was seeing Dr. Gornet for his "back/neck." (RX1).

Petitioner presented for the second examination on February 19, 2015 with films of his cervical MRI. (RX2). Dr. Petkovich could not identify the disc herniations and/or protrusions appreciated by both the radiologist and Dr. Gornet. *Id.* He concluded that Petitioner did not sustain any injury or aggravation to his cervical spine or degenerative disc disease as a result of the May 2012 accidental injury. *Id.*

On March 19, 2015, Dr. Gornet noted that Petitioner continued to suffer from neck pain, which adversely affected Petitioner's quality of life. (PX4, 3/19/15). Dr. Gornet reviewed Dr. Petkovich's IME report, and with regard to Dr. Petkovich's conclusions he stated:

> To my knowledge, there has never been an opinion given that Mr. Quick's injury caused or accelerated his disc degeneration. What we can clearly state is that Mr. Quick had not seen me for almost three years. He was a long established patient of mine. His last visit in my office in 2009 for a two year follow-up showed that he was doing moderately well, working full duty and not having any significant problems. The next visit he came to the office was on 7/19/12, shortly after his work related injury. He did not recall any previous problems of significance

> between this interim period. It is important to note that the reason why Mr. Quick returned was that he was symptomatic. . . It was our opinion that Mr. Quick suffered a central herniation at C4-5 more to the left as well as at C6-7. These herniations are always associated with some level of disc degeneration and again, there is no indication that he had any symptomatic pathology of significance in his neck prior to his work related injury of May of 2012.
>
> At this point, I continue to believe his symptoms are casually connected to his work related injury. I have recommended steroid injections at C4-5 and one at C6-7. . . *Id.*

Petitioner underwent the recommended injections, but returned to Dr. Gornet on May 28, 2015, and July 30, 2015 with persistent symptoms. (PX4, 5/28/15, 7/30/15). Dr. Gornet recommended disc replacement surgery at C4-5 and C6-7. (PX4, 7/30/15). Petitioner testified that he wishes to receive the care and treatment recommended by Dr. Gornet. (T.14).

Respondent took the deposition of its examiner, Dr. Petkovich, on June 30, 2015. (RX3). Dr. Petkovich again stated that Petitioner denied any injury to his cervical spine, despite his own intake questionnaire to the contrary. (RX3, p.13). His testimony regarding the findings on Petitioner's MRI omitted any reference to herniations, protrusion or bulges; he claimed Petitioner's radiographs showed only "degenerative changes" which he believed were present prior to the accident. *Id.* at 18, 19. He stated that the "degenerative cervical disc condition is completely unrelated to that work incident on May 4, 2012. *Id.* at 20. When asked about Dr. Gornet's initial treatment record following the May 2012 accident which documented that Petitioner presented with complaints of neck pain, Dr. Petkovich stated that he believed that Petitioner was "complaining of chronic conditions" despite the fact that Petitioner had not sought any care whatsoever since October of 2009 and the intake form listed date of onset as May 4, 2012. *Id.* at 13, 29, 30. Dr. Petkovich testified that he has not performed any spinal surgery in the last 3 to 4 years. *Id.* at 36, 37.

Dr. Gornet testified by way of deposition on July 22, 2015. (PX13). Dr. Gornet compared the MRI studies performed back in 2007 and those taken following the accident at issue in this case. He testified that Petitioner's 2007 studies showed an isolated disc herniation at C5-6, with all other levels being normal. *Id.* at 8. He testified that the new herniations at C4-5, C6-7 and C7-T1 shown on Petitioner's 2015 imaging studies "are new findings that were not present" before his 2012 injury. *Id.* at 14, 15. He confirmed that he did not see Petitioner at any time for treatment, other than the yearly routine follow-up in 2009, following Petitioner's placement at maximum medical improvement in 2008. *Id.* at 9. He confirmed that he did not see Petitioner at any time for any reason following the annual follow up in 2009, until after Petitioner sustained his new injury on May 4, 2012. *Id.* at 9. There were no indications in the records of any new accidents. *Id.* at 17, 18.

Dr. Gornet testified that it was necessary to care for Petitioner's low back and shoulder first, prior to addressing his cervical complaints. *Id.* at 10, 11. When asked why it was necessary to proceed with his shoulder evaluation first, he stated:

> Well, because in this particular situation the patient had symptoms in the shoulder. And the reason why we do that is because the shoulder is a region that can often have symptoms coming from two different areas. You can have a primary shoulder problem which causes shoulder pain, and you can also have a

> neck or cervical problem which refers pain into the shoulder. So we basically see patients such as this in conjunction as two types of physicians, each approaching it from their different specialty, because it's such an overlapping area and problem. *Id.* at 11, 12.

With regard to the new herniations shown on objective films, Dr. Gornet testified that Petitioner's subjective complaints correlated; and that even prior to obtaining those studies, Petitioner's positive findings on physical examination objectively correlated with the complaints and the studies later obtained. *Id.* at 16. He thus opined that Petitioner's cervical spine condition and the need for treatment is causally connected to the accident of May 4, 2012. *Id.* at 16.

CONCLUSIONS

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

The Arbitrator finds Petitioner to be a credible witness. Petitioner's testimony concerning his injury and his medical history was consistent and fully corroborated by the medical records. The Arbitrator further finds the testimony and opinions of Dr. Gornet more persuasive than those of Dr. Petkovich in this case.

The evidence clearly demonstrates that Petitioner was not under any active care for his cervical spine at the time of the accident. Furthermore, the objective radiographic studies show that Petitioner has developed 3 new herniations following the incident.

The Arbitrator notes that a significant amount of time elapsed between the injury and Petitioner's cervical care, Petitioner testified that he felt immediate pain in his neck following the injury. He mentioned these complaints to Dr. Gornet just two months following the injury, and Dr. Gornet and Dr. Mall documented Petitioner's persistent cervical complaints through their course of care. As Dr. Gornet credibly explained, shoulder conditions and complaints often overlap with neck symptoms and complaints. This could explain the failure of Respondent's chosen treating facility, St. Mary's Good Samaritan, to note Petitioner's neck complaints.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner met his burden of establishing that the current condition of ill-being of his cervical spine is causally related to his undisputed work accident of May 4, 2012

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

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

The Arbitrator finds that Petitioner's care and treatment was conservative and reasonable. Petitioner suffered from persistent cervical complaints with no improvement over time and exhausted conservative care prior to any recommendation for surgery.

Based upon the above findings with regard to issue F, and the record taken as a whole, Respondent shall pay reasonable and necessary medical services of $465,628.60, as set forth in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall have credit for any expenses paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act. Respondent shall further authorize and pay for the necessary care and treatment recommended by Dr. Gornet, including but not limited to surgery.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Therese Kopytko,

Petitioner,

vs.

NO: 14 WC 35861

The Proctor & Gamble Company,

17IWCC0121

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, benefit rates, 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 8, 2015, is hereby affirmed and adopted.

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

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

17IWCC0121

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

DATED:
TJT:yl
o 1/10/17
51

FEB 28 2017

Joshua D. Luskin

Kevin W. Lamborn

DISSENT

I respectfully dissent from the majority decision. For the reasons that follow, I would reverse the Decision of the Arbitrator and find that the Petitioner, while an employee of the Respondent, sustained an accident on February 20, 2014, which arose out of and in the course of her employment. Accordingly, I would award the Petitioner workers' compensation benefits for her work related injuries.

A claimant has the burden of proving all of the elements of her case in order to recover benefits under the Workers' Compensation Act. This burden of proof must be met by a preponderance of the evidence. *Illinois Bell Tel. Co. v. Industrial Comm'n*, 265 Ill. App. 3d 681, 685 (Ill. App. Ct. 1st Dist. 1994). Given the evidence and the relevant case law, the Petitioner has met her burden of proof by a preponderance of the evidence.

The employee-employer relationship must be inferred from the conduct of the parties. Our Illinois Supreme Court set forth seven factors to consider from *Roberson v. Industrial Commission*, 225 Ill. 2d 159 (2007): Control, the worker's schedule, whether the worker was paid hourly or not, whether income and social security monies were withheld from the worker's paycheck, the ability to discharge the worker at will, the supply of materials and equipment to the worker, and whether the employer's general business encompasses the person's work. The right to control is the most important factor, although no single factor is determinative.

The Petitioner in this case should have been deemed an employee of the Respondent. Here, the Respondent had the right to control the Petitioner's work: The Respondent neither paid the Petitioner hourly nor withheld income or social security. The Respondent controlled the manner of the Petitioner's job with them and her schedule. The Respondent dictated the dress code, the days and hours the Petitioner was to work, the booth that the Petitioner worked at, and her specific job duties at the booth. She was given a specific time to arrive at the convention center. The materials and equipment that the Petitioner utilized at the booth were provided by the Respondent. Furthermore, she was given a badge to wear that identified her as an exhibitor for the Respondent at the convention.

17IWCC0121

The Petitioner sustained a full thickness tear in her right shoulder from her fall at the convention center. She also sustained a possible fracture of the wrist which improved without surgery, and she was diagnosed with flexor tenosynovitis of the right thumb which led to some loss of range of motion. She testified that she still experiences some symptoms that have had a negative impact on her daily activities.

For the aforementioned reasons, I would reverse the Arbitrator's decision and find that the Petitioner proved that she sustained an accident arising out of and in the course of her employment while working for the Respondent on February 20, 2014. Accordingly, I would award Petitioner the applicable benefits.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KOPYTKO, THERESE
Employee/Petitioner

Case# **14WC035861**

THE PROCTOR & GAMBLE COMPANY
Employer/Respondent

17IWCC0121

On 9/8/2015, 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 0.27% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 ESQ
111 W WASHINGTON ST SUITE 1030
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
TANMMY PAQUETTE
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

17IWCC0121

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

Therese Kopytko
Employee/Petitioner

v.

The Proctor & Gamble Company
Employer/Respondent

Case # **14** WC **35861**

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 **Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **06/29/2015**. 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 _____

17IWCC0121

FINDINGS

On **02/20/2014**, 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 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 **$0**; the average weekly wage was **$0**.

On the date of accident, Petitioner was **61** 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 **$0** under Section 8(j) of the Act.

ORDER

Petitioner has not proven, by a preponderance of the evidence, that she is an employee of Respondent therefore, no benefits are awarded, pursuant to the Act.

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

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

Findings of Fact

The disputed issues in this matter are: 1) whether Petitioner and Respondent were operating under the Illinois Workers' Compensation Act (the "Act") and was their relationship one of employer and employee; 2) accident; 3) notice; 4) causal connection; 5) earnings; 6) average weekly wage; 7) medical bills; and 8) the nature and extent of Petitioner's injuries. *See,* AX1.

Ms. Therese Kopytko, (the "Petitioner"), testified that she is a dental hygienist, employed by Prairie State College as an Adjunct Professor in the dental hygiene program. She noted that she has held that position since 1989. Petitioner went on to testify that she did some work with Proctor & Gamble at a dental convention where she would work the Mid-Winter Dental Convention at McCormick Place, manning the Oral-B booth at that convention. Petitioner testified that she had manned a booth at the convention in 2011, 2012 and 2013. Petitioner testified as part of manning the booth, she was assigned different roles such as cleaning sinks, demonstrating new products, toothpastes, dental floss, mouthwashes, etc. Tr. pp. 10-14.

February 20, 2014 was the first day Petitioner was to man a booth at the conference. Prior to being allowed in the convention area, Petitioner needed to pick up a badge in order to get into the exhibition hall where the booth was located. On February 20, 2014, as she got off the elevator to go to that designated area, Petitioner slipped and fell. Subsequent to this fall, Petitioner's testified that she did fill out a report with security and then went to the registration area, received her badge and was given her post. After manning this post for less than an hour, Petitioner indicated she could not handle the pain and ultimately left and presented to Rush University Hospital. Petitioner then sought treatment with Hinsdale Orthopedic Associates, specifically Dr. Chudik. Tr. pp. 27-37.

Petitioner subsequently underwent surgery to the right shoulder. This surgery was done with two weeks remaining in the spring semester at school and she did not work during that time but did continue to receive her salary. The remaining time that Petitioner was kept off work by her doctor was during the summer and she would not have been working at that time anyway. Petitioner was last seen by Dr. Chudik on September 12, 2014, at which point she was discharged from care. At hearing, Petitioner testified that she is currently working in a full duty capacity, making the same or more per hour, as she was prior to her fall. Tr. pp. 30-54.

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

Petitioner bears the burden of proving every aspect of his claim by a preponderance of the evidence. Hutson v. Industrial Commission, 223 Ill App. 3d 706 (1992). "Liability under the Workmen's Compensation Act may not be based on imagination, speculation, or conjecture, but must have a foundation of facts established by a preponderance of the evidence..." Shell Petroleum Corp. v. Industrial Commission, 10 N.E. 2d 352 (1937). 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. *Revere Paint & Varnish Corp. v. Industrial Commission,* 41 Ill.2d. 59. Preponderance of the evidence means greater weight of the evidence in merit and worth that which has more evidence for it than against it. *Spankroy v. Alesky*, 45 Ill. App.3d 432 (1st Dis. 1977).

Automatic coverage under the Act pursuant to Section 3 (17)(a) applies to "[a]ny business or enterprise in which goods, wares or merchandise are sold or in which services are rendered to the public at large, provided that this shall not apply to such business or enterprise unless the annual payroll during the year next preceding the date of injury shall be in excess of $1,000." While the Arbitrator finds that Respondent may potentially fall under this provision of the Act, there was no evidence presented to support that finding. Therefore, Petitioner has failed to prove, by a preponderance of the evidence that Respondent was operating under and subject to the Illinois Workers' Compensation Act.

B. Was there was an employee-employer relationship?

The Arbitrator notes that it must be determined whether there was control, consent and consideration between the parties to establish such a relationship. Given that Petitioner had not yet arrived at the location to obtain her credentials for day one, drop off her W-9, obtain her booth assignment or performed any activities in connection with working the booth, she was not yet within the control of the Respondent and therefore, was not an employee of the Respondent at the time of the fall. More importantly, the terms "employer' and "employee" are defined in to Sections 1(a) and 1(b) of the Illinois Workers' Compensation Act. And while there is no specific litmus test for determining whether an employee-employer relationship exists, such a relationship could be inferred from the conduct of the parties. In assessing the nature of the relationship, the Illinois Supreme Court has set forth the following factors to consider: (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. *Roberson v. Industrial Commission, 225* Ill.2d 159, 866 N.E.2d 191(2007). While no single factor is determinative and the determination rests on the totality of the circumstances, the right to control the work is the most important consideration. *Roberson,* 225 Ill.2d at 162.

Here, the Respondent did not pay the petitioner hourly and did not withhold income and social security taxes however, the Respondent did control the manner in which the Petitioner performed her work. However, while she worked on Petitioner's schedule, she was able to choose the days that she wanted to work. The respondent dictated the dress code and the specific duties Petitioner was to perform, including cleaning sinks used to test products. The materials and equipment were provided

by Respondent and Petitioner was given a badge to wear that identified her as an exhibitor for Crest Oral-B, a Proctor & Gamble product line. Some facts suggest that Petitioner was an employee and other facts suggest she was an independent contractor. As such, looking at the totality of the circumstances, the Arbitrator finds and concludes that Petitioner has not proven, by a preponderance of the evidence that she is an employee of Respondent. As such, she is not entitled to benefits under the Act, in the subject matter. As the petitioner had not proven that she is an employee of the respondent, all other issues are moot and will not be addressed.

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
14WC35861
SIGNATURE PAGE

17IWCC0121

L Thompson Smith
Signature of Arbitrator

September 8, 2015
Date of Decision

SEP 8 - 2015