STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rhiane Hoots,

Petitioner,

vs.

NO: 14WC 34926

Illinois College,

18IWCC0074

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 medical expenses, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 26, 2017 is hereby affirmed and adopted.

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

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

18IWCC0074

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $59,400.00. 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 1 - 2018
SJM/sj
o-1/25/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HOOTS, RHIANE
Employee/Petitioner

Case# **14WC034926**

ILLINOIS COLLEGE
Employer/Respondent

18IWCC0074

On 6/26/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2333 WOODRUFF JOHNSON & EVANS
JAY JOHNSON
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

2593 GANAN & SHAPIRO PC
TIMOTHY C STEIL
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

18IWCC0074

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Rhiane Hoots
Employee/Petitioner

v.

Illinois College
Employer/Respondent

Case # **14 WC 34926**

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 **Champaign**, on **4/13/2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On 3/31/2014, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$20,800.00**; the average weekly wage was **$400.00**.

On the date of accident, Petitioner was **24** 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.

ORDER

The Respondent shall pay Petitioner permanent partial disability benefits of $240.00/week for 127.95 weeks, because the injury sustained caused 18% loss of person as a whole, as provided in Section 8(d)(2) of the Act, and 15% loss of use of the right arm as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner the following reasonable and necessary medical expenses: Prescription Partners, $413.67 per the fee schedule.

Medical charges from Orthopedic & Shoulder Center in the amount of $28,162.00 are reasonable and necessary medical services, as provided in Section 8(a) of the Act. The Arbitrator orders Respondent to pay Petitioner for these charges, subject to the 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.

Edward Lee
Signature of Arbitrator

6/21/17
Date

JUN 26 2017

FACTS OF CASE

On March 31, 2014, Petitioner had an undisputed accident when he was picking up a bag of grass seed that weighed approximately 50 pounds when he noticed his shoulder popped. As a result of the accident, Petitioner underwent surgery on May 13, 2014 consisting of a right shoulder arthroscopy, debridement and labral repair. Petitioner continued to have symptoms and thereafter underwent a second shoulder surgery on August 19, 2014 consisting of a labral repair. After the second surgery, Petitioner was placed in an elbow sling and noticed numbness in his fourth and fifth fingers.

Petitioner was seen by Dr. Lawrence Li for an IME at Respondent's request on May 27, 2015. Dr. Li diagnosed Petitioner with failed labral repairs and recurrent tears in the superior labrum as well as possible failed repair in the posterior labrum. Dr. Li also diagnosed Petitioner with right cubital tunnel syndrome as a result of wearing a sling for a prolonged period. Dr. Li then became the Petitioner's treating physician. On July 15, 2015, Petitioner underwent a third surgery consisting of a right shoulder arthroscopy with biceps tenodesis, arthroscopic subacromial decompression, extensive debridement of tenosynovitis and recurrent SLAP tear repair. On October 9, 2015, Petitioner underwent a right cubital tunnel release performed by Dr. Li.

Petitioner testified the Game Ready device provided by Dr. Li was helpful. Petitioner testified that he was not provided with a Game Ready device after his cubital tunnel surgery that was performed on October 9, 2015.

On January 14, 2016, Dr. Li allowed Petitioner to return to work without restrictions and placed Petitioner at MMI.

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

Respondent disputes certain charges from Dr. Lawrence Li which relate to therapy charges for the Game Ready device. The Arbitrator notes that Dr. Li was Respondent's Section 12 physician who later became Petitioner's treating physician. Petitioner testified that the Game Ready device is a therapy modality that uses motion and cold compression. He testified that Dr. Li prescribed the device for home use following his shoulder surgery. He testified that a company came to his home to set up this device. He further testified that he had used the same type of device in a clinical therapy setting following the shoulder surgeries that Dr. Leutz had performed. The Arbitrator notes that those charges are not in dispute.

Petitioner testified that the Game Ready device provided substantial relief. He testified that he used it even more than prescribed because of the relief it provided. The device helped relieve his pain and improved his motion.

Respondent denied the Game Ready device based on a UR report. Dr. Li certified this device as medically necessary and explained why in his pre-surgery prescription dated June 26, 2015. (Rx 2). He further explained the reasonableness and necessity of the device in both his October 16, 2015 reconsideration report and his November 4, 2015 Utilization Review appeal letter. Dr. Li's medical records document Petitioner's use of the device and favorable response to its use following surgery. Petitioner's response to the use of the device mirrors Dr. Li's documentation supporting the reason for the use of the device. (Px 3). Based upon Petitioner's testimony, Dr. Li's UR response, and Dr. Li's medical records documenting Petitioner's improvement with the use of this device, the Arbitrator disagrees with the Utilization Review reports and finds that the Game Ready device was reasonable and necessary to treat the ill-effects of Petitioner's work related injury. As such, he orders Respondent to pay Petitioner the charges, subject to the fee schedule.

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

The parties stipulated and the Arbitrator is in agreement Petitioner is entitled to 18% man as a whole as provided under Section 8(d)(2) of the Act and 15% loss of use of the arm as provided under Section 8(e) of the Act as a result of this accident.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kerry Hooten,
Petitioner,

18IWCC0075

vs.

NO: 15 WC 23096

Empire Comfort Systems,
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, causal connection, 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 17, 2017, is hereby affirmed and adopted.

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

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

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 - 2018
o12/7/17
DLS/rm
046

Deborah L. Simpson

Stephen J. Mathis

DISSENT

I respectfully dissent from the majority decision and would reverse the Arbitrator's decision and find accident and causal connection to Petitioner's condition of ill being.

Petitioner had two prior claims involving his cervical spine and left shoulder. Petitioner returned to work full duty without restrictions in July 2012 with respect to those claims. Petitioner settled those prior claims in July and December of 2012. Although Petitioner testified to having lingering pain complaints at the time of settling his prior claims, he was able to do his job without issue until 2014. In October of 2014 Petitioner returned to his doctor with shoulder complaints and notified Respondent. Petitioner was diagnosed as suffering from failed fusion surgery and a revision surgery was prescribed. Dr. O'Boynick, Petitioner's doctor, opined that Petitioner's current condition was aggravated by his work activities. Respondent's §12 examiner, Dr. Gornet, opined that Petitioner's condition was related to his previous accident and was not causally related to any activity subsequent to July 2012.

The Arbitrator's decision finding no accident was strictly based upon Petitioner's settlement of his previous claims. There is no question that Petitioner had previous cervical and shoulder injuries, which resulted in surgeries and claims, which were settled in 2012. There is also no question that Petitioner testified to having lingering pain at the time he settled the previous claims. However, there is also no question that Petitioner was returned to work with no restrictions performing the same job duties he had prior to his injuries.

Dr. Gornet opined that Petitioner's current condition was related to Petitioner's previous accidents, accidents that involved Petitioner performing the same activities which are the basis for the present claim. Dr. Gornet opined that Petitioner incurred a failed fusion prior to his settlement of the previous claims. Given the fact that Petitioner worked full duty for over two years without restrictions or incident would appear to make that opinion nonsensical. The Arbitrator's apparent reliance on Dr. Gornet's opinion over Dr. O'Boynick's is misplaced. Petitioner performed his full duty job without restrictions for over two years before he deteriorated to a condition in which he could no longer do his job and he sought medical treatment. Petitioner incurred a new accident separate and apart from his previous claims. It is quite apparent that Petitioner's post settlement job activities aggravated Petitioner's pre-existing condition. Dr. O'Boynick opined that Petitioner's current condition of ill being was aggravated by his job activities. The Arbitrator's characterization that the hypothetical given to Dr. O'Boynick was inconsistent with Petitioner's testimony is inaccurate. Petitioner's testimony of performing work over the shoulder and above is consistent with the hypothetical given to Dr. O'Boynick and corroborated by Respondent's witness. Accordingly, I would reverse the majority decision and find that the Petitioner incurred an accident arising out of and in the course of his employment on October 1, 2014 and that his current condition of ill being is causally related to his work activities.

David L. Gore

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

18IWCC0075

HOOTEN, KERRY
Employee/Petitioner

Case# **15WC023096**

EMPIRE COMFORT SYSTEMS
Employer/Respondent

On 5/17/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.02% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1580 BECKER SCHROADER & CHAPMAN PC
TODD SCHROADER
3673 HWY 111 PO BOX 488
GRANITE CITY, IL 62040

0299 KEEFE & DePAULI PC
JAMES K KEEFE JR
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

18IWCC0075

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Kerry Hooten
Employee/Petitioner

v.

Empire Comfort Systems
Employer/Respondent

Case # **15** WC **23096**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **March 30, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 1, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

In the year preceding the injury, Petitioner earned **$32,176.56**; the average weekly wage was **$618.78**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **0** dependent children.

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

Respondent is entitled to a credit of **$4,699.23** under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that he sustained an accident that arose out of and in the course of his employment with Respondent, and that his current condition of ill-being is casually related to his alleged accident. All benefits are denied; the remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

Respondent is entitled to a credit of **$4,699.23** under Section 8(j) of the Act.

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

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

Melinda M. Pope Gullion

Signature of Arbitrator

5/16/17

Date

ICArbDec19(b)

MAY 17 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Kerry Hooten
Employee/Petitioner

Case # **15** WC **23096**

v.

Consolidated cases: **N/A**

Empire Comfort Systems
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he works for Respondent as a Lead Man and makes fireplaces and heaters. He testified that his job entails such activities as moving people around to move the press and to make sure there are no jams in the line, and that as a Lead Man he participates in the manufacturing process. He testified that if someone is not able to keep up on assembly line, he steps in and helps. He testified that the videos shown in Respondent's Exhibit 8 are part of the process. He testified that there are time periods where he is working overhead, like when he is hanging on the paint line. He testified that hanging items on the paint line was not his normal job, but that he could do it on a daily basis when he had to jump in and help.

Petitioner testified that additional jobs he performs include air drops for a DVD, which are a component of a fireplace. He testified that it looked like an "L"- shaped item and was approximately 3½-4 feet long. He testified that there are 4-inch tubes attached at the front and are similar to those shown on the video. He testified that he uses the tube "swedger" machine and that when he puts tubes in the machine, he uses both hands and that the machine is at shoulder height. He testified that he has to use force to pull the machine down. He testified that his shoulder and neck hurt when he does this. He testified that when performing work on the paint line, it hurts because he is reaching overhead.

Petitioner testified that he also works on a brake press when he needs to fill in. He testified that the brake press is used to bend metal with accurate angles. He testified that when bending metal, the metal can be above shoulder height. He testified that the twisting and turning aggravates him.

Petitioner testified that he has worked for Respondent for almost 25 years and that he has worked as a Lead Man for 25 years in July. He testified that during this time period, he has had two settlements. He testified that he had a cervical spine surgery performed and that the case settled, and that he also had a left shoulder surgery in 2012 for which the case was settled as well. He testified that before those surgeries were performed, he was working in the same exact job he is working now. He testified that Respondent authorized the treatment for the cervical spine surgery as well as the surgery performed by Dr. Dusek on his left shoulder.

Petitioner testified that in October of 2014, he had been doing air drops again and that he was hurting and stated that he wanted to see if he could get help again. He testified that he saw Ron Musenbrock, the safety director. He testified that a little while after that he eventually returned to Dr. Dusek, who referred him to Dr. O'Boynick who felt it was not a left shoulder condition but rather it was a

neck condition. He testified that he saw Dr. O'Boynick who feels that he needs surgery and that he wants to have the surgery recommended by him.

Petitioner testified that on a typical day, he gets at work about 6:00 a.m. and has two 10-minute morning breaks, a 30-minute lunch break and one more afternoon break. He testified that after he had the left shoulder surgery by Dr. Dusek, when he returned to work he was "pretty decent" for about 6 months or so. He testified that as a Lead Man, his position was pretty hands-on and did not involve as much supervising. When asked what aspects of the job caused the most symptoms, Petitioner responded that it would be working the air drop station on a continuous basis every day.

Petitioner testified that there were several new hires on the line and that when there were new people on the line, there was a lot of extra work because they needed to avoid mistakes. He testified that there was a lot of turnover. He testified that there is now a device on the paint line that helps to lift the items. He testified that there were still hooks that attached to the fireboxes. He testified that the running of the brake press was not shown on the video, nor was the paint line. He testified that the video did not show the building of the air drops.

On cross examination, Petitioner agreed that he testified that around October of 2014 he reported to Ron Musenbrock that he was having problems with his neck and shoulders, but admitted that he did not ask him to complete an accident report. He denied having received any treatment for his shoulder or neck in 2014. He agreed that he did not see Dr. Dusek until August of 2015.

On cross examination, Petitioner agreed that he underwent surgery on his neck on January 5, 2011 and that he had two levels operated on by Dr. Poulos. He testified that he was released by Dr. Poulos in approximately May of 2011. He agreed that had left shoulder by Dr. Dusek in April of 2012 and that he was released from care in May of 2012. He agreed that he settled his neck claim for 25% man-as-a-whole in July of 2012 and that he understood that when the case settled he was giving up his right to future medical treatment for his neck. He agreed that he settled the shoulder claim in December of 2012, and further agreed that he understood he was giving up his right to more treatment for left shoulder injury as part of that agreement.

On cross examination, Petitioner agreed that he had improvement in his left shoulder after the surgery but that testified that he could not say that he was pain-free. He testified that he did not remember whether he was still having some pain in the left shoulder when he was released in May of 2012. He denied having pain in his neck at the time he was released by Dr. Poulos in May of 2011. He did not dispute that when he underwent the FCE in 2011, he was still reporting pain in the neck up to at least 5/10. He agreed that when he was released by Dr. Poulos in 2011, he went back to his regular job. He further agreed that when Dr. Dusek released him, he went back to his regular job. He agreed that he was doing some overhead work when he was released for both of those conditions. He agreed that when he was released for his neck in 2011, he was never pain-free in his neck. He further agreed that when he was last seen by Dr. Dusek, he reported 80-90% pain relief and that he was not pain-free in his left shoulder.

On cross examination, Petitioner agreed that he testified that his pain got worse in October of 2014. When asked if he had pain in his neck between 2012 when he was released by Dr. Dusek and October of 2014, Petitioner responded that he did not notice it as much until 2014. He agreed that the pain was present in his neck in 2012, 2013 and 2014. He further agreed that there was some pain in his left shoulder in 2012, 2013 and 2014. He agreed that he still settled his two cases despite having pain in both his neck and left shoulder.

On cross examination, Petitioner agreed that most days he was doing several different jobs. When asked if he was constantly doing the same thing for an entire shift, Petitioner responded that some days he

did while other days he did not. He testified that he did not do much supervisory work as it was not part of his job. He agreed that part of his job was letting people know they were doing something incorrectly and to show them how to do it correctly. He agreed that once he showed them how to do it correctly, he observed and made sure that they continued to do it correctly.

On cross examination, Petitioner agreed that he has several hobbies outside of work. He admitted that some of his hobbies involved doing things at shoulder height or above, including fishing and riding a motorcycle. He testified that he hunts with a shotgun as well as a bow. He testified that he is right-handed. He denied having any side jobs outside of his work for Respondent.

On redirect, Petitioner testified that his pain level in 2014 was aggravated as compared to the pain he felt in 2011 and 2012. When asked what prompted him to say something was wrong in 2014, Petitioner responded that he felt he had better say something before something really bad happened. He testified that the pain got worse and progressed, going down both his left and right shoulders. He testified that he had a left shoulder condition in 2011, but not the right shoulder. He denied having any problems with his right shoulder when he was released by Dr. Dusek.

On redirect, Petitioner agreed that he was able to go back and perform his full duty job after his neck shoulder surgeries. He testified that both of those surgeries were "accepted" by the company and that both of those claims were based on his doing the Lead Man job.

Ron Musenbrock was called as a witness by Respondent at the time of arbitration. He testified that he is employed by Respondent and is currently the HR Manufacturing Specialist. He testified that he has worked 38 years for Respondent and has worked a number of different positions, including the Lead Person. He testified that he spent 7 years on the floor as a Lead Person. He testified that he heard Petitioner's testimony about the different jobs he performed as a Lead Person, but that he had not performed the fireplace line as he was out of production when the line was started. He testified that he had performed the paint line job, that he had not performed the air drop job, that he had operated the brake press, that he had filled containers with parts and put those on shelves and that he had done something similar to the welding of the tubes.

Mr. Musebrock testified that he spends about 5% of his time on the floor now and that he spends most of the day in his office handling employee issues. He testified that he had no doubt that Petitioner performed for Respondent the jobs he testified to. When asked the percentage of time that Petitioner would be doing work that would involve shoulder level or above, Mr. Musebrock that it was maybe 20% of the day. He testified that he based this estimate on the amount of units made per day and the number of times the bins were filled per day.

Mr. Musebrock testified that he was aware that Petitioner had two prior cases and was also aware that they settled in 2012. He testified that he heard Petitioner's testimony that he came to him in October of 2014, stating that he was having problems with his neck and shoulder. When asked if between 2012 when Petitioner settled his cases and October of 2014 when he said he came to see him whether Petitioner ever told him he was having problems with his neck or shoulders, Mr. Musebrock responded that he did not recall Petitioner saying that. He testified that he recalled Petitioner coming to him in October of 2014 and stating that he was still having shoulder and neck pain. He denied that Petitioner asked him to complete any type of accident report.

On cross examination, Mr. Musebrock agreed that Petitioner was a good Lead Man and employee. He agreed that the 20% of day estimate could vary depending on what was being made. He agreed that Petitioner might be required to perform more of someone else's job. He agreed that the job was very hands-on. He agreed that he had looked at the job video. He testified that he did not know why the air drop job was not filmed nor did he know why the paint line or brake press jobs were not recorded.

He testified that the only other things not recorded were that of assembly and helping other people with their jobs.

On redirect, Mr. Musebrock testified that when Petitioner came to him in October of 2014, he did not remember him saying that it was a work-related problem. He agreed that he was involved in the video and that he was asked to get a job video. He denied that since Petitioner came to him in October of 2014, that he has come to him stating that a particular job was giving him the most problem.

On redirect, Mr. Musebrock testified that probably 100% of the paint line job involved work shoulder level or above. He testified that the parts could weight anywhere from less than a pound up to 100 pounds, and that anything that big had a hydraulic lift. He testified that the heaviest part that a person had to manually lift for the paint line was 8 pounds.

The medical records of Dr. Dennis Dusek were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The records reflect that Petitioner was seen on August 18, 2015 for bilateral shoulder pain. It was noted that Petitioner was known from having done arthroscopic surgery on his left shoulder on April 17, 2012, at which time he was found to have no visible bursitis but there was a strain pattern of the supraspinatus tendon and a type I superior labral tear of the left shoulder. It was noted that by May 25th Petitioner had advised that he was 80-90% better and that he showed full motion and excellent strength. It was noted that Petitioner showed full unrestricted strong range of motion to his shoulder and was returned to unrestricted duty as of May 29th after having reached maximum medical improvement. It was noted that this was over three years ago, and that Petitioner now advised that he had some persistent soreness in his shoulder and that he was "never 100 percent." It was noted that Petitioner noted slight increase of pain after his return to work and that by last October of 2014, he had noted pain in the right shoulder as well that was anterolaterally located and aggravated by reaching overhead. It was noted that Petitioner worked at Empire Comfort Systems and had done that for 23 ½ years and was doing repetitive overhead work especially when he hung parts on an overhead line for paint application. The assessment was noted to be that of shoulder bursitis. Petitioner was started on a course of Meloxicam. It was noted that Petitioner's pain seemed to be aggravated by shoulder motion but was almost exactly where the C5 dermatome would overlap and the tingling in his index finger as well as the adjacent two digits was somewhat concerning for C4-5 disc disease. (PX1).

The records of Dr. Dusek reflect that Petitioner was seen on October 29, 2015 for his upper extremity pain. It was noted that Petitioner remained on Meloxicam and was given shoulder subacromial bursal injections but stated that they gave little relief. It was noted that after reviewing the results of the radiology reading by Dr. Ruyle from August 19th, it was evident that Petitioner was felt also by Dr. Ruyle to have advanced degenerative changes at C4-5 with disc height loss and endplate spurring. It was noted that a CT scan had been recommended by Dr. Ruyle which was ordered by Dr. Dusek, as well as an MRI of the cervical spine. It was noted that subsequent to the imaging Petitioner was to follow up with Dr. O'Boynick as Dr. Dusek believed that most of his symptoms were probably rooted in the neck. (PX1).

The medical records of Dr. Christopher O'Boynick were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen on November 13, 2015, at which time it was noted that he was a laborer who performed a significant amount of overhead work. It was noted that Petitioner had a long history, better than a year or more, of difficulty performing overhead work resulting in numbness in his hands bilaterally. It was noted that Petitioner noticed it when he was sleeping and that he had some stabbing pains in his shoulders. It was noted that Petitioner had had significant surgeries in the past, including a two-level fusion in 2011 and a shoulder surgery by Dr. Dusek in 2012. It was noted that Petitioner continued to have aching and complaints of pain in his shoulders bilaterally and additionally he had numbness and tingling in his hands and fingers, which was typically more severe when he was doing any sort of work above his head. The assessment was noted to be that of cervical pseudoarthrosis. It was noted that Petitioner's neurologic exam was not consistent with any

specific radicular-type symptoms and that he had imaging that demonstrated C3-4 disc herniation as well as juxtafusional breakdown at C4-5, which could have some affect on his nerve roots at times. It was noted that based on his complaints, Petitioner may have carpal tunnel syndrome secondary to the pain in his hands mostly at night and also when performing overhead activities. It was noted that an EMG of the bilateral upper extremities was the next logical step to elucidate any sort of radicular or peripheral neuropathy. (PX2).

The records of Dr. O'Boynick reflect that Petitioner was seen on November 23, 2015, at which time it was noted that he had been referred to Dr. Kumar for a bilateral EMG study and had returned for review of the results and further treatment options. The assessment was noted to be that of right and left carpal tunnel syndrome. It was noted that Petitioner performed significant overhead activities and had increased numbness and tingling into the hands particularly with overhead activities, with driving and with sleeping. It was noted that Petitioner had EMG findings consistent with carpal tunnel syndrome. It was noted that Petitioner elected to trial injections into the bilateral carpal tunnels and would trial a wrist brace at night on the left wrist to see if he had any relief. Petitioner was also ordered to undergo physical therapy. At the time of the December 28, 2015 visit, it was noted that Petitioner had undergone bilateral carpal tunnel injections with minimal response per Petitioner's report. It was noted that Petitioner had been trying some bracing on the left wrist at night and felt that he had some minor improvements in his numbness, particularly in the mornings. It was noted that Petitioner most recently was doing a lot of sandbagging of his town due to flood waters and felt that he may have aggravated his underlying issues. It was noted that Petitioner also continued to complain of bilateral shoulder pain, that there was pain in and around the deltoid and that there was weakness in the rotator cuff muscles. It was also noted that Petitioner had a pseudoarthrosis at C6-7 and some juxtafusional breakdown at C4-5. It was noted that Petitioner had a "laundry list of issues," that Petitioner had previous shoulder surgery which was a SLAP repair on the left side and that he continued to have a lot of aches and discomfort about the shoulders, particularly when performing overhead activities. It was noted that Petitioner had decreased rotator cuff strength on examination. It was noted that as to the pseudoarthrosis and cervical pathology, Dr. O'Boynick thought that it was asymptomatic at that point and that Petitioner had some juxtafusional breakdown above his construct which could result in a C5 radiculopathy but would not affect his rotator cuff strength. It was noted that Petitioner had clinical signs as well as EMG evidence of a carpal tunnel syndrome which did not respond to injections but had responded somewhat favorably to night bracing. Petitioner was referred to Dr. Otto for evaluation of his shoulder complaints. It was noted that Petitioner was given treatment options for the carpal tunnel syndrome and would be in touch. It was noted that Dr. O'Boynick did not think that Petitioner was suffering from a pseudoarthrosis and that it would continue to be followed conservatively. (PX2).

The records of Dr. O'Boynick reflect that Petitioner was seen on March 25, 2016, at which time it was noted that he had a history of bilateral carpal tunnel syndrome and bilateral shoulder pain/numbness/tingling. It was noted that Petitioner had been seen by Dr. Dusek for his shoulders as well as Dr. Otto, that he had previous C5-C7 anterior cervical discectomy and fusion and that there was concern for a non-union at those levels, and that he was being seen in follow-up after a C4-5 epidural with Dr. Gahn. It was noted that Petitioner reported that the selective nerve root block provided significant relief to his pain, that he still had pain in his shoulder but that his non-descript pain got better with the injection and that his pain was 50-60% improved with the injection. It was noted that Dr. O'Boynick would consider a C4 to C7 anterior cervical discectomy and fusion revision with extension up to C4-5, and that they would potentially take down and try to re-graft his nonunion area at C6-7. It was noted that Petitioner was to be seen by an ENT first to make sure that both of his vocal cords were working before they selected a surgical approach. (PX2).

The records of Dr. O'Boynick reflect that Petitioner was seen on May 18, 2016, at which time it was noted that he had an MRI as well as a CT of the cervical spine which confirmed non-union at C6-7 in

addition to the spondylosis at C4-5 with some foraminal narrowing. It was noted that Petitioner was most recently seen by an ENT for evaluation of his vocal cords which revealed complete paralysis on the side of his previous approach. It was noted that Petitioner reported bilateral shoulder pain and mild left-sided neck pain. It was noted that Petitioner's occupation involved a lot of repetitive work, "as per wife." It was noted that Dr. O'Boynick thought that Petitioner's bilateral shoulder pain was related to his juxtafusional breakdown and foraminal stenosis at C4-5. It was noted that surgical options would include a stand-alone device at C4-5 to address the shoulder pain versus a complete revision of the construct with take down of the plate as well as the nonunion at C6-7 and revision fusion at C6-7 in addition to anterior cervical discectomy and fusion at C4-5. It was noted that Petitioner and his wife were going to discuss the options. (PX2).

The medical records of Dr. Randall Otto were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on January 12, 2016, at which time it was noted that he had had bilateral shoulder pain for over a year, that he had a previous SLAP debridement in April of 2012 which initially was better but that, over the last year, he had been having some increased pain. It was noted that Petitioner underwent some injections with minimal relief. It was also noted that Petitioner had a history of a neck fusion and had had a nonunion at one level of his cervical fusion, and that he also had some hand numbness which was consistent with a carpal tunnel syndrome on EMG and nerve conduction studies. The assessment was noted to be that of pain in the joints of the right and left shoulders. It was noted that Petitioner likely had some contribution from his shoulders, but that he may also have some contribution of his neck which was causing him pain. It was noted that Petitioner was recommended to undergo a trial of physical therapy as well as intraarticular injections into both shoulders. It was noted that if this significantly improved but that Petitioner failed conservative management, then Dr. Otto would discuss MRI scans and further treatment options as necessary. It was noted that if the injections failed to provide any significant relief, then they would need to concentrate more on his cervical spine as the potential culprit of his pain. (PX3).

The records of Dr. Otto reflect that Petitioner was seen on February 9, 2016, at which time it was noted that he had minimal relief from his diagnostic injections into the glenohumeral joints. The assessment was noted to be that of cervical pseudoarthrosis. It was noted that Dr. Otto did not recommend evaluating with any MRI scans, as it was most concerning that the shoulders were not the issue because he did not get any relief from the cortisone injections. Petitioner was recommended to undergo bilateral nerve root injections at C5 to see if these alleviated the pain in the neck and shoulders and if they did, Petitioner would continue to follow up with Dr. O'Boynick for that. It was noted that if they failed to provide relief, a referral to pain management would be recommended. (PX3).

The medical records of Dr. Ashok Kumar were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on January 22, 2016 for bilateral shoulder pain. It was noted that Petitioner was being seen at the request of Dr. Otto for bilateral shoulder intraarticular injections and that Petitioner had had chronic shoulder issues for some time. It was noted that Petitioner had a previous left-sided shoulder arthroscopic shaving of the superior glenoid labrum SLAP Type I tear by Dr. Dusek in 2012, which Petitioner felt helped him temporarily. It was noted that Petitioner had had injections in the shoulder before and that he had a history of a cervical spine fusion. It was noted that Petitioner's current pain was bilaterally in the shoulder region anteriorly with worsening of pain on motion. Petitioner underwent bilateral shoulder intraarticular injections under fluoroscopy. (PX4).

The medical records of Dr. Richard Gahn were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on February 19, 2016, at which time it was noted that he complained of persisting pain involving the neck, shoulders and proximal upper extremities. It was noted that Petitioner stated this had been problematic for the past 1½ years and that the pain was constant to some degree but in general was worsened with various movement and activities.

It was noted that it was improved somewhat with applying ice. It was noted that Petitioner noted intermittent associated tingling and numbness involving the proximal areas of the upper extremities as well as a feeling of weakness. It was noted that Petitioner's current problem started on October 9, 2014 and was caused by lifting, twisting, bending and pulling and that he was injured at work. It was noted that in the past, Petitioner had undergone physical therapy to treat the problem. Petitioner underwent a cervical epidural steroid injection targeted at C4-5. (PX5).

The records of Dr. Gahn reflect that Petitioner was seen on March 4, 2016, at which time it was noted that he had no new numbness, tingling or weakness. It was noted that Petitioner had no problems with his first injection. It was noted that Petitioner felt that the pain was unchanged since the last procedure. A second cervical epidural steroid injection was performed on that date. At the time of the March 18, 2016 visit, it was noted that Petitioner's two cervical epidural steroid injections targeted at C4-5 had not helped much with his neck and shoulder symptoms and that he continued with his Tramadol and Aleve. It was noted that Petitioner had no new numbness or weakness. It was noted that a discussion was had regarding trying a C5 selective nerve root block. It was noted that Petitioner stated that his left-sided pain was more severe than his right. The records reflect that a selective nerve root block – left at C4-5 was performed on that date. It was noted that Petitioner indicated he would be following up with Dr. O'Boynick. (PX5).

The medical records of Dr. Mark Szewsczky were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner was seen on April 29, 2016 for a vocal cord evaluation. It was noted that Petitioner had had previous cervical spine surgery through an anterior approach. It was noted that Petitioner needed a second surgery and that an approach through the left side was preferred. It was noted that Petitioner's exam, including endoscopy, showed either a very dense paresis or perhaps total paralysis of the right vocal cord. It was noted that given the paresis on the right hand side, any surgical intervention around the left recurrent laryngeal nerve should be approached with extra caution. (PX6).

The Interpretive Report for x-rays of the bilateral shoulders dated August 18, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The report reflects that the films were interpreted as revealing no sign of congenital, metabolic or neoplastic disease, nor any fracture, dislocation or calcification. (PX7).

The Interpretive Report for x-rays of the cervical spine dated August 19, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The report reflects that the films were interpreted as revealing (1) ACDF C5/6 with solid C5/6 fusion but persistently visible interspace at C6/7; CT would better evaluate the degree of fusion across these segments if indicated; (2) advanced degenerative changes C4/5 with disc height loss and endplate spurring. (PX8).

The Interpretive Report for x-rays of the cervical spine dated May 18, 2016 was entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The report reflects that the films were interpreted as revealing instrumented fusion from C5 to C7; what looks to be a nonunion at C6-7; there may be some evidence of some hallowing around the screws in the most inferior aspect of the construct but the screws in C5 and C6 appear to be intact; the AP view shows relatively reasonable alignment; C4-5 does have a lot of spondylosis; some spurring along the posterior margin of the body as well at C4-5; may have a little bit of uncovertebral joint hypertrophy at C4-5 as well. (PX9).

The Interpretive Report for the CT of the cervical spine dated November 6, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The report reflects that the films were interpreted as revealing (1) markedly degenerative disc at C4-C5 with sclerotic change of the endplates and about 3 mm pseudoretrolisthesis of C4 against C5 with marginal spurs; (2) completely fused C5-C6

disc level with hardware in good position; (3) incomplete fusion of C6-C7 with lucencies surrounding the lower screws in the body of C7, could be loose screws. (PX10).

The Interpretive Report for the MRI of the cervical spine dated November 6, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 11. The report reflects that the films were interpreted as revealing (1) post-operative changes C5/6 and C6/7 with metallic artifact; (2) left-sided disc herniation at C3/4 possibly affecting the left C4 root; (3) moderate to advanced degenerative changes at C4/5 which appear progressed since the previous with bilateral foraminal narrowing; either of the C5 roots could be affected. (PX11).

The Interpretive Report for the EMG/Nerve Conduction Study dated November 19, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 12. The report reflects that the study was interpreted as revealing (1) electrodiagnostic evidence of bilateral median sensory-motor focal neuropathy at the wrists consistent with a clinical diagnosis of bilateral carpal tunnel syndrome; motor and sensory latencies are mild-moderately prolonged bilaterally; (2) normal bilateral ulnar and superficial radial nerve conductions; (3) needle EMG of bilateral upper extremity showed no denervation of selected muscles supplied from C5-T1 roots; chronic motor unit abnormalities were noted in few muscle groups bilaterally. It was noted that Petitioner had bilateral hand and fingertips numbness for few months; symptoms may be worse at night; Flick sign is positive; no weakness; previous neck fusion and also left shoulder surgery; currently denies any major neck or radicular pain. (PX12).

The medical records of ATI Physical Therapy were entered into evidence at the time of arbitration as Petitioner's Exhibit 13. The records reflect that Petitioner underwent an initial evaluation on January 18, 2016. It was noted that the primary complaint was that of severe bilateral shoulder pain that got worse with activity especially at work. It was noted that Petitioner described the pain as in the joints. It was noted that Petitioner had had shoulder problems since 2009, that he had had physical therapy on and off and that he also had a SLAP repair on his left shoulder in 2012. It was noted that in the fall of 2014 Petitioner noticed increased pain in both of his shoulders, that they were progressively getting worse and that he was scheduled for injections in his bilateral shoulders on January 22nd. The records reflect that Petitioner underwent physical therapy for the timeframe of January 18, 2016 through February 8, 2016. At the time of the January 27, 2016 visit, it was noted that Petitioner felt great on Monday after treatment but that all of his pain returned after working a full day on Tuesday. At the time of the January 29, 2016 visit, it was noted that Petitioner reported feeling the same and that work aggravated his symptoms yesterday. At the time of the February 1, 2016 visit, it was noted that Petitioner stated that his shoulders hurt a lot during a work day and that he did get some relief following therapy. At the time of the February 3, 2016 visit, it was noted that work continued to aggravate Petitioner's bilateral shoulder pain. At the time of the February 8, 2016 visit, it was noted that Petitioner had continued pain in his bilateral shoulders after working. The Discharge Summary dated February 8, 2016 noted that Petitioner continued to present with impairments involving range of motion, strength and pain. (PX13).

The transcript of the deposition of Dr. Christopher O'Boynick was entered into evidence at the time of arbitration as Petitioner's Exhibit 14. Dr. O'Boynick testified that he is a board-eligible orthopedic spine surgeon. He testified that Petitioner's initial visit occurred on November 13, 2015, at which time he identified himself as a laborer who performed significant overhead work and had a long history with difficulty performing overhead work resulting in numbness in his hands bilaterally and that he had pain in his shoulders. He testified that Petitioner had a previous two-level fusion in 2011 and a surgery by Dr. Dusek in 2012 but that he continued to have shoulder pain and issues. He testified that Petitioner's main comments were tingling and pain in the hands and numbness and bilateral shoulder pain. He testified that Petitioner had several injections in the shoulder along with some at the base of the neck, but had gotten no relief. (PX14).

Dr. O'Boynick testified that Petitioner had a healed surgical scar on the shoulder and on the neck, but that his clinical exam did not have a whole lot of identifiable pathology. He testified that overall he thought Petitioner's exam was relatively benign except for his complaints of pain. He testified that the MRI from November 6, 2015 showed a left-sided disc herniation at the C3-4 level along with some degenerative changes at the C4-5 level above his previous construct, which he thought could be causing some pressure on the C5 nerve root. He testified that Petitioner most likely had a nonunion of the fusion at C6-7. He testified that his assessment was that of a cervical pseudoarthrosis with neck pain and shoulder pain as well as some juxtafusional breakdown with C4-5 with foraminal stenosis. He testified that he recommended an EMG of the bilateral upper extremities, which was done by Dr. Kumar on November 19, 2015 and showed bilateral carpal tunnel syndrome. (PX14).

Dr. O'Boynick testified that at the time of the November 23, 2015 visit, they went over his EMG. He testified that they set Petitioner up with some injections into the carpal tunnel as well as putting him in a brace at night to try to alleviate some of the hand symptoms. He testified that Petitioner returned on December 28th, at which time he noted that the injections gave him minimal relief. He testified that Petitioner had been trying the bracing of the left wrist at night and thought he might have some minor improvements in the numbness particularly in the morning, but overall not a lot of improvement. He testified that Petitioner had been doing some work with sandbagging but was continuing to complain of bilateral shoulder pain, and that his pain was in and around the deltoids with some weakness in rotator cuff strength testing. He testified that Petitioner had some pain with resistive testing of the rotator cuff and that his strength was a little weak, worse on the left. He testified that he though the juxtafusional breakdown above the construct could be resulting in a C5 radiculopathy that would give bilateral shoulder pain and some weakness from the pain. He testified that he referred Petitioner to Dr. Otto for a shoulder evaluation. (PX14).

Dr. O'Boynick testified that Dr. Otto saw Petitioner on January 12, 2016 and February 9, 2016, and that he noted that Petitioner had really no improvement after the intraarticular injections. He testified that he then set Petitioner up for C5 nerve root injections. He testified that Petitioner returned to him on March 25, 2016 and that in the interim Petitioner had been set up with Dr. Gahn, a pain management physician who performed a C4-5 epidural. He testified that Petitioner reported significant improvement in his pain and that his nondescript pain in and around his shoulders was improved 50-60% per his report. He testified that Petitioner had a C4-5 spondylosis with foraminal stenosis and nerve root irritation, particularly the C5 nerve root, and that he had a positive response to the injection. He testified that the discussion was that of whether to take off the entire construct and revise or selectively address the 4-5 level and leave the pseudoarthrosis alone. (PX14).

Dr. O'Boynick testified that he saw Petitioner again on May 18, 2016 as he had sent him for additional testing on the vocal cords. He testified that Dr. Sedgwich did a fiberoptic laryngoscopy and identified paralysis of the nerve roots on the right side, so any procedure would have to be done through the same side with the risk of injuring his one working vocal cord. He testified that it was abnormal for it to be paralyzed but that it was very common after having an anterior cervical surgery. He testified that on that date Petitioner's wife described a lot of overhead repetitive work that was involved in Petitioner's work. He testified that a decision had not been made as to which procedure to perform, but that he would most likely do a revision and take off the previous hardware, take down the nonunion at the 6-7 level and place new bone and graft. He testified that typically his goal was to have patients back at three months with full duty without restriction unless there was some delay or issue with healing. (PX14).

Dr. O'Boynick testified that in comparing the old diagnostic studies (post first surgery) with the new diagnostic studies, there had been advancement of his spondylotic segment and the foraminal stenosis at the C4-5 level. He testified that he thought that Petitioner's symptoms were primarily coming from the C4-5 level. He testified that symptoms that would be emanating from the nonunion would typically be that of an axial neck pain and generalized discomfort in the neck. He testified that the

shoulder pain was coming from the C4-5 level and that it was Petitioner's good response with the injection that made him think it was the nerve root that was causing the problem. (PX14).

When posed with a hypothetical question as to Petitioner's job duties assembling fire place boxes, Dr. O'Boynick testified that he believed Petitioner's job duties aggravated his condition of ill-being. He testified that Petitioner had spondylotic segment that created foraminal stenosis and that when doing work above shoulder height looking up and taking things and putting them up to extend the neck and then flexing it, one was constantly going to pinch the nerve and aggravate it and that this was that made the shoulders hurt if it was the C5 nerve root. (PX14).

Dr. O'Boynick testified that if Petitioner had the surgery, he anticipated his being able to return to his duties and would anticipate that his pain would be improved. He testified that the pseudoarthrosis was unrelated and was the failure of the previous surgery and that C4-5 was his current problem that related to his shoulder. He testified that movement of the neck would aggravate the pseudoarthrosis and cause pain. (PX14).

On cross examination, Dr. O'Boynick agreed that he was leaning towards recommending the anterior cervical discectomy and fusion at C4-5, removal of the hardware at C6-7 and replacing it anteriorly. He testified that the pathology at C4-5 in and of itself could cause the neck pain that Petitioner had been complaining of. He testified that there was no way to establish the amount of pain, if any, that was coming from the C6-7 level. He agreed that he proved that C4-5 was symptomatic because the selective nerve root block gave Petitioner good relief of his symptoms. He testified that he believed that for Petitioner, the amount of arthritis that he had posteriorly in the facet joints made disc replacement a bad option. He agreed that the CT done in 2015 picked up the facet joint arthritis. He testified that he did not have any concerns about the left-side disc herniation at C3-4 because clinically, Petitioner did not seem to complain of anything that would be related to the C4 nerve root irritation. He agreed, however, that there was concern about a fusion at C4-5 potentially putting additional stress on C3-4 down the line. (PX14).

On cross examination, Dr. O'Boynick testified that the fusion at C5-6 and C6-7 likely played a role in the developing of the arthritic change and the pathology currently noted at C4-5. He agreed that the condition at C4-5 could develop to its current state just through normal degeneration and contribution from the prior fusion irrespective of what type of job Petitioner had. He denied ever asking Petitioner to complete a formal job description and testified that he discussed with him what his job involved as well as the information as provided in the hypothetical. He agreed that if Petitioner had been doing the same work activities for 2 or 2 ½ years, this could change his causation opinion as to whether the work activities were aggravating or contributing to the need for the surgery he had recommended. (PX14).

On cross examination, Dr. O'Boynick agreed that Dr. Dusek referred Petitioner to him. He agreed that he was the spine expert while Dr. Dusek focused on more general orthopedics. He agreed that at the time of the August 18, 2015 examination, Dr. Dusek noted that Petitioner in both shoulders had excellent muscle strength and tone. He agreed that the motor strength was noted to have been normal as well. He agreed that at the time of his first visit on November 13, 2015, his examination of Petitioner's neck was for the most part pretty normal. He testified that Petitioner had bilateral shoulder tenderness over the deltoids and the acromions but had otherwise a normal shoulder examination on that date. He agreed that after he saw Petitioner after the nerve conduction study was done, he was looking primarily at carpal tunnel syndrome. He testified that he discussed with Petitioner the potential for carpal tunnel releases, but that he was not interested in the procedure and it was not pursued any further. He agreed that up until November 23, 2015, he had not done a full work-up of the neck and there was no recommendation for cervical spine surgery at that point in time. (PX14).

On cross examination, Dr. O'Boynick agreed that at the time of the December 28th visit he noted that Petitioner had some weakness in the rotator cuff muscles. He agreed that this could come from the rotator cuff itself or a component of C4-5. He agreed that the activities that Petitioner described performing sandbagging could explain the basis and the change of exam findings from earlier in 2015 to when he examined Petitioner in December of 2015. He testified that he did not think that the activities that Petitioner described as sandbagging could be contributing to the need for the cervical spine surgery he recommended because there was evidence that Petitioner had the problem before. He testified that Petitioner complained before and that this was why he was seen by himself and Dr. Duek, and that while the sandbagging may have aggravated it more, it was already there. (PX14).

On cross examination, Dr. O'Boynick testified that he did not believe that he ever discussed with Petitioner any of his activities outside of work. He agreed that it was his opinion that the moving of the neck was contributing to the need for surgery more than the use of the arms. He agreed that the hobbies Petitioner listed on the 2011 FCE would require flexion of the neck that could aggravate his condition at C4-5, and that the hobbies that could potentially be affecting his condition were those of weightlifting, hunting, fishing, shooting and perhaps bicycling. (PX14).

On redirect, Dr. O'Boynick agreed that in reviewing the case in hindsight, he felt that the surgical recommendation was probably in play as of the first time that he saw Petitioner. He testified that if they had not gone down the road of carpal tunnel and were treating Petitioner more as a mechanical shoulder pain initially, they would have been working on the C4-5 diagnosis long before. He agreed that he had to go down those paths to rule it out and that this was part of the investigative side of medicine. (PX14).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 15.

The transcript of the deposition of Dr. Matthew Gornet was entered into evidence at the time of arbitration as Respondent's Exhibit 1. Dr. Gornet testified that he is a board-certified orthopedic surgeon whose practice is devoted to spine surgery. He testified that he performs multi-level spine surgery as well as performing a lot of revision surgeries. He testified that he performed a records review and authored a corresponding report dated March 16, 2017. He testified that he was provided various medical records and diagnostic imaging, as well as a job video purporting to show some of the work activities that Petitioner performs for Respondent. He agreed that he was asked to address whether the need for a proposed spine surgery was related to his work activities for Respondent since July of 2012 when Petitioner had settled a prior case. (RX1).

Dr. Gornet testified that Petitioner had an MRI of the cervical spine on May 13, 2010 and that he felt the films were of diagnostic quality. He agreed that the report indicated that the indication for the study was neck pain with left arm pain and numbness. He testified that his impression of the films was that there was disc pathology present at three levels, *i.e.*, C4-5, C5-6 and C6-7. He testified that the pathology showed not only loss of disc height and central disc protrusions, but also a strong structural indication of an annular tear at C4-5. He testified that the findings would cause neck pain and would cause symptoms to the left upper extremity. He testified that he has performed the anterior cervical discectomy and fusion at C5-6 and C6-7 procedure many times and that he is currently performing more of the disc replacement procedures. He testified that studies reflected that patients had higher patient satisfaction, earlier return to work, better functional outcomes and fewer revision surgeries. He testified that the revision rate with multilevel cervical fusions was high given adjacent level stresses placed on the cervical spine and that patients did not tend to heal. (RX1).

Dr. Gornet testified that Petitioner had a pseudoarthrosis or failed fusion at the C6-7 level. He testified that a failed fusion at that level could produce ongoing neck pain. He testified that in his review of the medical records and FCE, Petitioner never became totally asymptomatic. He testified that he has

reviewed the cervical MRI films of November 6, 2015, and that in his opinion the films revealed findings consistent with a failed fusion at C6-7, significant deterioration of the disc at C4-5 and disc pathology at C4-5 greater on the left than the right. He testified that he believed that Petitioner's fusion as performed by Dr. Poulos at C5 to C7 was essentially the factor of why Petitioner deteriorated so rapidly and was consistent with the disc pathology that was seen and witnessed in 2010. (RX1).

After being posed with the hypothetical assumption that Petitioner was pulling parts that weigh 20-30 pounds, putting them in a crate and carrying the crate as well as performing 20-30% overhead work at his job and having been asked whether he believed Petitioner's work activities would have contributed to the need for the revision in part and additional surgery recommended by Dr. O'Boynick, Dr. Gornet testified that he did not believe that the work activities contributed to the need. He testified that it may make him more symptomatic, but that this was something that was present from the very beginning back in 2010. He testified that Petitioner's need for surgery was directly based on the decision to fuse C5-6 and C6-76, and that his failed fusion was based on that as well. He testified that the deterioration seen was not something seen by simple work activities in two years, but rather was a direct result of the choice of surgery that was performed. (RX1).

On cross examination, Dr. Gornet testified that he would have recommended either doing a single or double level disc replacement depending on Petitioner's pathology. He testified that you could do less with disc replacements because you were retaining motion. He testified that a single level fusion increased the intradiscal stress by 150-300%, so having two fusions present, coupled with already showing disc pathology on the left side at C4-5, Petitioner was a set-up to have early failure. He testified that he believed that Petitioner's work activities as he saw in the video would easily make him more symptomatic and that he did not believe the work activities played a bearing in this situation because he believed it was going to occur independent of Petitioner's work activities. He testified that Petitioner was set up by the surgical plan to have this occur, even if he never worked another day in his life. (RX1).

On cross examination, Dr. Gornet admitted that the shoulder-related records he had were from 2015. He agreed that there was a gap where he was not sure of what Petitioner's complaints were. He testified that one possibility was that Petitioner had no symptoms, that it was possible that Petitioner had ongoing symptoms that did not warrant medical treatment and that it was also possible that Petitioner had ongoing symptoms that warranted medical treatment. (RX1).

On cross examination, Dr. Gornet testified that if you fused a patient to a disc that already had significant pathology, it was a predictable sequence that you would have that level "go" because of increasing stresses. He testified that the study was performed by Dr. Hildebrand, and that he quoted approximately 33% at about ten years for a cervical fusion. He testified that it varied depending on the age of the patient and the quality of the disc that was fused, and that a younger patient would tend to have a better result longer term because their adjacent discs were much healthier. (RX1).

On cross examination, Dr. Gornet testified that as to restricting overhead work with an individual with a fusion, he took the individual specifically and did not know if he would have done it with this particular patient but that this was the type of restriction that he often limited because he believed it may help their symptoms. He testified that he did not know if limited overhead activity resulted in less adjacent level failures. (RX1).

On cross examination, Dr. Gornet testified that in his experience, patients with a failed fusion usually had some level of symptoms if you compared them to patients who did not. He testified that it may be tolerable for them, but they were still symptomatic, relatively speaking, to a solid fusion. He agreed that physicians operated on patients based on their quality of life and their symptoms. He agreed that there was a progression to where both Petitioner's left and right shoulders were affected by pain. He agreed that Petitioner's right shoulder would be a different or new complaint as compared to his previous

complaints of neck pain and left shoulder pain. He testified that this would be a change in Petitioner's original symptom presentation. On cross examination, Dr. Gornet testified that if Petitioner were his patient he would probably replace the discs at C3-4 and C4-5 and revise the failed fusion at C6-7 based on the MRI of 2015. (RX1).

On cross examination, Dr. Gornet testified that when he received the materials, he did not recall whether he knew about any of the overhead work that Petitioner was doing. He testified that he did not recall the video at the time of the deposition. He testified that he did not have any video evidence of Petitioner working overhead. He agreed that there were a lot of prior medical records that were made available to him. He testified that he did not believe that he had the prior IME report of Dr. Petkovich. He agreed that he was not provided with any job study that revealed any kind of time analysis of what Petitioner did during the workday for Respondent. He testified that his recollection was that Petitioner worked on painting involved with the building of fireplaces. (RX1).

On cross examination, Dr. Gornet testified that the work activities were not the reason why Petitioner needed surgery and that it was because his pathology was present from the very beginning. He testified that this was a known sequela, and that it was, in his opinion, a poor decision plan to begin and was going to occur independent of whether Petitioner went back to work at all. He testified that this, coupled with the fact that his pseudoarthrosis was there and was never appropriately diagnosed or evaluated, all of these factors had to do with his original work injury and not any new activities, which was why he did not believe it was causally connected. He testified that one could not say within a reasonable degree of medical certainty that Petitioner's condition was related to the work activities when the literature was so clear that an adjacent level failure was a direct result of the surgical choice. He testified that because he believed it would have occurred anyway, independent of whether or not Petitioner went to work, he could not state within a reasonable degree of medical certainty that Petitioner's work activities contributed in any way in this particular situation. (RX1).

The Settlement Contracts for Case Nos. 10 WC 10995 and 12 WC 06821 were entered into evidence at the time of arbitration as Respondent's Exhibit 2. The Settlement Contract Lump Sum Petition and Order for 10 WC 10995 indicated that Petitioner alleged a repetitive trauma injury to the cervical spine for an alleged date of accident of December 2, 2009. The contract was approved on July 17, 2012 and it was noted that the claim was settled for 25% loss of use of the body as a whole. The Settlement Contract Lump Sum Petition and Order for 12 WC 6821 indicated that Petitioner alleged a repetitive trauma injury to the left shoulder for an alleged date of accident of December 7, 2011. The contract was approved on December 12, 2012 and settled for 20% loss of use of the left arm, or approximately 10% loss of use of the body as a whole. (RX2).

The medical records of Dr. Nicholas Poulos were entered into evidence at the time of arbitration as Respondent's Exhibit 3. The records reflect that Petitioner was seen on July 3, 2010, at which time it was noted that on December 2, 2009 he began to develop progressive neck pain that radiated into the left arm. It was noted that Petitioner localized the pain to the left shoulder and posterolateral aspect of his arm, and that there was some non-dermatomal numbness and paresthesias in his left hand. It was noted that because the "epicenter" initially seemed to be in his left shoulder, Petitioner was evaluated by Dr. Johnston from Orthopedics and that he had had two steroid injections in the shoulder that did not help. It was noted that Petitioner had also had physical therapy. It was noted that clinically, Petitioner had some radicular pain into his proximal arm that may be consistent with a radiculopathy and that radiographically, Petitioner had C5-C6 and C6-C7 foraminal stenosis. It was noted that Petitioner was recommended to undergo a left-sided epidural injection at both of those levels. (RX3).

The records of Dr. Poulos reflect that Petitioner was seen on July 29, 2010, at which time it was noted that he was being treated for a cervical radiculopathy. It was noted that they were still waiting approval for the cervical epidural injection. At the time of the August 23, 2010 visit, it was noted that

Petitioner continued to have left arm pain and that he was working in a light duty capacity. It was noted that the cervical epidural injection had not yet been authorized. At the time of the October 18, 2010 visit, it was noted that Petitioner underwent a left C5-C6 and C6-C7 epidural injection two weeks ago and that it only helped for one day. It was noted that Petitioner was recommended a two-level cervical discectomy, interbody fusion and plate stabilization. At the time of the October 25, 2010 visit, it was noted that Petitioner continued to have left arm pain and had failed conservative therapy. It was noted that surgery was discussed that the approval had been sought. (RX3).

The records of Dr. Poulos reflect that Petitioner was seen on January 3, 2011, at which time it was noted that he continued to have left arm pain. It was noted that Petitioner had known disc herniations at C5-C6 and C6-C7 and that a two-level cervical discectomy, interbody fusion and plate stabilization had been recommended. It was noted that Petitioner wished to proceed and that approval had been given. The Operative Report dated January 5, 2011 noted that Dr. Poulos performed (1) C5-C6 and C6-C7 anterior cervical discectomy for decompression of spinal cord and nerve roots; (2) anterior interbody fusion; (3) Stryker anterior plate stabilization; and (4) demineralized bone matrix putty, for a pre- and post-operative diagnosis of C5-C6 and C6-C7 foraminal stenosis. (RX3).

The records of Dr. Poulos reflect that Petitioner was seen on January 13, 2011, at which time it was noted that clinically he was doing great. It was noted that Petitioner's left arm was completely resolved and that post-operative rehabilitation was to begin in a week. At the time of the February 7, 2011 visit, it was noted that Petitioner was clinically doing great and that his left arm pain had completely resolved. It was noted that Petitioner only had a little discomfort when he fully abducted his arm above the shoulder and that this was only mild pain in the left shoulder joint itself. It was noted that the plan was for acute post-operative rehabilitation for two more weeks and then moving into work conditioning and work hardening. It was noted that Petitioner was happy with the result. At the time of the February 21, 2011 visit, it was noted that clinically Petitioner was doing great and that the left arm pain was gone. It was noted that Petitioner was to complete his acute post-operative rehabilitation that week and that he would transition to work conditioning and work hardening. (RX3).

The records of Dr. Poulos reflect that Petitioner was seen on March 28, 2011, at which time it was noted that he had completed 3½ weeks of work conditioning and work hardening. It was noted that other than a little soreness in his shoulder for which he was using over-the-counter medications, Petitioner felt great. It was noted that Petitioner's pre-operative radicular complaints had completely resolved. It was noted that an FCE was completed and reviewed, and that Petitioner's current level of functioning was consistent with his pre-injury job demand level. Petitioner was instructed to return to work in one week at full duty, no restrictions. At the time of the May 19, 2011 visit, it was noted that Petitioner was doing his old job without difficulty and had had no recurrent left arm pain. Petitioner was released to full duty, no restrictions and was released. It was noted that no further follow-up would be required. (RX2).

The Interpretive Report for the MRI of the cervical spine dated May 13, 2010 was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The report reflects that the films were interpreted as revealing mild cervical spondylosis greatest at C5-6 and C6-7; disc bulge and uncovertebral joint osteophytes contribute to bilateral neural foraminal narrowing, somewhat greater on the left side as described. The history was noted to be that of neck pain with left shoulder and arm pain; left arm numbness. (RX4).

The FCE report dated March 21, 2011 was entered into evidence at the time of arbitration as Respondent's Exhibit 5. It was noted that overall test findings, in combination with clinical observations, suggested the presence of high levels of physical effort on Petitioner's behalf and that there was also presence of minor inconsistency to the reliability and accuracy of Petitioner's reports of pain and disability. It was noted that Petitioner was capable of performing the physical demands of his pre-injury job. (RX5).

The St. Elizabeth's Physical Therapy and Work Conditioning records dated December 10, 2009 through March 18, 2011 were entered into evidence at the time of arbitration as Respondent's Exhibit 6. The Work Conditioning Re-Evaluation dated March 18, 2011 noted that Petitioner was discharged as his work conditioning goals had been achieved. (RX6).

The medical records of Dr. Dennis Dusek dated March 7, 2012 through May 25, 2012 were entered into evidence at the time of arbitration as Respondent's Exhibit 7. The records reflect that Petitioner was seen on March 7, 2012, at which time it was noted that he had worked for Respondent for 20 years and had started having left shoulder pain originally in roughly November of 2009. It was noted that the pain in the shoulder was overshadowed by what sounded like radicular pain into the left arm. It was noted that it was reported specific to the shoulder in December of 2009 and that Petitioner had seen Dr. Gordon, the company physician, who sent him to physical therapy. It was noted that Petitioner ultimately saw Dr. Johnson who ordered an MRI of his shoulder and gave him two cortisone injections to the shoulder which helped but only temporarily. It was noted that according to Petitioner, the MRI had shown a "pinhole tear of the rotator cuff." It was noted that the radicular pain in the left arm worsened to such a time that he had a cervical fusion in January of 2011, that he was off work following the fusion and that he was released to work in September of 2011. It was noted that Petitioner noted excellent relief of the radicular pain down his left arm following the cervical fusion but that after he began back at work at Respondent, he began insidiously to note recurrence of pain in his left shoulder, which he had not noted prior to November of 2009. The clinical impression was noted to be that of left shoulder pain. A repeat MRI was ordered at that time and was performed on March 13, 2012 and interpreted as revealing (1) distal supraspinatus tendinopathy with small partial undersurface tear at the insertion but no complete tear or retraction; (2) mild acromioclavicular spurring without impingement. (RX7).

The records of Dr. Dusek reflect that he authored a letter dated March 30, 2012 to Gallagher Bassett, noting that Petitioner had recommended arthroscopic surgery. The Operative Report dated April 17, 2012 indicated that Petitioner underwent left shoulder arthroscopic shaving of the superior glenoid labrum (type I SLAP tear) for a pre-operative diagnosis of left shoulder rotator cuff strain, rule out rotator cuff tear and a post-operative diagnosis of left shoulder rotator cuff strain with type I SLAP tear. At the time of the April 24, 2012 visit, it was noted that Petitioner indicated that the shoulder was still sore but that he thought his pain may be slightly better already than prior to surgery but that he had not been stressing it since the surgery. It was noted that the type I SLAP tear only required shaving and no repair of the labrum, so therefore his overall rehabilitation should be much quicker. It was noted that given Petitioner's overall good range of motion and strength, Dr. Dusek did not believe that he needed formal physical therapy. At the time of the May 25, 2012 visit, it was noted that Petitioner was doing very well and stated that he had 80-90% pain relief in the left shoulder, and that he showed full motion and excellent strength. It was also noted that Petitioner showed unrestricted strong range of motion to his shoulder. It was noted that Petitioner could return to work full duty as of Tuesday, May 20th. It was noted that Petitioner had reached maximum medical improvement and could return on an as needed basis. (RX7).

The Job Video was entered into evidence at the time of arbitration as Respondent's Exhibit 8.

CONCLUSIONS OF LAW

With respect to disputed issues (C) and (F), given the commonality of facts and evidence relative to both issues, the Arbitrator addresses those jointly.

The Arbitrator finds that Petitioner failed to prove that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on October 1, 2014, and that his current condition of ill-being is causally related to his work activities.

In so concluding that Petitioner failed to prove that he sustained accidental injuries that arose out of and in the course of his employment with Respondent, at the outset the Arbitrator notes that as part of the prior settlement agreement in Case No. 10 WC 10995, Petitioner waived his rights under Section 8(a) of the Act and it was specifically indicated that the settlement was based on Petitioner's present condition. (RX2). Petitioner admitted at the time of arbitration, however, that he was still symptomatic in the cervical spine after conclusion of this treatment for the alleged date of accident of December 2, 2009 as referenced in the settlement contract for Case No. 10 WC 10995. Similarly, the same holds true for Petitioner's issues with the left shoulder as contained in the settlement agreement set forth in Case No. 12 WC 6821. (RX2). Given Petitioner's admission of ongoing symptomology in both the neck and left shoulder subsequent to settlement contract approval for the prior claims, the Arbitrator finds that Petitioner waived his rights to additional medical treatment for those body parts – which are specifically overlapping with and temporally related to the complaints made in the current case at hand – as part of his prior settlement agreements. (RX2).

Furthermore, the Arbitrator finds the opinions of Dr. Gornet to be more persuasive than the opinions provided by Dr. O'Boynick. After being posed with the hypothetical assumption that Petitioner was pulling parts that weigh 20-30 pounds, putting them in a crate and carrying the crate as well as performing 20-30% overhead work at his job and having been asked whether he believed Petitioner's work activities would have contributed to the need for the revision in part and additional surgery recommended by Dr. O'Boynick, Dr. Gornet testified that he did not believe that the work activities contributed to the need. Dr. Gornet testified that Petitioner's need for surgery was directly based on the decision to fuse C5-6 and C6-76, and that his failed fusion was based on that as well. He testified that the deterioration seen was not something seen by simple work activities in two years, but rather was a direct result of the choice of surgery that was performed. (RX1). That said, in light of Petitioner's waiver of his rights to future medical treatment under Section 8(a) as part of the settlement terms in Case No. 10 WC 10995, the Arbitrator finds that failed to prove that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on October 1, 2014, and that his current condition of ill-being is causally related to his work activities.

The Arbitrator notes that while Dr. O'Boynick, when posed with a hypothetical question as to Petitioner's job duties assembling fire place boxes, testified that he believed Petitioner's job duties aggravated his condition of ill-being and that that when doing work above shoulder height looking up and taking things and putting them up to extend the neck and then flexing it one was constantly going to pinch the nerve and aggravate it. (PX14). At the time of arbitration, however, Petitioner proffered no such supportive testimony. Dr. Gornet, on the other hand, apparently understood the overhead work component to include approximately 20% of Petitioner's time, which was consistent with the testimony proffered by Ron Musenbrock at the time of arbitration. (RX1). That said, the Arbitrator places less reliance upon the opinions of Dr. O'Boynick given the flawed foundational elements upon which such opinions were based.

Based upon the foregoing and the record as a whole, the Arbitrator concludes that Petitioner has failed to prove that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on October 1, 2014, and that his current condition of ill-being is causally related to his work activities. All benefits are denied. The remaining issues of notice, medical bills and prospective medical treatment are moot, and the Arbitrator makes no conclusions as to those issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

18IWCC0076

Kerri Russell,

Petitioner,

vs. NO: 15 WC 39447

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 issue of 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. 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 1, 2017, is hereby affirmed and adopted.

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

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

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

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 - 2018
o12/14/17
DLS/rm
046

Deborah L. Simpson

Deborah L. Simpson

David L. Gore

David L. Gore

Stephen J. Mathis

Stephen J. Mathis

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

18IWCC0076

RUSSELL, KERRI
Employee/Petitioner

Case# **15WC039447**

UNITED AIRLINES INC
Employer/Respondent

On 2/1/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0391 HEALY SCANLON LAW FIRM
JACK CANNON
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
KAREN E COON
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Kerri Russell
Employee/Petitioner

v.

United Airlines, Inc.
Employer/Respondent

Case # **15 WC 39447**

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 **November 15, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [ ] Is Petitioner's current condition of ill-being causally related to the injury?
G. [x] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the 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 **Underpayment of TTD based on wage dispute.**

FINDINGS

On the date of accident, **3/3/15**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

On the date of accident, Petitioner was 46 years of age, ***single*** with 3 dependent children.

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

Respondent shall be given a credit of *$54,341.68* for TTD benefits paid prior to trial. The parties stipulated that TTD was up to date and ongoing at the time of trial.

ORDER

*The arbitrator finds that petitioner's earnings in the year prior to the accident were **$35,575.80** and her average weekly wage pursuant to Section 10 of the Act is **$905.56**.*

There is no underpayment of TTD benefits.

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

1.30.17
Date

ICArbDec19(b)

FEB 1 - 2017

Findings of Fact:

The petitioner is a 46-year-old United Airlines flight attendant who alleges injuries to her right knee while working on March 3, 2015. The petitioner testified that she was injured on an overnight flight to Sydney. (Tr. p. 110) While performing a seatbelt check, the flight attendant assisted a mother fastening a baby into a bassinet. She attempted to help the mother when the plane hit severe turbulence. (Tr. p. 112). She crawled back to her jump seat and experienced pain in her right knee. The accident and injuries alleged are not disputed.

The petitioner sought treatment at Hilltop Medical Clinic West on March 13, 2015, with Dr. Pierce. The records reflect a consistent history of the work accident and the petitioner reported ongoing pain and swelling. An x-ray of the right knee revealed no acute bony abnormalities. She was fitted with a knee brace and referred for orthopedic consultation to Dr. John Lange

On March 20, 2015, Petitioner returned to Hilltop Medical Clinic where she requested to be referred to Dr. Matthew Paul for orthopedic consultation. An MRI of the right knee was ordered to assess for a possible meniscus injury. She was authorized off of work beginning on March 20, 2015.

An MRI performed on April 15, 2015 demonstrated a horizontal tear in the anterior horn, body, and posterior horn of the lateral meniscus with a parameniscal cyst, which was decompressing anteriorly into Hoffa's fat-pad. There was also edema in the suprapatellar fat-pad, which may have been secondary to a high activity level. A low-grade chondral fissuring in the lateral patellar facet was also seen.

Petitioner presented to Dr. Paul for an orthopedic consultation on May 14, 2015. She reported increased pain, discomfort, and swelling on the right side of her knee since the work accident. Dr. Paul reviewed the MRI results, noting there was a horizontal tear of almost the entire lateral meniscus extending anteriorly to the posterolateral corner. There was also a soft outpouching, which Dr. Paul believed was likely consistent with a peri-meniscal cyst laterally. Upon examination, petitioner had positive McMurray's with catching on the right side. She was diagnosed with internal derangement of the right knee and a lateral meniscus tear. Arthroscopic surgery was prescribed.

On July 22, 2015, surgery was performed by Dr. Paul, consisting of a right knee arthroscopy with partial lateral meniscectomy. Dr. Paul reevaluated Petitioner after the surgery on July 30, 2015, at which time petitioner was doing very well with minimal pain and swelling of her right knee.

Petitioner began a course of physical therapy on September 1, 2015 at Maxim Physical Therapy. Although she stated that she was feeling better, Petitioner reported that if she did too much, her knee would swell. She also complained about her knee feeling empty.

The petitioner was seen in follow-up by Dr. Paul on September 10, 2015. She reported worsening symptoms with increased swelling and pain particularly on the lateral side. There was no evidence of a DVT. The doctor did note a bit of a catching sensation on exam with signs of inflammation. An over-the-counter cream, as well as an anti-inflammatory, was ordered and the petitioner was directed to continue physical therapy.

An IME was performed on December 9, 2015, by Dr. Ira Kornblatt. The doctor diagnosed petitioner as status post lateral meniscectomy with ongoing synovitis. It was noted that it was likely that Petitioner had some preexisting degenerative changes or even a degenerative tear of the lateral meniscus that was aggravated by the work injury as opposed to a truly acute traumatic injury. However, he opined that the preexisting condition was not solely responsible for her current diagnosis, treatment, and symptoms given she was asymptomatic prior to the work injury. The doctor causally related her ongoing condition to the work accident, and recommended she undergo aspiration of the knee and a steroid injection followed by another four to six weeks of physical therapy. If she continued to have symptoms, viscosupplementation may be necessary

Five months after undergoing right knee surgery, Petitioner received a corticosteroid injection from Dr. Paul on January 5, 2016. Dr. Paul noted that the petitioner only had a mild amount of swelling and the doctor did not think there was significant effusion in the right knee that he could aspirate. Physical therapy was put on hold to assess whether the injection would help. When she returned on February 2, 2016, while she seemed to be doing better, the doctor was concerned that the steroid injection was simply masking her underlying pathology. The doctor recommended that she resume physical therapy and try an off-loader brace to take pressure off the lateral side.

When the petitioner returned on March 3, 2016, she had not yet obtained her unloader brace and reported that the steroid shot had helped initially, but the pain seemed to have returned. An updated MRI was ordered to better assess her condition.

The MRI performed on March 29, 2016, showed a subtle vertical tear involving the peripheral third of the posterior horn of the medial meniscus, moderate sized effusion, moderate changes of the chondromalacia patella, and findings consistent with a sprain/strain involving the proximal LCL with moderate cartilage loss within the lateral knee compartment consistent with degenerative joint disease.

Dr. Paul reviewed the MRI on April 5, 2016, as showing moderate cartilage changes in the patella, as well as the lateral compartment, which is where her pain primarily was. The doctor agreed with the prior IME, which had suggested possible viscosupplementation if a conservative injection did not work.

Dr. Andrew Hunt performed an independent medical evaluation of Petitioner on May 16, 2016. Dr. Hunt diagnosed petitioner with moderate lateral compartment osteoarthritis of the right knee status post partial lateral meniscectomy, chondromalacia of the patella, and medial meniscal tear. He opined that it appeared Petitioner's knee pain and synovitis were caused by her work accident, but noted that she had a previous lateral meniscal tear in January of 2011 as well

as findings consistent with patellar chondromalacia at that time. The doctor agreed that the mechanism of injury would correlate with her recurrent symptoms and that the pain and synovitis was caused by the fall on March 3, 2015. The doctor agreed that viscosupplementation was the next step to treat her pain

Dr. Paul administered a viscosupplementation injection into Petitioner's right knee on June 30, 2016. When the petitioner followed up with Dr. Paul on November 3, 2016, she reported that her right knee pain had noticeably improved. She stated that there was still some irritability on the lateral side and underneath the kneecap, but overall, she was now starting to feel better. There was no significant swelling upon examination of the right knee, but Petitioner was tender over the lateral side. She reported there was a clicking and catching underneath the kneecap, which Dr. Paul was able to observe as well. Petitioner wished to proceed with a repeat injection into her right knee. Dr. Paul recommended she return toward the end of the year or beginning of the next year to receive the injection. She was to follow up in six to eight weeks.

Testimony of Jeff Heisey

Jeffrey Heisey testified on behalf of the petitioner. Mr. Heisey is a flight attendant for United Airlines and also serves as secretary/treasurer for the Association of Flight Attendants. His position in this regard includes working as bargaining representative for the flight attendants, (Tr. Pg. 8) The Arbitrator finds Mr. Heisey to be a credible and knowledgeable witness regarding flight attendant scheduling and payroll. Mr. Heisey testified, "So the way flight attendants get paid, our work is non-traditional work." (Tr. Pg. 11) Mr. Heisey explained that flight attendants work on board the airplane as well as in advance in preparation for flights. Flight attendants do not punch a clock. (Tr. Pg. 11)

Mr. Heisey completed a report and graphical representation of the activities of Ms. Russell for the period of the year prior to the work accident (PX No. 5, Pg. 1-3). Mr. Heisey explained that the petitioner worked an A/B rotation of alternating months being on reserve and being a line holder. Mr. Heisey described a line holder as receiving a line of flying "which is a sequence of what we call trip IDs or trip pairings, which is a sequence of flying that are placed into a monthly schedule; and that is what the flight attendants' pay is based on." (Tr. Pg. 35).

Because of where Ms. Russell was domiciled, she was on reserve every other month. Mr. Heisey explained that call in reserve means that you get your flight assignment the night before the. When calling in the flight attendant will either: 1) be assigned a trip; 2) assigned to standby at the airport for 4 hours; 3) converted to ready reserve which means that after midnight you must be available to show up at the airport within four hours for a trip; or 4) released for the day if the company's reserve coverage is such that they do not anticipate they will need you. (Tr. Pg. 79-81). Mr. Heisey explained that standby has a designated report time and a maximum time of four hours unless the company is in a drafting situation which can be extended up to five. If you are not used you are released and you are paid five hours for the duty period and go home. If you are used (i.e. called to work), it is replaced with an ID flight number and you fly that sequence (Tr. Pg. 75-76).

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Mr. Heisey explained that trip months are made into 30 or 31 day months which may include either the end of the prior month or beginning of the next month under Section 2(w) (Tr. Pg. 81-82). Mr. Heisey testified in a 31-day month a flight attendant would be on reserve for 19 days and in a 30-day month they would be on reserve for 18 days. (Tr. Pg. 84-85) The relative flight time value of pay for those days in a 30-day month is four hours and 20 minutes and the value in a 31-day months is four hours and seven minutes. (Tr. Pg. 85) Even if a flight attendant did not end up getting called (i.e. flying) at all in a reserve month, she would be paid 78 hours as the reserve minimum guarantee.

Flight attendants are paid on the first and sixteenth of each month. (Tr. Pg. 102) The first of the month the flight attendant gets an advance based on a percentage calculation using the minimum guarantee, the flight time or the total in the DFAP (electronic pay file) as of the 20th of the previous month. (Tr. Pg. 102-103) The second check then calculates what the flight attendant actually flew or the amount of hours they are entitled to under the guaranteed minimum and subtracts the advance paid on in the first check. (Tr. Pg. 103-104)

Testimony of Robert Krabbe

Mr. Krabbe testified on behalf of the respondent. Mr. Krabbe is the Director of Labor Relations for United Airlines and is responsible for administration of the flight attendant agreement and participated in negotiations and implementation of the Union contracts. The arbitrator also finds Mr. Krabbe was a knowledgeable and credible witness. The flight attendant agreement or Union contract takes usually two to three years to negotiate. (Tr. p. 152) The per diem paid to flight attendants was negotiated by the parties in those contract negotiations to provide reimbursement to employees for travel expenses while away from their domicile. (Tr. p. 153) Mr. Krabbe testified that it is meant to cover meals and incidental expenses while they are traveling for work. (Tr. p. 153) It is not taxable because it is considered reimbursement for expenses under the IRS code as reimbursement for meals. (Tr. p. 153) Upon questioning by this arbitrator, Mr. Krabbe clarified if it was simply a salary or a 'premium', it would be part of their wages and would be taxable. (Tr. p. 162)

Conclusions of Law:

The petitioner suffered a compensable injury to her right knee on March 3, 2016. The accident and causation are not disputed. The sole issue in dispute at this time is the calculation of the petitioner's wage pursuant to Section 10.

Section 10 of the Workers Compensation Act sets forth four methods for computing the average weekly wage i.e. the actual earnings of the employee in the employment in which she was working at the time of the injury. The computation methods are as follows:

1. The actual earnings at the time of the injury during the 52 weeks immediately preceding the date of injury divided by 52.

2. If the injured employee lost five or more days during such period, whether or not in the same weeks, then the earnings shall be divided by the number of weeks and parts thereof remaining after the time lost from work has been deducted.

3. When the employment prior to the injury extended over a period of less than 52 weeks, the earnings during that period shall be divided by the number of weeks and parts thereof which the employee actually earned wages.

4. When due to the shortness of time during which the employee has been working or the casual nature and terms of the employment it is impractical to compute the average weekly wage as defined, consideration shall be given to the average weekly amount during the 52 weeks preceding the injury that would have been earned by a person at the same grade employed at the same work for each such 52 weeks for the same number of hours per week by the same employer.

The 'weeks and parts thereof' language was addressed by the Supreme Court at length in *Sylvester v. Industrial Comm'n.*, 197 Ill.2d 225 (2001). The petitioner in *Sylvester* was a roofer who worked in 48 of the 52 weeks prior to the accident, but only worked a total of 131 days. Even though his hours would vary, there was unrebutted evidence at trial that he would work 5-day 40-hour weeks when available. Therefore, the Illinois Supreme Court held that to calculate the 'weeks and parts thereof', the claimant's AWW should be determined by not including each of the days that the claimant did not work through no fault of his own. The AWW was then calculated by taking the total number of days worked divided by five to determine the number of weeks and parts thereof worked. In rendering their decision, the Court relied on the evidence that claimant was a full-time employee and worked eight hours per day, five days per week, when work was available. Moreover, the union contract stated the regular workweek ran from Monday through Friday with a makeup on Saturday and began at 8:00 a.m. and ended at 4:30 p.m. Thus, the court found sufficient evidence to establish a regular 40-hour workweek in that case.

Ms. Russell does not work a standard 40 hour work week and being a flight attendant is not a 9 to 5 job. (Tr. Pg. 33) Mr. Heisey testified, "So the way flight attendants get paid, our work is non-traditional work." (Tr. Pg. 11) He also testified that flight attendants do not punch a clock. (Tr. Pg. 11)

The petitioner was also asked:

Q: "You don't have a normal week as such, is that fair?
A: I don't think there is anything normal about what we do." (Tr. Pg. 138)

In explaining that there are no set number of days in a standard work week, Mr. Heisey explained that the Union negotiated for flight attendants to be able to trade their schedules, to condense or extend their flying dates out over a month. (Tr. Pg. 43-44)

The union contract (Rx. 3) covers all aspects of scheduling, flying, and payroll involving United Airlines flight attendants. (Tr. Pg. 57-58) Mr. Heisey conceded that nowhere in the union

contract does it indicate the petitioner has a 40-hour work week (Tr. Pg. 58). And while the contract does not talk about a work week at all, it does talk about a month and actually defines a month in Section 2(w). (Tr. Pg. 58) (RX 3, pg. 6) The flight attendant union contract prohibits any flight attendant from being scheduled to work more than 95 actual flight hours in a month. (Rx. 3, Pg. 42) [1] The arbitrator notes that this would be approximately 23.75 hours per week.

From the evidence introduced, the petitioner worked an average of 11.68 hours per week to a maximum of 24.50 hours per week in any given month.[2] (Rx. 1)

Month	Total hours paid	Calculation Hours / days in that UAL month	Average per week
June 2014	50.10	50.10 / 4 weeks 2 days	11.68 hours/week
July 2014	83.34	83.34 / 4 weeks 2 days	19.44 hours/week
August 2014	75.16	75.16 / 4 weeks 2 days	17.54 hours/week
September 2014	108.47	108.47 / 4 weeks 3 days	24.50 hours/week
October 2014	78.22	78.22 / 4 weeks 3 days	17.66 hours/week
November 2014	95.40	95.40 / 4 weeks 3 days	21.54 hours/week
December 2014	89.11	89.11 / 4 weeks 2 days	20.79 hours/week
January 2015	101.52	101.52 / 4 weeks 3 days	22.93 hours/week
February 2015	104.41	104.41 / 4 weeks 3 days	12.60 hours/week

Evidence was also introduced that the petitioner regularly traded away trips to either have a day off or to pick up a different trip. (Rx. 1) Mr. Heisey testified that the listed RDOS on the Lines of Flying document (Rx 1) indicate that the petitioner traded away whatever flights/trip IDs were on those days. (Tr. Pg. 90) It is clear from this that the petitioner regularly changed her schedule to suit her preferences each month in which she was awarded a line of flying. Mr. Heisey testified, "So as flight attendants, we have a number of flexibilities that are negotiated into the agreement. So one of the ways we can change our schedule is by giving away the trips that we are assigned and waiting either for somebody to call in sick or whatever to pick up a trip of a different type." (Tr. Pg. 91-92) Mr. Heisey also testified, Q: So there seems to be a lot of flexibility in how flight attendants arrange their schedules, would that be accurate? A: Oh, yes, that would be accurate. (Tr. Pg. 92).

It is impossible to establish the 'weeks and parts thereof' remaining after lost time is removed and petitioner's average weekly wag cannot be calculated by distilling down her hours to a standard 40 hour work week.

[1] Mr. Heisey clarified that while there is a maximum of 95 hours that United can schedule an employee for in terms of actual flying hours although a schedule could be longer if the hours over are not actual flight time (Tr. Pg. 60-61) but are only credited flight time owed to bring the employee up to a minimum of 5 hours per day or in line with other requirements. (Tr. Pg. 62). As such while they may be scheduled or paid for more than 95 hours there would be no more than 95 hours actual flight time.)

[2] Figures taken from Respondent Exhibit 1, the "lines of flying" document. Petitioner was paid the greater of the minimum guarantee (designated GAR), actual flight time (ACT) or credited flight time (FTM). This document also demonstrates which days (30 or 31) were included in each month.

The Commission and Illinois Courts have regularly held that in order to follow the Sylvester model, a claimant must establish evidence of a regular workweek. In *Coday v. Illinois Workers' Compensation Comm'n.*, 08 IWCC 0811, the claimant worked irregular hours, ranging from 10 to 40 hours per week with two weeks during which the claimant did not work any hours. The Commission rejected using the *Sylvester* calculation to calculate claimant's average weekly wage because there was no evidence that the claimant generally worked a 40-hour work week and only lost time through no fault of his own. Similarly in *Warfield v. Enterprise Electric Corp*, 08 IWCC 0096, the Commission held that it was improper to calculate an average weekly wage using the Sylvester method for an employee who failed to establish at trial that he was hired to work a 40-hour week.

Similar to *Coday* and *Warfield*, Ms. Russell worked irregular hours and there is no evidence that Ms. Russell worked a 40 hour week as required for a *Sylvestor* analysis. Ms. Russell's hours not only varied from week to week, but during some months, she was a call-in reserve and did not know what days she would be working until the night before. In addition, she regularly traded trips and days off to rearrange her schedule to suit her preferences. Attempting to reduce her days worked to a 40-hour workweek would be improper under the caselaw.

In addition to how petitioner's wages are calculated, the arbitrator must determine what aspects of the petitioner's pay are included in her wages. It is clear that her regular salary, vacation pay and sick time would be included in her regular earnings. In addition, there is no dispute between the parties that the taxable per diem [3]and duty free earnings should be included. The remaining pay components to be addressed include the non-taxable per diem, incentive pay and profit sharing.

As to the per diem, Mr. Heisey testified, "That money is intended for expenses that we incur while we are out on the trip." (Tr. Pg. 17). As it is a negotiated compromise as to the costs of being away from home, flight attendants do not submit written receipts of expenses to get the per diem. (Tr. Pg. 18) Petitioner testified she does not submit receipts for her per diem and did not keep track of what she spent her per diem on. (Tr. p. 138-139, 166) She testified that she packs a lot of own food because she likes to eat organic and she likes to go to Trader's Joe's (Tr. p. 139).

Pursuant to the case of *Swearingen v. The Industrial Commission*, 298 Ill.App.3d 666, 699 N.E.2d 237 (5th Dist. 1998), the Court must look at whether the per diem constitutes a real economic gain in order to determine whether it is to be included in the petitioner's average weekly wage. The Court in *Swearingen* was faced with an employer who attempted to recast 50% of his employee's wages as non-wages so as to avoid taxes by claiming the payments were actually reimbursements for employee travel expenses. The Court saw through the employer's ruse, as there was no bona fide purpose for the per diem to reimburse employees for expenses incurred while traveling.

[3] The per diem is taxable when a flight attendant does not meet the away from home standard i.e., when she leaves in the morning and then comes home and sleeps in her own bed at night (Tr. Pg. 26-27). Mr. Heisey testified, "That is an IRS standard that says if you are not away from home for a specific period of time, that money is actually considered taxable, as opposed to being non-taxable as an away from home business expense."

The issue of the United Airlines non-taxable per diem has been previously addressed by the Illinois Appellate Court in *United Airlines v. Workers' Compensation Commission and Mary Ritter*, 382 Ill.App.3d 437, 887 N.E.2d 888 (1st Dist. 2008). The Appellate Court found in Ms. Ritter's case that the per diem constituted a collectively bargained for and contractually agreed upon method of reimbursement for flight attendant expenses while away from home. The Court rejected Ms. Ritter's argument that the reimbursement for travel expenses should be included in her average weekly wage absent evidence of actual expenses, as this would place the burden on United Airlines to prove that the per diem payments did not represent real economic gain. The Appellate Court pointed out this would impermissibly shift the burden of proof to the employer and noted that it is the workers' compensation claimant, not the employer, who has the burden of proving the average weekly wage. The Appellate Court found that the petitioner's testimony was insufficient to establish that her entire per diem payments did not constitute real economic gain. In remanding this matter to the Commission for determination, they stated that there would need to be a determination as to what extent the claimant's per diem payments exceeded her actual expenses and the extent to which she had realized real economic gain.

The evidence introduced at trial was that Ms. Ritter would either bring food from home, go to a local grocery store or eat at inexpensive restaurants. Prior to her accident, she primarily flew to Japan. Her per diem payments were approximately $230.00 for each trip. The claimant testified that she would only spend around $50.00 when she went to Japan and that she would eat on the plane and buy food from a local grocery store. Ms. Ritter testified, "We usually had refrigerators in our room. A lot of times we would bring food from home with us. Certain types of foods you couldn't bring into Hawaii, but you usually had the grocery stores we go to or we knew places we could go and eat inexpensively and try to save." In addition, she testified that they would bring videos, walk in the gardens of the temple and read, and take a bus from the hotel and train into Tokyo. The petitioner was unable to testify as to the amount she spent on any particular trip in the year before the work injury. The Commission found on remand that this evidence was insufficient and that Ms. Ritter failed to establish real economic gain and excluded the non-taxable per diem. 10 IWCC 0031.

The testimony provided by Ms. Ritter was more detailed than that provided by Ms. Russell. Ms. Russel. has also provided no evidence of her actual expenses. She did not keep any receipts or records of her per diem monies spent. The Arbitrator notes that it is unrealistic to believe that she could spend only $20.00 on a six-day trip to Paris or a five- day trip to Sydney, particularly if she was buying organic food and food at Trader Joe's. Petitioner has therefore failed to meet her burden of establishing that the non-taxable per diem payments represent real economic gain.

The incentive pay and profit-sharing payments are both bonuses paid to petitioner. Section 10 of the Act specifically excludes overtime and bonuses. In Peri v. AMR- American Airlines, 00 IIC 0779, the petitioner received a bonus from his employer because the company made a profit in the previous year. The bonus was based on the profit the company made, the hours worked by petitioner and his seniority. The arbitrator found that this payment was really profit sharing and should not be included in the average weekly wage pursuant to Mayes v. Ford Motor Co., 94 IIC 1060.

Ms. Russell received operational incentive payments of $400.00. Mr. Heisey explained these operational incentive payments were part of a success sharing formula implemented by management to encourage employees in meeting customer service and on-time metrics for overall performance of the airline (Tr. Pg. 28). Ms. Russell did not do anything individually to earn this money (Tr. Pg. 29). She, in fact, received an incentive payment in April, a month in which she did not work at all. No testimony was provided regarding the profit-sharing payments. As such, the arbitrator finds these payments should be excluded from the wage calculation in Section 10 as a bonus.

Conclusion:

To calculate the petitioner's earnings based on an alleged 40-hour workweek as petitioner suggests would result in a windfall, not only well in excess of her earnings for any week in 2016, but many times over what she had earned in the previous four years.[4]

In the year prior to the March 3, 2015 work accident, the petitioner was off work for an unrelated medical condition until June 2014. As petitioner was injured on March 3, 2015, wages for March 2015 are also not included. Based on the petitioner's pay advices tendered by petitioner in Px1 and the wage statement provided by Respondent in Rx. 2, the arbitrator assesses that for the included categories of earnings discussed above for the months from June 2014 to February 2015, petitioner earned $35,575.80. As the earnings span over a period of 39 weeks and 2 days, this renders an average weekly wage of $905.56.

[4] Introduced into evidence were the petitioner's W2s for the four years prior to the work accident. (Px. 5, p. 17-21) The petitioner's earnings were as follows:

2012: $14,930.43
2013: $33,030.24
2014: $27,041.03
2015: $16,014.84

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INCLUDED EARNINGS UNDER SECTION 10 NOT INCLUDED

Month in Which Pay Received	Month Work Performed	Salary	Vacation	Sick Leave	Per Diem Taxable	Duty Free	Occupational Sick	Incentive pay	Per Diem Non-taxable	Profit Sharing
Apr 14	Mar 2014									
May 14	April 2014							$50.00		
Jun 14	May 2014									
Jul 14	June 2014	$2,665.03			$7.80				$414.23	
Aug 14	July 2014	$3,018.45		$589.62	$102.71			$125.00	$237.68	
Sep 14	Aug 2014	$2,729.39		$182.88					$273.67	
Oct 14	Sep 2014	$5,628.43						$50.00	$762.26	
Nov 14	Oct 2014	$3,388.94		$365.76					$450.04	
Dec 14	Nov 2014	$4,672.57							$632.28	
Jan 15	Dec 2014	$3,490.77	$960.12					$25.00	$437.59	
Feb 15	Jan 2015	$5,105.96				$19.13			$759.20	$1,453.64
Mar 15	Feb 2015	$653.27	$800.10	$1,165.86		$29.01		$50.00	$72.75	
Apr 15	Mar 2015	$1,452.04					$200.23	$100.00	$214.13	
Total= 35,575.80		31,352.81	1,760.22	2,304.12	110.51	48.14	0			

$35,575.80 / 39 weeks 2 days = $905.56 AWW
Green shaded boxes were used in AWW calculation for reasons outlined in the decision.

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STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James W. Hurt,

Petitioner,

vs.

NO: 14 WC 34036

East St. Louis Housing Authority,

Respondent.

18IWCC0077

DECISION AND OPINION ON REVIEW

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

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Petitioner was a 44-year-old employee of Respondent, who described his job as a security officer. His primary working career had been in law enforcement and security. At Respondent, Petitioner's duties consisted of responding by dispatch to incidents occurring at housing properties, like domestic disturbances, fights in progress, drug calls, disturbances; everything. He stated as an officer it requires some mediation. Petitioner did carry a weapon. The area he worked was considered an underprivileged area, high crime area. Petitioner would get into fights with people reluctant to leave or do what he told them and he would discharge his weapon if necessary while on the job. During his tenure at Respondent, Petitioner never missed days of work and had good reviews. From time to

time the U.S. States Attorney would visit his facility and he then had to do special security when they were engaging with residents at the properties. Petitioner was paid $16.79 per hour. Petitioner stated that he normally worked 40 hours per week ($671.60 per week). Petitioner worked more than 40 hours sometimes. He did not miss more than 5 days of work in the year before the injury other than in Spring of 2014 when he had pacemaker surgery and was off under doctor authorization. His usual two-week earnings were $1,343.20. Petitioner identified PX16 as a record of his earnings at Respondent. It indicated 2 weeks in April and 1 in May off due to the cardiac surgery.

- On the date of accident, September 16, 2014 (about 3:00am), Petitioner testified he was involved in a crash. Since the accident, he had not had any other traumas or wrecks. Prior to the accident, Petitioner had never seen a doctor regarding his left shoulder or neck and had no restrictions or complaints regarding those areas. Prior to then Petitioner stated that he never had a CT of his shoulder or neck. On the date of accident Petitioner was driving westbound on State Street in East St. Louis. He was at the 1700 block and as he was driving a pickup truck was traveling north at a high rate of speed and turned fast uncontrollably going eastbound on State and collided head on with the vehicle Petitioner was driving. Petitioner stated the other driver fled the scene; he had no insurance or license. Petitioner indicated Dr. Gornet was familiar with the speed of the crash (per deposition); as Petitioner relayed it to him. Petitioner testified that his vehicle was totaled and the air bags had deployed. An ambulance was called to the scene for Petitioner and Petitioner noticed his physical problems with pain and discomfort in his left arm, neck, knee, hip and hands. Petitioner also stated that he had some chest trauma. Petitioner testified that he advised the ambulance personnel of his problems. Petitioner told them of arm pain. Petitioner was placed on a cardiac monitor in the ambulance and he was taken to St. Louis University emergency room and he told the ER personnel of left hand problems and shoulder and neck problems. Petitioner stated that he never had problems with those areas before. Petitioner testified that a good deal of his treatment focused on his heart condition as he had blunt chest trauma and that was a major concern there. Petitioner's heart doctor is Dr. Sanjay Saheta. Dr. Saheta referred Petitioner to Dr. Gornet regarding neck treatment. Petitioner first saw him about October 20, 2014. Dr. Gornet ordered a cervical CT myelogram. Petitioner continued to treat with Dr. Gornet until about June 2016. Petitioner received some conservative care including cervical injections. Petitioner indicated there was no long-term relief (to about 5 days) with those. Petitioner was not satisfied with the short-term relief; it did not fix the problem long-term. Petitioner stated that he also had problems with his shoulder that were addressed when he first saw Dr. Gornet and he told the doctor of those problems as well. Dr. Paletta was the shoulder surgeon and Petitioner saw him the same first day he saw Dr. Gornet. Petitioner had left shoulder surgery on October 28, 2015 (more than a year after the crash). Petitioner stated that he did not have the shoulder surgery sooner as Dr. Gornet was concerned about the neck injury and the doctor wanted to make sure his neck was okay before that surgery. When he first saw Dr. Gornet, Petitioner testified he reported the pains in the hands, shoulder and neck; especially the left side of the neck. He stated he had a lot of left arm pain that he did not have before the crash. From the time of the accident to the shoulder surgery Petitioner testified he was never without left arm pain.

- Petitioner saw Dr. Van Fleet and the doctor did not ask if he had any left arm pain. Petitioner had neck surgery February 23, 2016 and he was ultimately released by Dr. Gornet on June 6, 2016. Petitioner also saw Dr. Mall regarding his left hip and he received therapy for that. Petitioner stated that he had seen Dr. Van Fleet (Respondent's IME) twice but he never suggested any treatment for Petitioner. Petitioner testified that after more than a year with pain in his neck and hand and the unsuccessful conservative care Dr. Gornet suggested the 2-level cervical disc replacement surgery that was done; no other doctor suggested other ways to address that issue. Petitioner was still taking medication (Meloxicam for pain and a muscle relaxer) prescribed by Dr. Gornet for his shoulder; when last seen June 2016. Petitioner takes that medication about every other day. Petitioner testified that currently he still has difficulty using his left shoulder. He has a lot of difficulty with bending the shoulder and with driving as he drove with his left arm mostly. He stated after lifting his arm overhead for a length of time he gets stiffness in his arm/shoulder.

- Petitioner currently drives as a locator for a repossession company. Petitioner testified that he currently drives 8-hours with cameras on his vehicle. Petitioner stated that he drives around St. Louis and the metro area. The cameras on his car takes pictures of license plates. If a vehicle needs to be repossessed he would contact a towing company to get the vehicle; his job is driving. Petitioner testified that he can have his left hand on the steering wheel for 5-7 minutes or so and then he has to rest it and he then drives with his right hand and rests his left hand on the door or his lap. Overhead his arm stiffens up and it gets numb and painful (to 3-4/10). Petitioner stated that he was satisfied with the shoulder surgery performed by Dr. Paletta. Petitioner stated that his arm will hurt and get stiff after helping his family. Petitioner stated that his arm hurts just hanging when he walks so he puts his hand in his pocket to rest. He stated that pushing with his left arm is not what it used to be. He can take lug nuts off his car but not as fast or easy as before. He does switch hands cleaning at home. He can lift enough to get by; lifting is a compromise; he can lift about 10 pounds. His son is 34 pounds and he sometimes feels like he would drop him when his arm hurts. He cannot put on his belt like he used to; his arm does not go back like before without pain. Generally, he was happy with results of the surgeries. Before the shoulder surgery he had more shoulder pain, that is better. His arm and neck did not feel better after the shoulder surgery. After neck surgery, his neck and arm felt better. He still had left hand pain. Before neck surgery his pain was 8-9/10 at times and now 3-4/10. His neck feels pretty nice as to pain. He agreed he has 2 artificial discs in his neck. His hip bothers him if he lies on it when he sleeps. Petitioner stated that he cannot do that for too long. His hip hurts at times so he sleeps on his right side.

- Petitioner testified that in his current position he makes $9 per hour. Petitioner stated that since his termination he reapplied at Respondent, however, he was told that there were no openings available so they did not take him back. Petitioner identified PX 4 as termination documents from Respondent and his letter requesting to keep the job before he was terminated. Petitioner had been terminated by Respondent January 31, 2015. Petitioner noted his mileage log from his treatment. He stated the drive to Dr. Van Fleet was further than the drive to his treating doctors.

The Commission finds that the parties stipulated to causal connection regarding the shoulder; Respondent disputed the extent of the cervical injury; (basically accepting strain only, temporary exacerbation). Petitioner clearly had pre-existing cervical disc degeneration. There is no indication of prior cervical treatment or complaints and even Respondent's Dr. Van Fleet indicated there was an aggravation of the pre-existing cervical condition. Petitioner was treated by Dr. Gornet regarding the cervical issue and eventually underwent 2-level disc replacement in February 2016. Petitioner was seen by Dr. Paletta regarding his shoulder injury. Petitioner was seen by Dr. Mall regarding the hip. Petitioner had also seen Dr. Saheta regarding his cardiac condition, with the prior cardiac pacemaker placement, after the accident due to blunt chest trauma. Petitioner had shoulder surgery performed by Dr. Paletta. Dr. Paletta released Petitioner February 8, 2016 regarding the shoulder. Petitioner noted a great result and no pain with daily activities. Through that time, Petitioner had seen Dr. Gornet for essentially conservative care regarding the neck; injections with no real long-lasting relief. Petitioner did not indicate any radicular type symptoms on the pain diagram when Dr. Gornet initially saw him shortly after the accident in October 2014. The initial ER and ambulance records did indicate neck, shoulder and arm complaints, but there can be overlap of symptoms with cervical and shoulder/arm conditions. Again, Petitioner had good recovery from the shoulder surgery and at that discharge from Dr. Paletta there was no real indications of radiculopathy. That was shortly before the 2-level cervical disc replacement (almost 1.5 years after the accident, and again, with conservative care regarding the neck through that time and not a lot to indicate radicular symptoms versus shoulder symptoms). The cervical surgery had been scheduled before Petitioner's release by Dr. Paletta. Respondent's Dr. Van Fleet saw Petitioner on 2 occasions and indicated there were no objective radicular findings on exam. Dr. Van Fleet noted that the lack of radicular findings on exam was consistent with the CT findings and treating records as well as the failure of the injections to provide any long-term relief; essentially indicating no objective radicular finding. While Dr. Gornet has done studies and written articles on the subject, there are discrepancies in the records and a lack of documentation of radiculopathy in the records to support his opinions of the need for the 2-level cervical disc replacement and causality to the accident. Again, Dr. Gornet scheduled surgery well before Dr. Paletta's release in February 2016 (just prior to the cervical surgery) that noted no radicular type symptoms and a good shoulder surgery result. After the failed injections (12/14 and 1/15), Petitioner was treating pretty much exclusively for the shoulder. The evidence and testimony finds that Petitioner proved some aggravation of the pre-existing cervical condition, but Petitioner failed to meet the burden of proving an ongoing causal relationship to the need for the cervical surgery. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to causal connection to cervical strain, and maximum medical improvement (MMI) as of February 8, 2016 when Petitioner was released by Dr. Paletta regarding the shoulder (MMI being prior to the cervical surgery 2/23/16).

The Commission finds that the Arbitrator found average weekly wage (AWW) was '$1,343.20' (clearly a clerical error noted in the findings, but the Arbitrator's calculated rates were correct assuming the AWW was $653.16 as calculated in the Conclusion of Law section). The Commission notes that Petitioner argued that the Arbitrator erred in determining AWW and they calculated AWW at $671.60 (TTD=$447.73; PPD=$402.96). The Commission notes that

Respondent stated AWW/Benefit rates should be affirmed. The Commission finds that per Petitioner's exhibit 16, East St. Louis Housing Authority earnings record, Petitioner's total gross pay for the prior 52 weeks was $34,134.51, resulting in an AWW of $657.00 and corresponding TTD and PPD rates of $438.00 and $394.20 per week respectively. The Commission acknowledges that the gross pay did not specify overtime versus regular pay, but that was the only evidence presented on the issue. The Commission finds the decision of the Arbitrator as contrary to the weight of the evidence, and, herein, modifies AWW/benefit rates as **AWW=$657.00; TTD=$438.00; PPD=$394.20**

The Commission, with the above finding regarding causal connection and AWW/benefit rates, finds the lost time as being from September 7, 2014 through February 8, 2016 (74-1/7 weeks). The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence as to the period of lost time, but, herein, modifies the Arbitrator's finding as to the total temporary disability rate. Petitioner is entitled TTD benefits of 74-1/7 weeks at $438.00 for $32,474.57 total TTD benefits. Respondent paid $33,956.99 in TTD benefits. Accordingly, Respondent is due a credit of $1,482.42 as a result of the overpayment of TTD benefits.

The Commission, with the finding of causal connection noted above, finds the evidence and testimony supporting the medical expenses award as is. 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.

The Commission, with the above finding regarding causal connection and AWW/benefit rates, finds the evidence and testimony supporting the PPD award. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and herein, affirms and adopts the Arbitrator's finding as to the nature and extent of Permanent partial disability, but modifies to a PPD rate of $394.20 per week. The Commission finds Petitioner entitled to a PPD award of 15% loss of use of Petitioner's person as a whole (75 weeks regarding the left shoulder) & 5% loss of use of Petitioner's person as a whole (25 weeks regarding cervical spine) under §8(d)(2) of the Act (100 total weeks at $394.20 per week, for $39,420.00 total PPD award, Credit of $1,482.42 to Respondent for overpayment of TTD).

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $438.00 per week for a period of 74-1/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $394.20 per week for a period of 100 total weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the 15% loss of use of Petitioner's person as a whole (75 weeks regarding the left shoulder) & 5% loss of use of Petitioner's person as a whole (25 weeks regarding the cervical spine) (Credit of $1,482.42 to Respondent for overpayment of TTD).

18IWCC0077

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $-0- for medical expenses under §8(a) of the Act; all reasonable and necessary and causally related medical expenses having been paid.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $38,100.00. 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 2 - 2018
0-12/7/17
DLG/jsf
045

David S. Gore

David Gore

Stephen J. Mathis

Stephen Mathis

Deborah L. Simpson

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HURT, JAMES W
Employee/Petitioner

Case# **14WC034036**

EAST ST LOUIS HOUSING AUTHORITY
Employer/Respondent

18IWCC0077

On 5/19/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.02% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0384 NELSON NELSON PC
ROBERT C NELSON
420 N HIGH ST
BELLEVILLE, IL 62223

0358 QUINN JOHNSTON HENDERSON ET AL
CHRIS CRAWFORD
227 N E JEFFERSON ST
PEORIA, IL 61602

18IWCC0077

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

JAMES W. HURT
Employee/Petitioner

v.

EAST ST. LOUIS HOUSING AUTHORITY
Employer/Respondent

Case # **14** WC **34036**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Collinsville**, on **August 29, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 16, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* 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 $**33,964.51**; the average weekly wage was $**1,343.20**.

On the date of accident, Petitioner was **44** 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 $**33,956.99** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**33,956.99**.

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

ORDER

As explained in the Arbitration Decision, Petitioner's current condition of ill-being with regard to his cervical condition is not causally related to his accident of September 16, 2014. Petitioner reached maximum medical improvement for his left shoulder, cervical spine, and all other conditions on February 8, 2016.

Respondent has paid all appropriate medical and temporary total disability benefits. Respondent is not liable for additional benefits, including mileage reimbursement.

Respondent shall pay Petitioner the sum of **$391.90/week** for a period of **100 weeks**, as provided in **Section 8(d)2** of the Act, because the injuries sustained caused a **15% loss of use of the person as a whole (75 weeks)** with respect to his **left shoulder** and **5% loss of use of the person as a whole (25 weeks)** with respect to his **cervical spine**.

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

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

Signature of Arbitrator

May 17, 2017
Date

MAY 19 2017

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

18IWCC0077

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JAMES W. HURT
Employee/Petitioner

v.

Case #: 14 WC 34036

EAST ST. LOUIS HOUSING AUTHORITY
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated that on September 16, 2014, Petitioner sustained an accident which arose out of and in the course of his employment with Respondent, resulting in multiple injuries including to his left shoulder and neck. The parties disputed whether Petitioner sustained injury to his neck to the extent alleged, and whether the cervical surgery performed was reasonable, necessary, and causally related to the accident. The parties further disputed Petitioner's earnings, medical treatment to the cervical spine after May 27, 2015, temporary total disability benefits, nature and extent of Petitioner's disability, and mileage. With regard to temporary total disability, the parties agreed Petitioner was temporarily disabled from September 17, 2014, through February 8, 2016, and Respondent previously paid benefits for that period. Petitioner alleges he was further entitled to benefits from February 9, 2016, through June 9, 2016. Respondent objected to Petitioner's Exhibit 3, post-accident pictures of the vehicle, and Exhibit 4, termination documents. Both exhibits were admitted at hearing over Respondent's objection.

On the date of accident, September 16, 2014, Petitioner was 44 years old, married, and had no dependent children. He was employed by Respondent as a security officer and had been so employed since 2013. His duties included responding to incidents that occurred on housing properties, such as domestic disturbances, fights in progress, drug calls, disturbances, and the like. The area where he worked was considered an underprivileged, blighted, and high-crime area. He was armed and, if necessary, would discharge his weapon. Petitioner testified his rate of pay was $16.79 an hour and he worked 40 hours or more per week. He did not miss work and had good reviews. In the year prior to the accident he missed some time in the spring of 2014 when he had surgery for a pacemaker. He testified he had reviewed Petitioner's Exhibit 15, which was his earning record, and noted there were two weeks in April and one week in May 2014 where his earnings were less than normal. This was the period of time during which he was recovering from his cardiac surgery. Other than that period, his ordinary earning over two weeks was $1,343.20.

Petitioner testified that on September 16, 2014, he was in his patrol car driving westbound on State Street at about 3:00 a.m. A northbound pickup truck, travelling at a high rate of speed, turned uncontrollably eastbound onto State Street and collided head-on with Petitioner's vehicle. The other driver fled the scene and was later arrested and given a citation in connection with the accident. The airbags in Petitioner's patrol car were deployed and the vehicle was ultimately deemed a total loss. Petitioner testified that prior to this accident he had never had any problems, complaints, or restrictions with respect to his left shoulder or neck.

Petitioner was taken by ambulance to St. Louis University Hospital. He testified he reported to the ambulance driver and the emergency room that he had pain and discomfort in his left arm, neck, knee, and chest. He was placed on a cardiac monitor in the ambulance, and the initial treatment at the hospital was focused a great deal on his heart condition.

Petitioner testified that his cardiologist, Dr. Saheta, referred him to Dr. Gornet for treatment of his neck complaints. He saw Dr. Gornet on October 20, 2014, who ordered a cervical CT myelogram. He underwent conservative treatment, including injections. He testified the injections gave relief after about a day, and the relief last for four or five days. They did not help him long-term. Petitioner testified that when he first presented to Dr. Gornet he had pain in his hands, shoulder, and neck, especially along the left side, and the pain remained until after surgery. Petitioner testified he treated with Dr. Paletta for his shoulder, and first saw Dr. Paletta the same day that he first saw Dr. Gornet. He eventually underwent surgery on his left shoulder on October 28, 2015. Petitioner also saw Dr. Nathan Mall for the injury to his left hip, for which he underwent physical therapy. In addition, he saw Dr. VanFleet on two occasions. Following his shoulder surgery, he continued to have problems with his arm and neck and ultimately underwent a two-level disc replacement surgery by Dr. Gornet.

Petitioner testified he currently takes a muscle relaxer as well as Meloxicam for pain about every other day. Both are prescribed by Dr. Gornet. He currently has difficulty bending his shoulder, such as when he is driving, and has to switch driving arms every five to seven minutes. He has trouble lifting his arm above his head for any length of time, and gets stiffness in his arm and shoulder. When he walks around he tends to put his hand in his pocket, as his arm hurts when it hangs to his side. He frequently has to switch arms with any activity he does. He testified he does not currently have pain in his neck. He sometimes has pain in his hip if he lays on it too long.

Petitioner currently works as a locator for a repossession company. He drives around for eight hours at a time with cameras on his vehicle. The cameras take pictures of license plates and if the plate comes back as a car that needs repossessed he contacts a tow truck to pick up the vehicle. He earns $9.00 an hour with this job. He testified he had reapplied to work for Respondent but was told there were no openings available.

On cross-examination, Petitioner testified that, with regard to his claim for mileage, it was 38 or 39 miles one way from his home to see Dr. Gornet or Dr. Paletta. He acknowledged that he chose to treat with those doctors and that his employer did not instruct him to do so. He testified that he has six sisters, all of whom rely on him to do work for them, such as handyman

work, putting up fence, repairing washers and dryers, and hanging televisions. He also does light car maintenance, such as changing a tire or battery or replacing an alternator. He testified that in looking for a job he attended two job fairs and met with the Illinois Employment Division. He acknowledged that he did not talk with anyone about what kind of jobs he could or could not do.

Petitioner acknowledged he completed a pain diagram when he initially saw Dr. Gornet and testified he was accurate and truthful in filling it out. He testified Dr. Gornet conducted a physical examination at the first appointment; however, he could not recall if he conducted an examination at the subsequent visits. Petitioner testified he was accurate and truthful with describing his symptoms and abilities to all of his doctors. He agreed that all of his doctors had released him to full duty work without restrictions.

On re-direct, Petitioner was asked about a reference by Dr. Paletta that his left arm moved better than his right arm and hand. He explained that he was born with a deformity in his right arm and that he learned to use his left arm more. He writes with his right hand, but uses his left arm for strength and control. With regard to the pain diagram he completed with Dr. Gornet, Petitioner testified that he marked only his neck and not his left arm or shoulder as a problem because his appointment was to see Dr. Gornet for his neck surgery. His shoulder issue was going to be addressed by Dr. Paletta at a later date. However, Dr. Gornet brought Dr. Paletta into the room at Petitioner's first appointment for a consult.

On re-cross, Petitioner was asked to review the pain diagram contained in Dr. Gornet's record, marked as Petitioner's Exhibit 6. He acknowledged that the diagram asked the patient to mark where the pain was and where certain other symptoms were being felt. He agreed that he marked an "X" on the neck and marked that he had ache on each side of the neck. He testified he did not mark any areas of radiation because he was seeing Dr. Gornet for his neck and he did not know he was going to be looking at anything else.

Following the accident, the East St. Louis Police Department responded to the scene. The Incident Report noted it was a hit and run accident and the fleeing offender was apprehended a short time later. It was noted Petitioner was transported to St. Louis University Hospital. PX2. Three accident scene photos were admitted, which show extensive damage to the front of the car, primarily in the right front area. PX3. The ambulance report noted Petitioner was sitting in the driver's seat upon their arrival and was awake and breathing. It was observed that a significant amount of damage was present to the front passenger side of Petitoner's vehicle and that the airbags deployed. Petitioner complained of pain in the head, upper back, bilateral shoulders and arms, and right knee. He was placed on a cardiac monitor. PX8.

Petitioner was transported to St. Louis University Hospital. It was noted he had complaints of pain in multiple locations, worst in the left shoulder, left hand, and right knee. He denied tenderness in the neck or back. He underwent CT scans of the head, chest/abdomen/pelvis, and the cervical, thoracic, and lumbar spine. The head CT was normal. The CT of the chest, abdomen, and pelvis were negative for acute traumatic injury. The cervical CT showed mild multilevel degenerative disc disease, most pronounced at C6-7 on the right, with mild neuroforaminal stenosis. The thoracic CT showed degenerative disc disease at T9-10 with osteophyte complex that caused moderate narrowing of the right aspect of the central canal.

The lumbar CT showed multilevel degenerative disc disease. It was most pronounced at L4-5, where there was subchondral cyst formation and endplate sclerosis. In addition, x-rays of the left shoulder, left hand, left foot, and right foot were normal. Right knee x-rays showed degeneration and ossification but no acute injury. Petitioner underwent cardiac workup, due to his history of bradycardia and pacemaker placement, as well as elevated troponins upon admission and having hit his chest on the steering wheel in the accident. He was discharged on September 18. PX5.

Petitioner followed up with his cardiologist, Dr. Sanjaya Saheta of St. Louis Heart and Vascular, on September 24, 2014. His pacemaker was checked and supraventricular tachycardia (SVT) was documented. He was started on Lopressor. On October 1 he underwent a radionuclide imaging study, an EKG, and an exercise tolerance test. He returned to Dr. Saheta on October 8, 2014. As he did not have symptoms and the test results were acceptable, he was advised he did not need to have a cardiac cath. He was instructed to remain off work for four weeks and to follow up in six months. PX13.

On October 14, 2014, Petitioner wrote a letter addressed to "Dear Sirs". He testified this letter was sent to his employer. The letter states he was currently authorized off work by his physician due to the injuries he sustained in his work accident on September 16. He further advised he was scheduled to see Dr. George Paletta for his left shoulder, Dr. Nathan Mall for his lower extremities, and Dr. Matthew Gornet for his neck. He stated all of these appointments were scheduled for October 20. He advised he was willing to work light duty if his physicians allowed him to at that point. Finally, pursuant to the Family Medical Leave Act, he requested that his job be held until he could return to work. PX4-1.

On October 20, 2014, Petitioner presented to Dr. Matthew Gornet of The Orthopedic Center of St. Louis. He completed a Medical Information form, which included a pain diagram. He marked that he had burning in the middle back of his neck and aching on both sides of his neck. There were no other markings on the diagram. He rated his pain at 6/10. Dr. Gornet's note reported Petitioner complained of neck pain to both sides, left greater than right, with headaches, bilateral trapezial pain, left shoulder pain down his left arm to the hand, and numbness and tingling into his left forearm and hand. His symptoms were constant, worse with turning his head, arm activity, overhead work or fixed head positions, and better with a neutral position. He indicated pain in the trapezius bilaterally and on both sides of his neck, particularly on the left side into the left shoulder, arm, scapula, and forearm. He had mild decrease in wrist dorsiflexion and sensation was decreased to C6-7 on the left. Dr. Gornet noted x-rays showed narrowing of the space available to the cord at the C3-4 level with some posterior osteophytes and some loss of disc height at C6-7. He referred Petitioner to Dr. Paletta for his left shoulder and noted that, "Dr. Paletta has referred the patient for a left hip issue to Dr. Mall." He ordered a CT arthrogram of the left shoulder and advised Petitioner he could work light duty with no lifting more than ten pounds, no overhead work, and alternating sitting and standing. PX6, Dep.PX2.

Petitioner also presented to Dr. Nathan Mall on October 20, upon referral by Dr. Gornet. On the new patient intake form, Petitioner indicated he was seeing Dr. Mall for the pain in his left hip following his accident. He gave a consistent history of the accident. On exam, he had pain to palpation over the hip abductor insertion on the greater trochanter and pain with flexion and internal rotation of the hip. There was some weakness with the hip abductors and some pain

and weakness with hip flexors. Hip x-rays showed impingement pathology with a reduced head-neck offset. Assessment was left hip trochanteric bursitis/possible hip abductor tear, and left hip impingement. Dr. Mall recommended a cortisone injection and hip strengthening therapy. PX7.

On October 27, 2014, Petitioner presented to St. Charles Sports Physical Therapy for his hip complaints. He advised he had a cortisone injection the previous Friday which helped for only a few hours. He reported constant pain over the left lateral hip that increased and traveled down his left leg with increased activity. The next therapy note is the re-evaluation dated November 12. He reported overall resolution of his low back and buttock pain, but noted he still had a dull ache and occasional pain when lying down at the end of the day. It was noted he had shown marked improvements in range of motion, strength, pain, and function. PX11.

On November 17, 2014, Petitioner underwent two procedures at CT Partners of Chesterfield. A cervical myelogram and post CT revealed (1) C5-6 central disc herniation extending to the cord, mild stenosis, no significant foraminal narrowing; (2) C6-7 degenerative disc disease with protrusion across the midline and osteophytes resulting in mild central stenosis with bilateral foraminal stenosis, where either of the C7 roots could be affected. An addendum report noted mild disc space narrowing at C5-6 with anterior osteophytes and no significant ventral impression upon the dura. A left shoulder arthrogram and post CT revealed a superior labral defect consistent with superior labral tear, without evidence of rotator cuff tear. PX9.

Immediately following the two procedures, Petitioner was seen by Dr. Gornet and Dr. Paletta. Dr. Gornet noted the CT myelogram "clearly reveals a disc herniation to the left side at C5-6 and a central herniation at C6-7 with some foraminal stenosis bilaterally, right greater than left". Petitioner reported continued left trapezial, left shoulder, and left arm symptoms. Dr. Gornet noted that Dr. Paletta's opinions regarding the shoulder would need to be incorporated in the treatment plan. Dr. Paletta's record of November 17 states Petitioner "returns today for continued follow up of his left shoulder". *The Arbitrator notes, however, that the evidence admitted at trial did not include a prior note from Dr. Paletta.* Dr. Paletta noted Petitioner's exam was "unchanged", but did not provide any specifics beyond that with respect to the examination. He reviewed the CT arthrogram and noted a small tear of the labrum in the left shoulder. He further noted Petitioner was having significant cervical issues as well and he did not recommend shoulder surgery at that time, as it appeared the neck was the most significant issue. He recommended an injection of the glenohumeral joint. He discussed physical therapy with Dr. Gornet, who wanted to wait on therapy pending results of the cervical injections, given the fairly significant disc herniation. The doctors were in agreement that the neck condition took priority over the shoulder. PX6. It appears Petitioner also saw Dr. Mall on November 17; however, the only record of the appointment was a Work Status Report releasing Petitioner to full duty for the hip. There was no office note admitted. The Arbitrator notes this is the final record from Dr. Mall with regard to Petitioner's left hip. PX7.

On December 22, 2014, Petitioner underwent a left C5-6 epidural steroid injection by Dr. Kaylea Boutwell at The St. Louis Spine and Orthopedic Surgery Center. He rated his pain as 8/10 before and after the injection. He underwent a second injection on January 5, 2015. He rated his pain as 7/10 before and after the injection. PX12.

On January 6, 2015, Respondent sent a letter to Petitioner advising his FMLA status would end on January 14 and asked that he contact Human Resources. He was advised to provide a medical status report by January 9 or his FMLA status would be terminated. PX4-2.

On January 26, 2015, Petitioner returned to Dr. Paletta, who noted he had had an injection, anti-inflammatories, and some physical therapy. He reported the injection provided significant relief for about a month, but about three weeks ago he had gradual recurrence of shoulder pain and it was back to the same level as before the injection. Physical examination was unchanged and impression was persistently symptomatic SLAP tear in the setting of concomitant cervical pathology. *The Arbitrator notes there was no mention of Petitioner having pain down his left arm or into his left hand.* Dr. Paletta opined that the SLAP tear was a significant component of Petitioner's shoulder complaints. The injection provided only temporary relief and he was not confident another injection would provide sustained relief. He believed Petitioner needed arthroscopy with probable labral debridement or repair. He noted that if his neck issue took precedent over the shoulder, then the neck should be addressed first.

Petitioner also returned to Dr. Gornet on January 26, 2015. His cervical examination showed mild decrease in wrist dorsiflexion and decreased sensation at left C6-7. Dr. Gornet recommended a two-level cervical disc replacement. He discussed the situation with Dr. Paletta and recommended the neck be treated first and then the shoulder, after Petitioner recovered from his neck. Dr. Paletta made a similar addendum note in his record, and agreed that the neck should be prioritized above the shoulder.

On February 5, 2015, Respondent sent a letter to Petitioner advising that his employment was terminated effective January 15, 2015. It was noted he was granted 12 weeks of leave under FMLA and that during that time he had been responsible for payment of his benefits, which was due immediately. PX4-3.

On April 21, 2015, Petitioner was evaluated by Respondent's Section 12 examiner, Dr. Timothy VanFleet. Dr. VanFleet reviewed notes from Dr. Paletta, Dr. Gornet, and St. Louis University Hospital; as well CT scans of the cervical, thoracic, and lumbar spine taken the day of Petitioner's accident. He noted he did not have a report or images from the cervical CT myelogram done in November 2014. Petitioner gave a consistent history of the accident and reported that since then he had had neck pain and pain radiating into his left shoulder. He denied prior history of neck problems. Cervical examination showed he could flex his chin to his chest, extend 40 degrees, and rotate 70 degrees bilaterally. Shoulder examination showed he had diminished range of motion with difficulty, positive supraspinatus stress test, symmetric reflexes, and give way in the motor groups at the shoulder and left biceps. Dr. VanFleet did not have the cervical CT myelogram, but stated that clinically Petitioner did not appear to have cervical radiculopathy, as he did not demonstrate any evidence of radiculopathic pain complaints other than into his shoulder. He opined Petitioner's shoulder pain appeared to be more mechanical and consistent with the diagnosis of internal shoulder derangement. He recommended review of the cervical CT myelogram and opined that a bilateral upper extremity EMG may be beneficial. He agreed with Dr. Gornet's light duty work restrictions. He opined that Petitioner's current condition was directly related to his work related motor vehicle accident. RX1, Dep.RX2.

On May 27, 2015, Dr. VanFleet issued a supplemental report following review of Petitoner's cervical CT myelogram. He interpreted the tests to show (1) soft disc protrusion paracentral and slightly toward the left side at the C5-6 level, (2) contact with the cervical cord centrally and evidence of good CSF fluid posterior to the spinal cord, (3) some contact of the thecal sac towards the right side, (4) C6-7 disc space bone-on-bone with evidence of some narrowing bilaterally of the neural foramina. He also reviewed the left shoulder CT arthrogram, which he interpreted as being consistent with labral tearing. He did not believe Petitioner demonstrated any evidence of cervical radiculopathy-type symptoms, but rather believed his symptoms were mechanical into the shoulder. He opined that Petitioner did not manifest any kind of objective findings that would correlate to a C5-6 or C6-7 level of neural impairment. He opined that Petitioner would benefit from an EMG and recommended same. RX1, Dep.RX3.

On July 6, 2015, Dr. Paletta authored an office note indicating Petitoner's cervical treatment had not been approved and that he continued to have issues with his shoulder and needed surgery. He discussed the situation with Dr. Gornet, who believed Petitioner was safe to undergo the shoulder surgery. PX6.

On July 15, 2015, Petitioner returned to Dr. Paletta and reported ongoing pain in his left shoulder, difficulty lying on the left side, and pain in the overhead position. He noted he also had cervical radicular symptoms with pain all the way down the arm as well as numbness and tingling. *The Arbitrator notes this is the first mention in Dr. Paletta's record of complaints of pain down the left arm or numbness or tingling.* Dr. Paletta again noted he had discussed the matter with Dr. Gornet, who believed Petitioner had a cervical condition that needed treatment, but that it was reasonable and safe to proceed with treatment for the shoulder. Dr. Paletta advised Petitioner that the surgery would likely help significantly with the shoulder complaints, but likely would not affect the pain he had down the arm or the numbness, tingling, and paresthesias coming from his cervical issue. PX6.

On July 15, 2015, Petitioner also followed up with Dr. Gornet and presented his IME report from Dr. VanFleet. Dr. Gornet authored a page-long note commenting on the report and on his disagreement with Dr. VanFleet's assessment. He was particularly critical of his assertion that Petitioner did not manifest any significant objective findings that correlated to the C5-6 and C6-7 levels, as the protrusion paracentral and to the left at C5-6 "clearly would manifest itself as neck and shoulder pain". Although he was willing to order an EMG, Dr. Gornet opined that Petitioner's pain and symptoms into his shoulder and arm were not measured by EMG. PX6.

On September 22, 2015, Dr. Paletta completed a Work Status Report indicating Petitioner could work light duty, with no lifting over 10 pounds and no overhead work. There is no corresponding office note to indicate whether an examination took place that day. PX6.

On October 28, 2015, Petitioner underwent surgery on his left shoulder by Dr. Paletta. The procedures included (1) extensive debridement of the superior labrum, (2) subacromial decompression, bursectomy, and acromioplasty, and (3) open subpectoral biceps tenodesis. PX10. He followed up on November 9 and was noted to be doing well. He was to begin physical therapy. PX6.

On November 13, 2015, Petitioner presented to St. Charles Sports Physical Therapy for an initial evaluation. A progress report of December 16 noted he had overall improvement in his left shoulder pain and mobility during daily activities, but continued to wake up due to pain and could not lie on his left shoulder. A progress report of January 20, 2016, noted he had tightness with reaching all the way overhead or behind his back and ached after those motions. He had full range of motion with some discomfort with end range reaching and end range reaching behind his back. It appears he was discharged at that time. *The Arbitrator notes there were no daily therapy notes admitted for this treatment.* PX11.

On December 18, 2015, Petitioner followed up with Dr. Paletta and was noted to be doing well. He returned on February 8, 2016, and reported his left shoulder was "doing great". He still had some discomfort sleeping on the left side but otherwise did not have any pain with activities of daily living. On exam, it was noted he had better motion on the left shoulder than the right, where he had some chronic motion losses due to previous fracture. Testing was negative and neurovascular status was intact. Dr. Paletta stated that with respect to the shoulder, Petitioner had an excellent outcome. He required no restrictions or limitations and was allowed to return to work without restrictions. He was placed at maximum medical improvement for the shoulder. Petitioner reported he was scheduled for cervical surgery on February 23 by Dr. Gornet, who continued to have him off work. PX6.

On February 15, 2016, Petitioner returned to Dr. Gornet. He completed a Medical Information form and in response to the question of whether there were any significant changes since his last visit, Petitioner wrote, "stiffness-tingling-needles-left thumb area". A cervical CT scan was done which showed (1) disc height loss with circumferential disc bulge at C6-7, stable in appearance, (2) probable mild central canal stenosis at C6-7, and (3) bilateral foraminal stenosis at C6-7 and C7-T1. Dr. Gornet stated, "He is still having some residual left shoulder and left arm symptoms. His main complaint is again neck pain into the left trapezius, left shoulder, and down his left arm with numbness and tingling in the C6 distribution of the left hand. His exam is unchanged." Dr. Gornet noted he had spoken to Petitioner's cardiologist about the surgery taking place in the Surgery Center, and the cardiologist was to review the chart and let him know if that would be acceptable. PX6.

On February 16, 2016, Petitioner returned to Dr. VanFleet for another Section 12 exam. Dr. VanFleet reviewed updated records, including Dr. Paletta's note from February 8, 2016, and Dr. Gornet's narrative note from July 15, 2015, commenting on the prior IME reports. Petitioner reported he was taking ibuprofen twice a day and had pain in his shoulder, neck, and hip. Dr. VanFleet referenced a pain diagram completed by Petitioner, but the Arbitrator notes the diagram was not included in the record admitted at trial. He stated the diagram showed numbness and aching across the neck, especially towards the left, an ache in the left shoulder, pins and needles and numbness in the left arm, and pins and needles and numbness in the left hand. Petitioner reported he had pain if he used or moved his left arm. RX1, Dep.RX4.

On examination, Petitioner was able to rotate his head 60 degrees bilaterally, flex his chin to his chest, and extend 30 degrees. He appeared to have a positive impingement sign, as he complained of pain when his left arm was elevated, abducted and internally rotated. Strength testing showed give way in the deltoid and biceps on the left. Sensation was not impaired and

Hoffmann's sign was negative. Dr. VanFleet opined there were no objective findings of cervical radiculopathy on examination. Petitioner had some mechanical complaints in the shoulder with range of motion and movement, but no findings of cervical radiculopathy. His diagnosis was cervical degenerative disc disease and status post left shoulder arthroscopy. He stated, "I think it is unclear at this time that the gentleman has cervical radiculopathy." Petitioner reported a poor response to the cervical injection, and Dr. VanFleet noted Dr. Gornet took issue with that. He opined that, in the absence of a positive response to an injection and lacking any type of EMG findings consistent with radiculopathy, Petitioner's prognosis would be poor for surgical treatment. He noted he did not have Petitioner's job description and was unable to comment on his ability to work full duty, but did believe he could work light duty. RX1, Dep.RX4.

On February 23, 2016, Petitioner underwent cervical surgery by Dr. Gornet, consisting of disc replacement at C5-6 and C6-7. He followed up on March 17 and reported he was doing well. He had some mild shoulder pain that was resolving and he was overall pleased with his progress. On April 18 he returned to Dr. Gornet and reported he still had some left-sided pain in his shoulder and arm. He was referred for physical therapy in St. Charles. *The Arbitrator notes no therapy notes were admitted for this treatment.* Petitioner returned on June 9, 2016, and it was noted he "continues to do wonderfully well". His neck pain and headaches were gone and his shoulder pain was dramatically improved. Dr. Gornet released him to return to work full duty with no restrictions. He noted, "He is exceedingly pleased with his progress." Dr. Gornet noted he had referred Petitioner for physical therapy, but "according to the patient and the description of what was performed, this physical therapy was ineffective" and it was agreed the therapy should be discontinued. It was noted Petitioner was to return in three months; however, the Arbitrator notes this was the final treatment record submitted. PX6.

Dr. VanFleet issued a supplemental report on March 21, 2016. After reviewing Petitioner's job description, he opined he could return to his job. The Arbitrator notes this report was issued subsequent to Petitioner's cervical surgery, and it does not appear Dr. VanFleet was aware at that time that surgery had taken place. RX1, Dep.RX5.

Dr. Gornet testified by way of deposition on June 20, 2016. He is a Board Certified Orthopedic Surgeon whose practice is devoted to spine surgery. Dr. Gornet testified consistent with his treating records and opined Petitioner was expected to be at maximum medical improvement one year post-op. His diagnosis was cervical radiculopathy secondary to structural injury to the disc and disc mechanism at C5-6 and C6-7, with aggravation of some pre-existing foraminal stenosis at C6-7. He opined the injuries and aggravation were caused by Petitioner's work related motor vehicle accident. Besides routine post-operative follow up, Dr. Gornet testified Petitioner did not need further care. PX6.

When asked if the EMG recommended by Dr. VanFleet was necessary, Dr. Gornet testified that for most cervical spine injuries EMG nerve function studies are usually inconclusive and not indicative or predictive of surgery results. He has seen patients with severe motor weakness, clear radiculopathy and pain, who had normal nerve function studies. He testified Petitioner's case was a "perfect example" of someone with radicular symptoms who had an excellent result with surgery. He did not believe the EMG was needed in this case. He disagreed with Dr. VanFleet's opinion that Petitioner did not have cervical radiculopathy, and

testified there was objective evidence of radiculopathy on the studies, the intraoperative findings, and his response to surgery. PX6.

On cross-examination, Dr. Gornet testified that Petitioner's radiculopathy into the left arm was not the indication for surgery, but rather it was in addition to the structural injury to the disc and disc mechanism as an indication for the surgery. With regard to the EMG, he testified it does not measure cervical cord compression, but can measure a cervical nerve root irritation if it is present and detectible on the EMG. Dr. Gornet agreed that Petitoner's radicular symptoms were mild or moderate. It was noted that he had conducted a physical examination the first time he saw Petitioner, but it did not appear he conducted a physical exam in subsequent visits. He testified, "I probably did, but it's not documented...So, your point is well taken." Dr. Gornet testified that surgery was not based solely on the radicular complaints, but rather was based on the structural injury to the disc and disc mechanism. He further testified that symptoms alone were enough of an indication to perform a two-level disc replacement. PX6.

Dr. VanFleet testified by way of deposition on June 29, 2016. He is a Board Certified Orthopedic Surgeon. He testified consistent with his reports. He noted Petitioner's examination revealed he had symmetric strength in his triceps, wrist extensors, and flexors, which would be the C6 and C7 myotomes. He opined this was significant because it showed a lack of radiculopathy, which was often associated with not only pain but also weakness and numbness, and the weakness would correlate to the specific nerve root that was related to the disc spaces that were pathologic. He testified he reviewed Petitoner's myelogram and post CT and that the findings could support a clinical diagnosis of radiculopathy. However, he found no objective evidence of radiculopathy upon examination, and Petitioner did not complain of symptoms that related to cervical radiculopathy that corresponded to the C5-6 and C6-7 levels. RX1.

Dr. VanFleet testified he examined Petitioner a second time, after he had undergone shoulder surgery. He had been released for the shoulder but was still treating for the neck, and disc replacement surgery had been planned. He recommended an EMG at that time, to help confirm radiculopathy, rule out peripheral neuropathy, and/or rule out brachial plexopathy. At the second exam, Petitioner completed a pain diagram and noted numbness and aching across the neck, especially toward the left, ache in left shoulder, and pins and needles and numbness into the left arm and hand. Dr. VanFleet testified that radiculopathy is, generally speaking, pain radiating down into the extremity. With a C5-6 and C-6-7 problem, then the C6 and C7 nerve roots should be involved, which should produce pain down the arm and into the hand. Petitioner reported more mechanical symptoms of pain with use of the arm and pain in the shoulder, complaints that were more mechanical and not consistent with radiculopathy. Dr. VanFleet testified that following the second examination he was unclear about the diagnosis of cervical radiculopathy, as Petitoner's symptoms were not cervical radiculopathy and he did not have much in the way of physical examination findings. Dr. VanFleet testified that the arthroplasty surgery was not appropriate, as it was not supported, and that surgery should not be done based on the presence of degenerative changes only. He testified that pain should also not be a reason to perform such surgery. He noted that when Petitioner saw Dr. Gornet the first time on October 20, 2014, he made no markings on his pain diagram consistent with cervical radiculopathy; rather, they were consistent with burning across the back of the neck, which could have been

consistent with whiplash. He testified Petitioner sustained an exacerbation of his underlying degenerative disc disease in the work accident. RX1.

On cross-examination, Dr. VanFleet acknowledged he was not aware of Petitioner having any prior neck problems or treatment. He agreed Petitioner had a disc protrusion, paracentral and slightly towards the left at C5-6, as well as a displaced thecal sac contacting the cord slightly to the left. He acknowledged that response to treatment could confirm a diagnosis. He was not aware that Petitioner had undergone cervical surgery. He agreed that in trying to determine whether or not the diagnosis made by Dr. Gornet was correct, it might be helpful to learn Petitoner's response to the two-level disc replacement surgery, though qualified that it would not be 100% predictive.

Dr. Saheta testified by way of deposition on July 7, 2016. He is board certified in cardiology, interventional cardiology, nuclear cardiology, and internal medicine. He testified he implanted a Boston Scientific permanent pacemaker in Petitioner on March 19, 2014. Petitioner experienced a dislodgement of his pacemaker leads on March 29 after lifting one of his children over his shoulder. The lead was repositioned and he did well after that. He had a pacemaker check done on September 10, which showed no significant events. RX2.

Dr. Saheta examined Petitioner on September 24, following his work accident. He noted the hospital records immediately after the accident showed elevated troponin, which was deemed to be due to cardiac contusion from airbag deployment. He testified that Petitioner's current cardiac medications were aspirin, metoprolol succinate, Pravachol (pravastatin) for cholesterol, and Lisinopril for blood pressure. Petitioner was also on Viagra, which was not cardiac related. Dr. Saheta testified that, with the exception of metoprolol succinate, Petitioner was on all of these medications prior to the work accident. The metoprolol was added after the pacemaker check showed three episodes of supraventricular tachycardia (SVT). All three episodes of SVT occurred prior to Petitoner's work accident. Dr. Saheta testified that the SVT episodes following Petitioner's accident on September 16, 2014, may be "part and parcel" with his conduction abnormality for which he had received the pacemaker, or may be a different item. He testified that Petitioner's cardiac condition was stable following the accident and that there were no changes in his cardiac condition following the accident. RX2.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After review of the evidence and due deliberations, the Arbitrator finds on the issues presented at trial as follows.

In support of the Arbitrator's decision relating to issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

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

The parties stipulated that Petitioner's left shoulder injury and treatment thereof was causally related to his accident. The parties disputed whether Petitioner sustained injury to his neck **to the extent alleged**, and whether the cervical surgery performed was reasonable, necessary, and causally related to the accident.

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that the alleged extent of his cervical condition is causally related to his work accident of September 16, 2014. Rather, the Arbitrator finds that Petitioner suffered a cervical strain that resulted in axial neck pain, consistent with the opinions of Dr. VanFleet. The Arbitrator further finds that the surgery performed by Dr. Gornet was not reasonable, necessary, or causally related to Petitoner's accident. In so concluding, the Arbitrator finds significant the inconsistencies and lack of documentation contained within the treating records and in the testimony of both Petitioner and Dr. Gornet.

Petitioner testified that when he first saw Dr. Gornet on October 20, 2014, he had pain in his hands, shoulder, left arm, and neck. However, on the pain diagram he himself filled out that day, he only marked that he had burning in the middle of the back of his neck and aching on either side of his neck. Although the form asked him to mark the areas of radiation and to include all affected areas, he made no such markings. He attempted to explain this by testifying that he was only seeing Dr. Gornet for his neck, and that Dr. Paletta was going to see him for his shoulder at a later appointment. He testified he ended up seeing Dr. Paletta the same day that he first saw Dr. Gornet, on October 20, and that **he did not know** that was going to happen. However, that testimony is directly contradicted by the letter he sent to his employer on October 14, 2014, in which he stated he was scheduled to see Dr. Paletta for his shoulder and arm, Dr. Mall for his lower extremities, and Dr. Gornet for his neck, and that all of the appointments were scheduled for October 20. The Arbitrator finds Petitioner to not be credible on this issue.

Dr. Gornet's records contain several inconsistencies which the Arbitrator finds significant. On October 20, 2014, he noted, "I would like to refer him to Dr. Paletta for evaluation of his shoulder." Yet, as discussed above, Petitioner was aware on October 14 that he was going to be seeing Dr. Paletta. Later in the same paragraph, Dr. Gornet noted, "Dr. Paletta has referred the patient for a left hip issue to Dr. Mall." Yet, Dr. Mall's first record of that same date clearly states he saw Petitioner upon referral by Dr. Gornet, as did Dr. Mall's new patient intake form completed by Petitioner that day. While these inconsistencies may seem benign on the surface, they call into question the accuracy and veracity of Dr. Gornet's record as a whole, as discussed in more detail below.

Dr. Gornet's records document that he conducted a physical examination of Petitioner on October 20, 2014. However, none of his subsequent notes document any physical examination whatsoever. When questioned whether he conducted additional examinations, Dr. Gornet testified, "I probably did, but it's not documented." Further, when Petitioner was asked on cross-examination whether Dr. Gornet conducted any physical examinations after the first visit of

October 20, 2014, he testified, "I do not recall." The Arbitrator finds this disturbing, and finds it further calls into question the accuracy and veracity of Dr. Gornet's record and his testimony. The only record that documented a physical examination also contained complaints purportedly expressed by Petitioner that he himself did not write on his pain diagram, namely pain radiating "down his left arm and into his hand with numbness and tingling into his left forearm and hand".

Dr. Gornet claimed to rely in part upon Petitioner's response to the cervical injections in December 2014 and January 2015 as justification for the cervical surgery. However, his records are completely void of any discussion regarding Petitioner's response, and it is unclear whether he was even aware of Petitioner's response to the injections. Conversely, Dr. Boutwell's record following each injection clearly documented that Petitioner got no relief, and Petitioner reported the same to Dr. VanFleet. Although Dr. Gornet took issue with Dr. VanFleet's assertion that the injections provided no relief, his own records do not document that he was even aware of whether the injections helped or not. Dr. VanFleet testified that Petitioner's response to the injections was important in the consideration of whether he was a candidate for cervical surgery and, because he reported no relief, surgery was not warranted.

Dr. Gornet testified that prior to considering cervical surgery "everybody gets conservative care first", to try and separate out the patients who will get better or whose symptoms are tolerable enough to avoid surgery and the patients who have intolerable symptoms or symptoms that limit their function. Yet, in Petitioner's case, not only was such conservative care not undertaken, the record does not document that Petitioner had intolerable symptoms.

The Arbitrator finds particularly significant the medical records from February 2016. Petitioner saw Dr. Paletta on February 8, 2016, for a final exam following his left shoulder surgery of October 28, 2015. He reported "the left shoulder is doing great" and he did not have any pain with activities of daily living. He had finished physical therapy and was continuing his home exercise program. Dr. Paletta stated, "Examination of the left shoulder reveals outstanding motion." He noted that Petitioner had an excellent outcome, required no restrictions or limitations, and was at maximum medical improvement for the shoulder. He went on to note that Petitioner informed him **he was scheduled to have cervical surgery** on February 23, 2016. Yet, review of the record shows that Petitioner had not been seen by Dr. Gornet since July 15, 2015, more than seven months prior.

On February 15, 2016, one week after his exam by Dr. Paletta, Petitioner returned to Dr. Gornet for the first time since July 15, 2015. Dr. Gornet recorded that Petitioner was "still having some residual left shoulder and left arm symptoms" and that he had neck pain into the left trapezius, left shoulder, and down his left arm, along with numbness and tingling in the C6 distribution of his left hand. Yet **none** of these complaints were documented by Dr. Paletta just one week prior. The Arbitrator is mindful that Dr. Paletta was treating Petitioner for his shoulder, but reason would dictate that if Petitioner's symptoms were as severe as Dr. Gornet documented on February 15, they would have at least existed to some degree and been noted by Dr. Paletta on February 8. But they were not. Further, Dr. Paletta's February 8 record clearly shows that Dr. Gornet had **already** scheduled the cervical surgery prior to Petitioner's appointment with him on February 15. The Arbitrator again finds it significant that prior to February 15, Dr. Gornet had not seen Petitioner since July 15, 2015, such that complaints and

exam findings on February 15 would appear to have been irrelevant to Dr. Gornet's scheduling and performing cervical surgery. In addition, the appointment of July 15, 2015, appears to have been for the sole purpose of Dr. Gornet's review of Dr. VanFleet's report, and no examination was documented on that day.

On February 16, 2016, the day after his appointment with Dr. Gornet, Petitioner was again examined by Dr. VanFleet. He reported pain in the shoulder, neck, and hip, as well as pins and needles and numbness down the left arm and into the left hand. He also reported that the left arm hurt to move it and that he had pain if he used it. The Arbitrator is again struck by the stark difference between Petitioner's complaints to Dr. VanFleet on February 16 and his lack of complaints to Dr. Paletta only eight days prior, on February 8.

Dr. VanFleet examined Petitioner on two occasion, documented extensive physical examinations each time, and recorded a lack of any objective findings of cervical radiculopathy. He noted Petitioner did have mechanical complaints in the shoulder with range of motion and movement, but no objective findings of cervical radiculopathy. He testified that with a C5-6 and C6-7 problem, the C6 and C7 nerve roots should be involved, which should produce pain down the arm and into the hand. However, Petitioner reported more mechanical symptoms of pain if he used the arm and pain in the shoulder, which was not consistent with radiculopathy. He further testified that Petitioner did not have much in the way of physical examination findings. He opined that disc replacement surgery was not appropriate and was not supported in this case. The Arbitrator agrees.

The Arbitrator is mindful that a treating doctor's opinions are generally afforded greater weight than those of an examining physician. However, the record simply does not justify doing so in this case. The Arbitrator finds the inconsistencies, lack of documentation, and Dr. Gornet's scheduling of surgery without having seen Petitioner for seven months to be dispositive.

Based on the foregoing and the record in its entirety, the Arbitrator finds that Petitioner failed to meet his burden of proof on the issue of causal connection with regard to the two-level disc replacement surgery performed by Dr. Gornet. The Arbitrator further finds that Petitioner reached maximum medical improvement for all alleged conditions on February 8, 2016.

In support of the Arbitrator's decision relating to issue (G), Petitioner's earnings, the Arbitrator finds the following:

Petitioner's Exhibit 16 is a wage record of checks issued from September 20, 2013, through September 5, 2014, a total of 26 paychecks. The record shows the total gross amount earned was $33,964.51. Petitioner testified that his rate of pay was $16.79 per hour and that he normally worked 40 hours per week, but sometimes worked more. Of the 26 paychecks, 17 were $1,343.20, which appears to be the total of $16.79 per hour for 40 hours times two weeks. The Arbitrator notes three paychecks in which the total earned was about half the amount normally earned, and further notes six other paychecks which were higher or lower than the normal amount. Neither party introduced evidence as to why those six paychecks were higher or lower, including whether they represented some overtime pay. Petitioner testified that the three

paychecks which were about half were reduced because he missed three weeks of work while recovering from the implantation of his pacemaker. However, he presented no further detailed evidence with regard to the days worked or missed during those pay periods.

The Arbitrator finds Petitioner earned $33,964.51 in the 52 weeks preceding his accident and further finds his average weekly wage is $653.16.

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

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

In light of the Arbitrator's findings with respect to issue (F), the Arbitrator finds that medical services rendered through February 8, 2016, were reasonable and necessary in Petitioner's care and treatment relative to his accident of September 16, 2016, **with the exception** of those itemized below. All medical services rendered after February 8, 2016, including the cervical disc replacement surgery performed by Dr. Gornet, are denied. In comparing Petitioner's Exhibit 14 (medical bills) and Respondent's Exhibit 3 (payments), it appears Respondent has paid all medical bills for which they are liable, pursuant to the Arbitrator's findings. Specifically, Respondent has paid the bills from St. Louis University Hospital, Dr. Nathan Mall, and Dr. George Paletta. Respondent is not liable for any of the additional medical bills set forth in Petitoner's Exhibit 14.

The Arbitrator **declines** to award charges billed by any medical provider for CPT code 99080, Special Report. A provider may not charge a fee for writing a standard report that is generated in the normal course of treatment. Although a provider may charge an additional fee for a special report that is unusual or outside the standard reporting form, the Arbitrator finds that none of the medical reports admitted into evidence meet this standard. As such, the charges for such reports are not reasonable and the Arbitrator finds that Respondent is not liable for them. Specifically, the following charges are not reasonable and the provider is not entitled to payment:

1. Dr. Nathan Mall/Regeneration Orthopedics, 10/20/14 $ 30.00
2. Dr. Matthew Gornet, 4 charges @ $33
   10/20/14, 11/17/14, 1/26/15, 7/15/15 $132.00

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

In light of the Arbitrator's findings with respect to issue (F), the Arbitrator finds Petitioner was temporarily and totally disabled from September 17, 2014, through February 8, 2016, that being the date he reached maximum medical improvement. The parties stipulated that

Respondent had paid TTD benefits for this period and is entitled to credit for same. Petitioner alleged entitlement to additional benefits from February 9, 2016, through June 9, 2016, when he was released by Dr. Gornet. In light of the Arbitrator's findings with respect to issue (F), temporary total disability benefits for that time period are denied.

In support of the Arbitrator's decision relating to issue (O), Petitioner's entitlement to mileage reimbursement, the Arbitrator finds the following:

In order to be entitled to mileage reimbursement the Petitioner must show that he was required to travel outside of his local area to obtain reasonable and necessary medical treatment. *Batson v. Knight Hawk Coal*, 12 IWCC 0320 (2012). A reasonableness standard is applied to the determination of whether a claimant is entitled to expenses for traveling to see a physician. *General Tire v. Industrial Commission*, 221 Ill.App.3d 641 (1991).

Petitioner claimed he was entitled to mileage reimbursement for round trips he made to Dr. Mall, Dr. Paletta, Dr. Gornet, St. Charles Sports & Physical Therapy, and various other medical providers of his choosing in the St. Louis area. The record shows Petitioner lives in Suburban St. Louis, right across the river in Illinois and he traveled west to the St. Louis suburbs for treatment. The Arbitrator considers this area to be Petitioner's locale relative to his request for mileage reimbursement. His care and treatment occurred within this locale and his request for mileage reimbursement is denied.

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

With regard to the nature and extent of disability, for accidents occurring on or after September 1, 2011, pursuant to Section 8.1 of the Act, in determining the level of permanent partial disability the Arbitrator must look at the following five factors:

In regard to factor **(i) the reported level of impairment pursuant to Subsection (a)**, although this accident was after the effective date of Section 8.1b of the Act, neither party offered into evidence a reported level of impairment pursuant to subsection (a). As such, the Arbitrator gives no weight to this factor.

In regard to factor **(ii) the occupation of the injured employee**, the record reveals Petitioner was employed as a security officer at the time of the accident. He testified he was employed the majority of his adult life in similar positions as a security officer or police officer. Following the accident, Respondent allowed him to retain his position until his FMLA period expired, at which time he was terminated. Petitioner testified he is currently employed as a locator for a repossession company. However, all of Petitioner's treating physicians, including Dr. Gornet, indicated he could return to work full duty in his prior capacity. The Arbitrator gives greater weight to this factor.

In regard to factor **(iii) the age of the employee at the time of the injury**, Petitioner was 44 years old at the time of the accident and can be expected to work for several more years. Over the coming years his condition could improve, stay the same, or get worse. There was no

evidence offered to indicate with any degree of likelihood how his age would impact his disability. The Arbitrator gives some weight to this factor.

In regard to factor **(iv) the employee's future earning capacity**, Petitioner testified he was terminated by Respondent and that when he was released by his physicians he secured employment with a repossession company. He specifically stipulated that he was not claiming a wage differential, but did testify he was currently earning $9.00 per hour. He would like to re-apply for his position with Respondent once the job is posted. The Arbitrator gives greater weight to this factor.

In regard to factor **(v) evidence of disability corroborated by the treating medical records**, the Arbitrator notes Petitioner sustained a left superior labral anterior and posterior (SLAP) tear, with subacromial impingement syndrome. He underwent surgery on his left shoulder which consisted of (1) extensive debridement of the superior labrum, (2) subacromial decompression, bursectomy, and acromioplasty, and (3) open subpectoral biceps tenodesis. His shoulder complaints are well-documented in the medical records. He testified he continued to have limited range of motion and difficulty lying on his left arm. Dr. Paletta's note following Petitoner's final visit of February 8, 2016, documents he reported "the left shoulder is doing great" and he did not have any pain with activities of daily living. Dr. Paletta stated, "Examination of the left shoulder reveals outstanding motion." He noted Petitioner had an excellent outcome and required no restrictions or limitations with regard to his left shoulder. With regard to his neck, Petitioner testified he does not currently have pain or limitation. The Arbitrator has previously addressed the lack of documentation in the medical records with respect to Petitioner's neck, but does note Petitioner underwent two cervical injections as well as a myelogram. The Arbitrator places significant weight on this factor.

The Arbitrator notes that consideration of the factors enumerated in Section 8.1 does not simply require a calculation, but rather a measured evaluation of all five factors, of which no single factor is the sole determinant on the issue of permanency. Taking the above five factors into consideration, and based on the record in its entirety, the Arbitrator finds that Petitioner has sustained a 15% loss of use of the person as a whole (75 weeks) with respect to his left shoulder pursuant to Section 8(d)2 of the Act. The Arbitrator further finds that Petitioner has sustained a 5% loss of use of the person as a whole (25 weeks) with respect to his cervical spine pursuant to Section 8(d) 2 of the Act. Having previously found that Petitoner's average weekly wage was $653.16, the Arbitrator finds his permanent partial disability rate is $391.90.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
CHAMPAIGN

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DEBORA HAMICK,

Petitioner,

vs. NO: 10 WC 36126

QUAKER OATS,

Respondent.

18IWCC0078

DECISION AND OPINION ON REVIEW

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

FINDINGS OF FACT

1. Petitioner has worked for Respondent for approximately 20 years, the last eight as an oven operator. PX9, p. 14.

2. On May 25, 2010, slightly over one month prior to the undisputed accident at issue herein, Petitioner presented to Dr. Bikramjit Malhotra at Danville Polyclinic and complained of a knot, swelling and discoloration of the left leg; she denied any trauma or falls. Examination of the left leg revealed an "area of ecchymosis and swollen, enlarged varicose vein on the thigh." A venous duplex of the left leg conducted the next day was negative for deep vein thrombosis, and Petitioner was diagnosed with superficial femoral thrombophlebitis clinically. PX2.

3. On June 30, 2010, Petitioner sustained an undisputed accident arising out of and in the course of her employment. She described the incident as follows: "My oven is located up on the fifth floor…I was up on the platform making syrup. And when I went to step down I stepped down

on a guard rail, iron guard rail, and I thought I was stepping down on the floor and my left foot and ankle turned sideways and turned and I fell to the ground." PX9, p. 15. She testified to an immediate onset of pain in her left ankle. PX9, p. 15-16. After reporting to the plant's nurse's station, Petitioner was sent to the occupational health clinic. PX9, p. 17.

4. On June 30, 2010, Petitioner presented to Provena United Samaritans Medical Center where she was evaluated by Dr. Christine Cisneros. The records reflect Petitioner provided a history of stepping on a rail which caused her left ankle to invert and foot to twist. Examination revealed diffuse swelling of the left ankle and foot, mild decrease in range of motion, and discomfort to palpation over the dorsum of the foot. X-rays of the left foot/ankle were negative for fracture. Dr. Cisneros diagnosed left ankle and foot sprain; the doctor provided pain medication as well as a Coban wrap and stirrup brace, and restricted Petitioner to sit down work. PX1. An accommodated position was provided and Petitioner continued working.

5. On July 6, 2010, Petitioner followed up with Dr. Cisneros; her condition was improved but she continued to have pain and discoloration in her foot. On examination, Dr. Cisneros observed a significant reduction in the swelling of the ankle and foot and decreased tenderness; Petitioner exhibited full range of motion of the ankle. Dr. Cisneros' assessment was resolving ankle and foot sprain. Another Ace wrap was provided and Petitioner was directed to remain under the seated work restriction and begin physical therapy. PX1.

6. On July 14, 2010, Dr. Cisneros re-evaluated Petitioner who advised her pain and swelling continued to decrease; she further reported she had not commenced physical therapy. Dr. Cisneros again recommended therapy but eased Petitioner's restrictions: limited walking, part-time sitting and no work on uneven surfaces. PX1.

7. On July 18, 2010, Petitioner presented to the emergency room at Provena with complaints of left leg pain. She provided a history of the June 30 fall at work but stated she was now having "different pain." Petitioner, who was noted to have a history of deep vein thrombosis, pointed to an area of redness in her left thigh. Examination revealed tenderness in the soft-tissue of the thigh. Testing ruled out deep vein thrombosis and pulmonary embolism, and the emergency room physician diagnosed Petitioner with cellulitis and superficial phlebitis, and discharged her. PX1.

8. On July 26, 2010, Petitioner was re-evaluated by Dr. Cisneros. In addition to ongoing discomfort on the outside of her left ankle, over the peroneus longus and brevis tendon area, Petitioner also expressed concern regarding a varicose vein on the "left anteromedial thigh." Petitioner stated the area was red at the time of the injury; she further informed Dr. Cisneros she had consulted with Dr. Malhotra and been informed it would not get better. Petitioner requested a referral to have the varicose vein assessed by a specialist. Dr. Cisneros' examination findings included a varicose vein over the left anteromedial thigh with no warmth or redness; regarding the left foot and ankle, there was no appreciable swelling and the mortise was stable. Dr. Cisneros concluded Petitioner's ankle and foot required no further therapy or work restriction, and Petitioner was released to resume her regular work duties beginning July 26, 2010. As to the varicosity, Dr. Cisneros memorialized she "cannot relate this to her work injury" and instructed Petitioner to discuss it with Dr. Malhotra. PX1.

9. On August 29, 2010, Petitioner presented to Danville Polyclinic. The record, which is handwritten and difficult to read, demonstrates Petitioner presented on an urgent basis and stated she thought a varicose vein in her left lower leg had ruptured; she had first noticed the issue that morning. Evaluation by a vascular surgeon was recommended. PX2.

10. On September 8, 2010, Petitioner consulted with Dr. Adolf Lo. The records reflect a chief complaint of varicose veins with thrombophlebitis. Petitioner reported an onset of varicose veins after falling at work on June 30, 2010, and twisting her left ankle. She indicated the veins in her left thigh hurt and "popped out"; she additionally complained that since the fall, she was getting knots in her veins from the thigh to the ankle. Dr. Lo diagnosed left leg thrombophlebitis and smoke abuse. After an ultrasound/venous duplex of the left leg revealed reflux in the greater saphenous vein from the knee to the ankle, Dr. Lo recommended radiofrequency ablation and phlebectomy. PX3.

11. On October 25, 2010, Dr. Joseph Monaco conducted an examination of Petitioner at Respondent's request pursuant to Section 12 of the Act. Dr. Monaco concluded Petitioner sustained a sprain of the left ankle and this had fully resolved. Dr. Monaco further concluded Petitioner's left thigh complaints involving varicose veins were unrelated to the injury of June 30, 2010. RX2.

12. On November 15, 2010, Dr. Lo authored a letter wherein he opined Petitioner's injury, *i.e.*, twisting her left ankle during the fall, could have contributed to the development of thrombophlebitis in the left leg and further noted any trauma or prolonged compression can contribute to the cause of phlebitis. PX3.

13. On December 6, 2010, Dr. Lo performed radiofrequency ablation of the left greater saphenous vein and stab phlebectomy. The pre-op history documents Petitioner had been referred by Dr. Malhotra regarding a long history of varicose veins; recently, she also had fallen on the job and subsequently developed superficial thrombophlebitis. PX3.

14. Petitioner attended follow up appointments with Dr. Lo on December 8, 2010; December 20, 2010; and January 26, 2011. PX3.

15. Petitioner testified she seemed better and returned to work but as time went on, a "knot" formed: "On my left leg there was, I noticed there was a knot and it kept growing in my leg, and it started getting real discolored and it started hurting on the inside and it would throb, and it got to where I couldn't stay on it for real long lengths of time." PX9, p. 26. She indicated the knot was on the inside of her left leg directly above her knee, the size of a baseball, and a blackish bluish color. PX9, p. 28.

16. On December 12, 2012, Petitioner presented to Dr. Lo and complained of swelling in the veins of her thigh and a knot in the left thigh. Dr. Lo recommended left distal thigh to calf ablation. PX3.

17. On December 27, 2012, Dr. Lo performed left leg vein stripping and ligation, thrombectomy. The post-operative diagnosis was recurrent varicose vein of the left leg. PX3.

18. On January 15, 2013, Petitioner presented to the emergency room at Provena complaining of shortness of breath and coughing up blood. Workup revealed bilateral pulmonary emboli and deep vein thrombosis in the left leg secondary to surgical intervention. Petitioner was admitted, remained inpatient through January 22, 2013, and thereafter followed-up with Dr. Malhotra. PX1.

19. On March 20, 2015, Dr. Randy Irwin performed a record review at Respondent's request. Dr. Irwin opined Petitioner had venous insufficiency and varicose veins prior to her June 30, 2010 sprained ankle, and the swelling, trauma, and bruising associated with her ankle sprain did not cause nor exacerbate her previous venous insufficiency. RX1, DepX1.

20. Petitioner testified she continues to follow-up with Dr. Malhotra, who has released her to full duty. PX9, p. 31-32. She has resumed her oven-operator position but testified she no longer works overtime owing to a lack of strength in the leg which does not allow for standing for long periods of time. PX9, p. 32.

21. Petitioner denied having an ongoing diagnosis of deep vein thrombosis in both legs since 2006, and stated she "had had a blood clot in my right leg and I was on Coumadin for that blood clot and then that was it." PX9, p. 18. She further stated she had been off Coumadin for quite a few years, and the deep vein thrombosis in her leg resolved. PX9, p. 18.

22. Petitioner was asked about the May 25, 2010 appointment with Dr. Malhotra; she testified she had been working in her yard hauling branches and bruised and hurt her left leg, so she went to the clinic to ensure there was no blood clot. PX9, p. 18-19. The doctor ordered a doppler, no blood clot was identified, and "a couple days after everything was fine." PX9, p. 19. Petitioner testified her leg "totally" changed after her accident. PX9, p. 20.

23. The evidence depositions of Drs. Lo, Malhotra, and Irwin were admitted as Petitioner's Exhibit 7, Petitioner's Exhibit 8, and Respondent's Exhibit 1, respectively.

CONCLUSIONS OF LAW

I. Causation

The parties do not dispute Petitioner's left ankle sprain is causally related to her June 30, 2010 work accident. At issue is causation of Petitioner's venous insufficiency and subsequent deep vein thrombosis and pulmonary emboli. Given the deep vein thrombosis and pulmonary emboli were sequelae of treatment for the venous insufficiency, the threshold issue is whether the venous insufficiency is causally related to the work accident. The Commission observes only Dr. Lo and Dr. Irwin offered causation opinions regarding Petitioner's venous insufficiency.

In his November 15, 2010 letter, Dr. Lo echoed the history as recited by Petitioner: "fell at work on June 30, 2010, and twisted her left ankle. The patient said that she felt something happen to her leg during this fall. Her left leg hurt and became red and knots developed along the leg. She had no leg pain before the fall. The varicose vein appeared in the upper left leg." The doctor then opined twisting the left ankle during the fall could have contributed to the development of

thrombophlebitis in Petitioner's left leg, and further noted, "Any trauma or prolonged compression can contribute to the cause of phlebitis." PX3, p. 184.

Dr. Lo testified his causation opinion was predicated on Petitioner having "the sudden onset of symptoms directly related to the time sequence of the fall. And subsequently involved more bulging around the vein." PX7, p. 8. Dr. Lo then reiterated his opinion Petitioner's fall aggravated her vein problem: "I think it is a major force. She has previous condition by twisting, falling, a blunt trauma. It could have squeezed her leg, get more reflux and aggravated the reflux situation and causing further varicose vein bulging as she has experienced and reported." PX7, p. 12. On cross-examination, Dr. Lo conceded he had no objective information on the condition of Petitioner's superficial vein prior to the fall and affirmed his causation opinion was based on Petitioner's reported history: "the history of fall and immediate appearance of knots in her leg, of bulging in her leg, and by the pain." PX7, p. 27. When presented with the May 25, 2010 record wherein Petitioner complained of a knot, swelling and discoloration of the left leg, Dr. Lo responded that could alter his causation opinion depending on the location of the knot; the doctor then stated Petitioner informed him she had a prior problem in the calf but after the fall, "the knots became appearing in her thigh." PX7, p. 28. The Commission highlights, however, the May 25, 2010 record clearly demonstrates Petitioner's knot was on her thigh: "area of ecchymosis and swollen, enlarged varicose vein on thigh." PX2. The Commission also observes that in Dr. Cisneros' July 26, 2010 office note, the doctor documented Petitioner stated she "has seen Dr. Malhotra" regarding a varicose vein on her left anteromedial thigh and was "informed it would not get better." PX1. The record establishes Petitioner did not see Dr. Malhotra between June 30, 2010 and July 26, 2010; therefore, the Commission infers the discussion wherein Dr. Malhotra informed Petitioner the varicose vein "would not get better" occurred on May 25, 2010. As Dr. Lo was unaware of this pre-accident varicose vein on Petitioner's thigh, the doctor had a flawed understanding of Petitioner's history and his causation opinion is undermined. *See, e.g., Sunny Hill of Will County v. Illinois Workers' Compensation Commission*, 2014 IL App (3d) 130028WC, ¶36, 14 N.E.3d 16 (Expert opinions must be supported by facts and are only as valid as the facts underlying them.)

In contrast, Dr. Irwin opined Petitioner's ankle sprain had no effect on her pre-existing venous insufficiency and varicose veins. In the report from his record review, Dr. Irwin noted Petitioner had multiple risk factors for venous insufficiency and thrombophlebitis including previous deep vein thrombosis or thrombophlebitis, thrombophilia, smoking, family history, female gender, and obesity. Dr. Irwin then explained that although it is possible for direct trauma to the vein to cause thrombophlebitis, "the injury related to foot inversion is along the lateral ankle at the peroneal tendons and not the site of her venous insufficiency along the medial calf. The associated swelling, trauma, and bruising related to her ankle sprain did not cause or exacerbate her previous venous insufficiency." Dr. Irwin similarly ruled out immobility as a cause, explaining any such episode would occur "acutely not months later." RX1, DepX1.

At his deposition, Dr. Irwin reaffirmed his conclusion the ankle sprain "had nothing to do with" Petitioner's venous insufficiency. RX1, p. 7. In fact, Dr. Irwin testified the mechanism of injury is inconsistent with the claimed pathology. Dr. Irwin agreed direct trauma to the vein can cause thrombophlebitis (RX1, p. 13), but there was no such direct trauma here:

> When she developed an ankle sprain, she inverted her foot which causes strain and pressure on the outside of her foot. That's where her swelling and tenderness was at. The vein resides on the inside of the foot and opposite the location of where the injury occurred, and I do not believe the venous insufficiency on the inside of her foot is related to the sprain on the outside of her foot. RX1, p. 16-17.

Dr. Irwin further stated he could completely eliminate the accident as a causative factor: "As a board-certified vascular surgeon with 15 years of experience in treating venous insufficiency, taking care of patients, reviewing the literature, I am unfamiliar with an ankle sprain exacerbating pre-existing venous insufficiency, particularly in this case." RX1, p. 18-19. The Commission finds Dr. Irwin's opinion is most consistent with the evidence, and therefore, the most persuasive and affords it considerable weight.

The Commission finds Petitioner's venous insufficiency is not causally related to her work accident. Consequently, because Petitioner's post-operative pulmonary emboli and deep vein thrombosis were secondary to treatment for her unrelated venous insufficiency, the Commission denies a causal relationship between those conditions and the June 30, 2010 work accident.

II. Permanent Disability

On July 26, 2010, Dr. Cisneros concluded Petitioner's foot and ankle required no further treatment, and Dr. Cisneros released her to full duty. PX1. Dr. Monaco likewise concluded Petitioner's sprain had resolved. RX2. Petitioner testified she has occasional weakness and instability in her ankle but otherwise her ankle is fine. PX9, p. 37. She further testified those persistent symptoms are partially responsible for her inability to work overtime as she did prior to her accident. PX9, p. 37.

Given Petitioner was released to full duty after a limited course of conservative care and testified to mild ongoing difficulties, the Commission finds the proper measure of Petitioner's permanent disability is 5% loss of use of the left foot, as provided in §8(e)11. The Commission orders that Respondent pay to Petitioner the sum of $523.44 per week for a period of 8.35 weeks.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 30, 2016, as modified above, 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.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 5 - 2018

LEC/mck

O: 12/5/17

43

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Charles J. DeVriendt

Charles J. DeVriendt

Joshua D. Luskin

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HAMICK, DEBORA
Employee/Petitioner

Case# **10WC036126**

QUAKER OATS
Employer/Respondent

18IWCC0078

On 9/30/2016, 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:

1937 TUGGLE SCHIRO & LICHTENBERGER
NICHOLAS M SCHIRO
510 N VERMILION
DANVILLE, IL 61832

0522 THOMAS MAMER & HAUGHEY
ERIC CHOVANEC
30 MAIN ST SUITE 500
CHAMPAIGN, IL 61820

18IWCC0078

STATE OF ILLINOIS)
)SS.
COUNTY OF Champaign)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Debora Hamick
Employee/Petitioner

v.

Quaker Oats
Employer/Respondent

Case # **10** WC **36126**

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 **Urbana, Illinois**, on **7/14/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On June 30, 2010, Respondent *were* operating under and 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.

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

In the year preceding the injury, Petitioner earned $44,469.73; the average weekly wage was $872.40.

On the date of accident, Petitioner was 50 years of age, single with 0 children under 18.

ORDER

The Respondent shall pay Petitioner permanent partial disability benefits of $ 523.44/week for 12.525 weeks because injuries sustained caused 7 ½ % of the use of the left foot as provided in section 8(e) of the Act.

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

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

Edward Lee
Signature of Arbitrator

9/27/16
Date

SEP 30 2016

STATE OF ILLINOIS)
)ss
COUNTY OF CHAMPAIGN)

18IWCC0078

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DEBRA HAMICK,
Employee/Petitioner

v.

QUAKER OATS,
Employer/Respondent

Case # 10-WC-036126

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The petitioner, Debra Hamick, was an employee for respondent, Quaker Oats, on 6/30/10 and was working her normal shift when she stepped down onto a guard rail and turned her left foot and ankle sideways. (Trans. 15) She testified that she immediately felt pain in her left ankle. *Id.* She reported to Dr. Cisneros on the date of the accident who assessed her with a left ankle and left foot sprain. (Px. Ex. 1) She returned to Dr. Cisneros on 7/6/10 and was still experiencing some pain in her left foot and ankle, but it was improving. *Id.* On 7/14/10, she returned to Dr. Cisneros and reported that there was a decrease in swelling and at present she reported no pain with non-weight bearing and minimal discomfort when weight bearing and using her brace. *Id.* On 7/26/10, she had a final appointment with Dr. Cisneros who informed her that there is no further need for therapy or work restrictions and released her back to regular duties beginning 7/26/10. *Id.*

The petitioner is also complaining that a left thigh condition involving deep vein thrombosis, varicose veins and an eventual pulmonary embolism are also related to this accident.

On 6/29/06, the petitioner saw Dr. Vikramjit Malhotra whose notes showed a past medical history of DVT. (Rx. Ex. 3) Then on 5/25/10, five days prior to the accident, the petitioner came in to Dr. Malhotra complaining of "a knot, swelling and discoloration of the left leg." *Id.* Dr. Malhotra stated

that the left showed an area of ecchymosis and a swollen, enlarged varicose vein on the thigh. On 5/26/10, four days before the accident, the petitioner underwent a venous duplex study of the left leg which showed no evidence for deep vein thrombosis of the visualized veins, but did show superficial femoral thrombophlebitis. Petitioner then sustained a compensable accident on 6/30/10. During her office visits with Dr. Cisneros on 6/30/10, 7/6/10 and 7/14/10, there is no mention in the notes of her complaining of her varicose vein in the left thigh. It is on 7/26/10 when petitioner first raises concerns regarding a varicose vein over her left anterior medial anteromedial thigh and she stated that it was initially red at the time of the injury. Dr. Cisneros stated, "As to the varicosity that she reports and has concerns about, I have discussed it with her and I cannot relate this to her work injury." *Id.* The petitioner specifically testified that she did not have a diagnosis of deep venous thrombosis since approximately 2006. (Trans. 18) Moreover, she testified that the visit with Dr. Malhotra five days prior to the work accident was because she was doing yard work and had bruised her leg and she was scared that she was going to have a blood clot. (Trans. 18-19) When asked on cross examination, she confirmed that she only suffered a bruise on 5/25/10. (Trans. 39)

She reported for the first time to Dr. Lo on 9/8/10 and told him that she had a varicose vein since the accident of 6/30/10 and that since the fall her veins popped out in her leg. (Px. Ex. 3) Dr. Lo issued a letter to the petitioner's attorney on 11/15/10 stating that the twisting of the left ankle during the fall could have contributed to the development of thrombophlebitis in the patient's left leg. *Id.* The petitioner underwent a radiofrequency ablation to correct her varicose veins on 12/6/10 with Dr. Lo. *Id.* She then does not seek medical treatment until over two years later on 12/27/12 when she sees Dr. Lo and undergoes a left leg stripping and ligation to address a recurrent varicose vein of the left leg. *Id.*

On 1/15/13, petitioner went in to see Dr. Malhotra with shortness of breath and was discharged with a diagnosis of acute deep vein thrombosis of the right leg, deep venous thrombosis secondary to surgical intervention, varicose veins in the left leg.

Dr. Adolph Lo testified via deposition on 9/23/14. Dr. Lo testified that the only medical records he had reviewed prior to the deposition were from Dr. Malhotra. (Px. Ex. 7) Dr. Lo also testified that her left leg venous condition was causally related to her accident and he based it on the sudden onset of symptoms directly related to the time sequence of the fall. *Id.* When asked about the difference between her left leg prior to the accident and following the accident, Dr. Lo stated, "The history would suggest that she did not have a big bulge before. Although I do not have a test of similar type to compare before and after. From the history, yes. From the objective tests such as a reflux test, I don't have." *Id.* When asked on cross examination whether he had any knowledge of what her condition was prior to the 6/30/10 accident, he responded "No, I do not." *Id.* When asked whether her condition was aggravated by the accident, he responded, "But a history of fall and immediate appearance of knots in her leg, of bulging in her leg and by the pain out. I would not say, unfortunately, I don't have the comparison." *Id.* When asked whether it would change his opinion if on 5/25/10 she was complaining of a knot, swelling and discoloration of the left leg prior to the work accident, Dr. Lo stated, "I have to know the location. She mentioned about she did have a problem in her calf. She did after she fell, the knots became appearing in her thigh which is much higher. So the knots in her lower leg, I don't know." *Id.*

Respondent sent petitioner for a records review with Dr. Randy Irwin. Dr. Irwin is a board certified vascular surgeon. (Rx. Ex. 1) It was Dr. Irwin's opinion that the sprained ankle she suffered had nothing to do with her venous insufficiency. Dr. Irwin based this opinion upon the previous documentation of varicose veins, her several risk factors for developing thrombophlebitis which included previous deep vein thrombosis, history of thrombophilia, smoking, family history of venous insufficiency, female sex and obesity. *Id.* Most importantly, was her previous diagnosis of both varicose veins in the same area in the same position was well as a previous deep vein thrombosis and history of thrombophilia. Moreover, Dr. Irwin stated that:

> when she developed an ankle sprain, she inverted her foot which causes strain and pressure on the outside of her foot. That is where her swelling and tenderness was at. The vein resides on the inside of the foot and opposite the location of where the injury occurred, and I do not believe the venous insufficiency on the inside of her foot is related to the sprain on the outside of her foot.

Id.

CONCLUSIONS OF LAW

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

The arbitrator finds that the petitioner's left ankle sprain is causally related to her work accident of 6/30/10, but that her venous insufficiency in the left leg is not related to her work accident of 6/30/10.

Despite petitioner's testimony to the contrary as to her 5/25/10 visit with Dr. Malhotra, the petitioner went to Dr. Malhotra complaining of a knot, swelling and discoloration of the left leg in the thigh region. (Rx. Ex. 3) Dr. Malhotra's physical examination revealed an area of ecchymosis and a swollen, enlarged varicose vein on the left thigh. *Id.* Beyond this, the petitioner has a history of deep vein thrombosis in both of her legs prior to 2006 that was mentioned on all of Dr. Malhotra's medical notes.

Moreover, the petitioner fails to mention any problem regarding her venous insufficiency to her treating doctor following the accident until one month after the accident. On 7/26/10, is when she first makes mention of her venous insufficiency issue to her treating doctor, Dr. Cisneros. Dr. Cisneros, specifically states that she cannot relate this issue to her left ankle sprain.

Even the petitioner's treating doctor's causation opinion does not truly give causation as it is based upon a faulty understanding of her prior condition. On page 28 of his deposition, Dr. Lo states, in regards to her prior venous insufficiency that, "I have to know the location. She mentioned about she did have a problem in a calf. She said after she fell, the knots became appearing in her thigh which

is much higher. So the knots in the lower leg, I don't know." (Px. Ex. 7) Clearly, from the medical records, Dr. Lo's understanding of her prior venous insufficiency condition is incorrect. She had an enlarged varicose vein on her left thigh five days prior to this accident. There is then no medical documentation to support that she experienced new enlarged veins as she never reported to a doctor for a month following the accident.

The medical documentation simply does not support the petitioner's testimony and claims regarding her venous insufficiency condition.

Additionally, the testimony of Dr. Irwin explains why her left leg venous insufficiency cannot be related to her work accident. (Rx. Ex. 1) Dr. Irwin stated that:

> when she developed an ankle sprain, she inverted her foot which causes strain and pressure on the outside of her foot. That is where her swelling and tenderness was at. The vein resides on the inside of the foot and opposite the location of where the injury occurred, and I do not believe the venous insufficiency on the inside of her foot is related to the sprain on the outside of her foot.

Thus, beyond the fact that she had varicose veins 5 days prior to the work accident and that she had been previously diagnosed with DVT in the left leg, the work accident could did not even cause pressure or strain to the area in which she was experiencing the venous insufficiency.

The arbitrator finds that the petitioner's left ankle sprain is causally related to her work accident of 6/30/10, but her multiple left leg venous insufficiency conditions are not related to said 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?

Based upon the arbitrator's decision as to issue "F", all medical bills outside of petitioner's 6/30/10, 7/6/10, 7/14/10 and 7/26/10 visits with Dr. Cisneros are denied.

"K" -- What temporary benefits are in dispute? TTD

Based upon the arbitrator's decision as to issue "F", all claims for TTD are hereby denied.

"L" -- What is the nature and extent of the injury?

Based upon the arbitrator's decision as to issue "F", there is no permanent partial disability as to petitioner's left leg venous insufficiency conditions. However, she is due permanent partial disability in regards to her ankle sprain. The records support that she sought medical attention on four dates, underwent some physical therapy and was released to return to work without restrictions one month following the work accident. The petitioner is awarded 7.5% of the left foot pursuant to Section 8(e)(11).

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

☐ 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 Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dante Beattie,

Petitioner,

vs.

NO: 14 WC 36859

St. Clair County Sheriff's Department,

18IWCC0079

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice provided to all parties, the Commission, after considering the issues of average weekly wage, temporary total disability benefits, permanent disability benefits, and credit due to Respondent and being advised of the facts and the 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 wages earned from Petitioner's work with MetroLink are excluded from the average weekly wage calculation. No employee/employer relationship existed between Petitioner and MetroLink, and therefore, MetroLink was not a concurrent employer whose wages would be factored into the calculation of the average weekly wage pursuant to Section 10 of the Act.

Concurrent Wages

Pursuant to Section 10 of the Act, a claimant who works for two employers concurrently and Respondent-employer has knowledge of such employment, then wages from both employers are factored into the calculation of the average weekly wage. 820 ILCS 305/10 (West 2013). As

such, it is incumbent on Petitioner to prove an employee/employer relationship existed with MetroLink, the alleged concurrent employer. Petitioner has failed to meet his burden.

> [T]here can be no employer/employee relationship and therefore no liability under the Act in the absence of a contract for hire, express or implied. [Citation]. No rigid rule of law governs the determination of whether an employer/employee relationship exists and that determination depends on the facts of the particular case. [Citation]. No single fact controls and such factors as the right to control the manner in which the work is done, the method of payment, the right to discharge, the skill required and work done, and the furnishing of tools, material and equipment must be considered. [Citation]. *Chicago Housing Authority v. Industrial Commission*, 240 Ill. App. 3d 820, 822, 608 N.E. 2d 385 (1992).

On direct examination, Petitioner testified in the year preceding his injury, he worked for Respondent as a correctional officer as well as with MetroLink as a public safety officer. T. 17-18. Petitioner testified as a correctional officer he was authorized to work at MetroLink after completing his one-year probationary period with Respondent. T. 18. Petitioner testified after completing his probationary period, he worked at MetroLink approximately 16 to 20 hours per week earning $16.50 per hour. T. 19-20. Petitioner testified after his injury, he was not scheduled at MetroLink as Respondent did not allow such work while Petitioner was under light duty restrictions. *Id.* Petitioner's job duties with MetroLink were that of an armed officer on site. T. 21. Petitioner testified since his accident, he has not returned to work for MetroLink, and he did not believe correctional officers presently worked for MetroLink but was unsure of the same. T. 34.

On cross-examination, Petitioner reiterated his testimony that Respondent established when Petitioner could work for MetroLink, and the same was only following the one-year probationary period. T. 37. Petitioner testified Respondent offered two options for additional hours, MetroLink or hospital detail, both of which were purely voluntary. T. 37-38. Petitioner testified he performed hospital detail on occasion. T. 38. Petitioner testified for either additional job (MetroLink or hospital detail), he spoke with Lieutenant Jim Lay from Respondent who would assign the hours based on Petitioner's availability, but such hours were not guaranteed. T. 40-41.

Petitioner testified when performing his duties at MetroLink, he wore his Sheriff's deputy uniform and carried his Sheriff's deputy badge and weapon all provided by Respondent. T. 41. During his shifts at MetroLink, Petitioner worked with either other Sheriff deputies or persons assigned to MetroLink through road patrol. T. 41. Petitioner testified he was interviewed by Ms. Merriweather, a human resources representative of MetroLink. T. 43. Petitioner testified when reporting to work at MetroLink, he would contact dispatch at Respondent or alternatively, present at the metro station. *Id.* During the latter part of the year, Petitioner would contact MetroLink dispatch and advise of his presence. T. 43-44.

Petitioner testified MetroLink employs its own public safety officers who are unaffiliated with Respondent, and Petitioner was not employed in such capacity. T. 44. Petitioner testified if he was unable to attend his shift at MetroLink, he would contact Respondent's personnel department, and a different Sheriff's deputy would be assigned. *Id.* If Petitioner wished to switch his shift, he would contact another deputy at Respondent. *Id.* Petitioner testified if he needed to leave his shift at MetroLink, he would contact the supervisor at Respondent. T. 45. If any issue arose during his shift, Petitioner would contact a representative at Respondent. T. 46.

Petitioner testified if an incident or arrest occurred during his shift at MetroLink, he would complete a Sheriff's Department report, and the suspect would be transported to the Sheriff's Department. T. 46. Petitioner testified during some arrests, East St. Louis police were notified, and for certain warrants, the Sheriff's Department was notified. T. 47.

Petitioner testified if he violated a Sheriff's Department policy, he would be subject to discipline by Respondent and not MetroLink. T. 49-50. Petitioner testified he received a termination letter from Respondent and not MetroLink. T. 50. Petitioner testified Respondent controlled all aspects of the job duties and assignment as a correctional officer as well as a public safety officer with MetroLink. *Id.*

Petitioner submitted a 2013 W-2 issued by Bi-State Development Agency (MetroLink) to Petitioner, and this was admitted into evidence as PX12, which evidences wages of $11,385.00.

The matter of *Chicago Housing Authority v. Industrial Commission*, 240 Ill. App. 3d 820, 608 N.E. 2d 385 (1992), is instructive. Claimant worked for the Chicago Police Department (CPD). The CPD in conjunction with the Chicago Housing Authority (CHA) created an employment program where CPD officers worked on their days off patrolling public housing units. Claimant's activities were directed by a CPD supervisor; he wore his CPD uniform while at the CHA; he received a separate pay-check at the same hourly rate as his CPD pay. While pursuing a suspect at the CHA, claimant was injured. Claimant argued he was an employee of the CHA, and the Commission agreed. On appeal, the Court reversed finding claimant failed to establish an employee/employer relationship. In so finding, the Court held claimant remained under the control of CPD at all times. *Id.* at 822.

Likewise, Petitioner remained under the control of Respondent at all times. Petitioner testified Respondent controlled all aspects of the job duties and assignments while he performed his shift at MetroLink. Respondent allowed correctional officers to volunteer for supplemental hours only after a year probationary period. Such supplemental hours were only provided through Respondent. Respondent scheduled the hours Petitioner worked at MetroLink at Respondent's sole discretion. Respondent supervised Petitioner while he worked at MetroLink. If an issue arose during his shift at MetroLink, Petitioner contacted personnel at Respondent. If Petitioner needed to leave his shift at MetroLink, he contacted personnel at Respondent. If Petitioner violated a policy, he was subject to discipline by Respondent and not MetroLink. During his shifts with MetroLink, Petitioner wore his Sheriff's deputy uniform and carried his

Sheriff's deputy badge and gun. Petitioner did interview with a person at MetroLink and received wages from MetroLink (which may or may not have been reimbursed by Respondent), but such factors do not overcome the control maintained by Respondent. Petitioner testified MetroLink employs their own public safety officers unaffiliated with Respondent, but he was not employed in such capacity. Instead Petitioner received his hours at MetroLink through Respondent. Petitioner was an employee of Respondent and not MetroLink. As no employment relationship existed between Petitioner and MetroLink, the wages earned from the hours worked at MetroLink are not included in the calculation of the average weekly wage as such wages are voluntary overtime wages. See *Airborne Express, Inc. v. Illinois Workers' Compensation Commission*, 372 Ill. App. 3d 549, 554, 865 N.E.2d 979 (2007) ("Overtime includes those hours in excess of an employee's regular weekly hours of employment that he or she is not required to work as a condition of his or her employment or which are not part of a set number of hours consistently worked each week").

Average Weekly Wage Calculation and Corresponding Rates

There is no dispute Respondent employed Petitioner as a full-time correctional officer for the 52-week period prior to his November 11, 2013 injury. The County of St. Clair Payroll History Report, RX1, evidences from November 2, 2012 to November 15, 2013 gross pay of $49,445.31. Overtime pay at time and a half equals $148.82. Deducting the premium of $49.61 ($148.82 reduced by 1/3) from $49,445.31 equals $49,395.70 for the 52-week period prior to the injury. $49,395.70 ÷ 52 weeks equals $949.92, average weekly wage for Petitioner's employment with Respondent. This yields a TTD rate of $633.28.

At trial, the parties stipulated Petitioner was temporarily totally disabled from May 29, 2014 through July 1, 2014 (4-6/7 weeks) and from April 29, 2015 through February 23, 2016, MMI date (43 weeks). The Arbitrator awarded these periods. In a Stipulation filed on August 21, 2017 while pending Review, the parties again stipulated to the above periods but claimed the total period equaled 49 weeks. The Arbitrator awarded a period of 47-6/7 weeks, and the Commission finds this to be correct. The Commission awards Petitioner temporary total disability benefits of 47-6/7 weeks at the rate of $633.28 per week under §8(b) of the Act.

The Arbitrator found Petitioner was temporarily partially disabled from July 1, 2014 through April 29, 2015, a period of 43-2/7 weeks at $168.67 per week pursuant to §8(a) of the Act. Petitioner testified he worked light duty during this period for Respondent but did not work at MetroLink. T. 24-25. As previously stated, the Commission finds the wages regarding Petitioner's work at MetroLink are not included in the calculation of the average weekly wage pursuant to Section 10 of the Act. Section 10 of the Act "states that the definition of average weekly wage contained therein shall form the 'basis for computing the compensation provided in Section 7 and 8 of the Act.' *820 ILCS 305/8(d)(1)* (West 2000)." *Copperweld Tubing Products Co. v. Illinois Workers' Compensation Commission*, 402 Ill. App. 3d 630, 635, 931 N.E.2d 762 (2010). As such, the Arbitrator's award of temporary partial disability benefits is vacated.

The Arbitrator found Petitioner was entitled to maintenance benefits from February 24, 2016 through June 1, 2016, a period of 14-1/7, and awarded the same. In their Stipulation, the parties agreed the above is the applicable maintenance period. The Commission finds this to be correct based on the record. The Commission awards Petitioner maintenance of 14-1/7 weeks at the rate of $633.28 per week pursuant to §8(a) of the Act.

The Arbitrator awarded Respondent credit for payment of TTD benefits and maintenance benefits in the amount of $47,875.90. This figure is verified by RX2, and the parties agreed Respondent paid this amount. The Commission affirms this credit.

Petitioner accepted a job as a patrol officer at a marina in Florida working 40 hours per week earning $13.00 per hour. T. 26. Therefore, Petitioner's current weekly wage equals $520.00. Petitioner testified correctional officers currently earn $24.99 per hour and work approximately 43 hours per week. RX1 evidences regular hours of 2,187.75 over 52 weeks which supports Petitioner's testimony of 43 hours per week. As such, in full performance of his job duties, Petitioner would earn $1074.57. Petitioner's hours earned while working at MetroLink are voluntary overtime hours and are not included in the calculation of the wage differential award. See *Copperweld Tubing Products Co. v. Illinois Workers' Compensation Commission*, 402 Ill. App. 3d 630, 637, 931 N.E.2d 762 (2010) (Section 10 of the Act excludes overtime hours from employee's wages, and this exclusion applies when calculating a wage differential benefit). Therefore pursuant to §8(d)1 of the Act, the Commission awards benefits of $369.71 per week commencing on June 2, 2016. The Commission affirms the credit of $12,440.97 for benefits previously paid, for the period of June 1, 2016 through March 30, 2017.

The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's May 26, 2017 decision is modified for the reasons stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the average weekly wage equals $949.92.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $633.28 per week for a period of 47-6/7 weeks, representing May 29, 2014 through July 1, 2014 and April 29, 2015 through February 23, 2016 that being the period of temporary total incapacity for work pursuant to §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of $168.67 per week for a period of 43-2/7 weeks, representing July 1, 2014 through April 29, 2015 that being the period of temporary partial incapacity from work pursuant to §8(a) of the Act is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $633.28 per week for a period of 14-1/7 weeks, representing February 24, 2016 through June 1, 2016 that being the period of maintenance benefits pursuant to §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that commencing on June 2, 2016, Respondent pay to Petitioner the sum of $369.71 per week for the duration of his disability, as provided in §8(d)1 of the Act, for the reason that the injuries sustained permanently incapacitated Petitioner from pursuing the duties of his usual and customary line of employment.

IT IS FURTHER ORDERED BY THE COMMISION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. The Commission notes Respondent paid $60,316.87 in benefits.

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

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

DATED: FEB 5 - 2018
LEC/maw
o12/06/17
43

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BEATTIE, DANTE
Employee/Petitioner

Case# **14WC036859**

ST CLAIR COUNTY SHERIFF'S DEPT
Employer/Respondent

18IWCC0079

On 5/26/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0384 NELSON & NELSON
ROBERT C NELSON
420 N HIGH ST PO BOX Y
BELLEVILLE, IL 62220

0810 BECKER PAULSON HOERNER ET AL
AARON CHAPPELL
5111 W MAIN ST
BELLEVILLE, IL 62226

18IWCC0079

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

Dante Beattie
Employee/Petitioner

v.

St. Clair County Sheriff's Department
Employer/Respondent

Case # **14** WC **36859**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **March 30, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **November 11, 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 **$62,551.84**; the average weekly wage was **$1,202.92**.

On the date of accident, Petitioner was **42** years of age, ***single*** with **0** dependent children.

Respondent shall be given a credit of **$47,875.90** for TTD, **$12,440.97** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$60,316.87**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$801.95**/week for **47 6/7** weeks, for the timeframes of May 29, 2014 through July 1, 2014 and April 29, 2015 through February 23, 2016 as provided in Section 8(b) of the Act. Respondent shall pay Petitioner maintenance benefits of **$801.95**/week for **14 1/7 weeks**, for the timeframe of February 24, 2016 through June 1, 2016, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of **$168.67**/week for **43 2/7** weeks, for the timeframe of July 1, 2014 through April 29, 2015, as provided in Section 8(a) of the Act.

Respondent shall be given a credit of **$47,875.90** for TTD, **$12,440.97** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$60,316.87**.

Respondent shall pay Petitioner permanent partial disability benefits of **$353.16/week,** commencing March 31, 2017, 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.

Melinda M. Pope Sullivan
Signature of Arbitrator

5/24/17
Date

ICArbDec p. 2

MAY 26 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Dante Beattie
Employee/Petitioner

Case # 14 WC 36859

v.

Consolidated cases: N/A

St. Clair County Sheriff's Department
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that on November 11, 2013 at approximately 5:00 a.m. he was exiting through the jail gate. He testified that he attempted to go sideways through the gate when the gate operator closed the gate on him and that the gate struck his right side, causing his right arm to extend across his body. He testified that he reported the accident immediately to his supervisor and sought medical treatment the following day. He testified that he had fairly extensive treatment with two orthopedic surgeons, Dr. Johnston and Dr. Keener. He testified that he underwent physical therapy, seven injections and two surgeries. He testified that he ultimately underwent a functional capacity evaluation and was given permanent restrictions pursuant to the FCE. He testified that he agreed with the findings of the FCE.

Petitioner testified that he was terminated from his employment with Respondent on May 2, 2016. He testified that after undergoing job placement services provided by Respondent, he found suitable employment within his restrictions working as a security guard at a marina in Florida and that he began working in this capacity on June 1, 2016. He testified that he is paid $13.00 per hour and works at least 40 hours per week, and that his current job duties include patrolling parking lots and docking boats. The Arbitrator notes that the parties stipulated at the time of arbitration that Petitioner was paid all appropriate temporary partial disability benefits from June 1, 2016 to the date of hearing, which was that of March 30, 2017. The Arbitrator further notes that the parties further stipulated at the time of arbitration that had Petitioner remained in the employment of Respondent, he would currently earn $24.99 per hour in his occupation as a correctional officer.

Petitioner testified that he still has difficulty performing activities with his right shoulder. He testified that he has trouble sleeping, lifting overhead and picking up a gallon of milk on the top shelf of the refrigerator. He testified that his range of motion in his right shoulder is very poor and causes him difficulty in performing such activities as shampooing and shaving. He testified that he drives with his left arm know and even has to walk with his right hand in his pocket because his right shoulder hurts from the swinging motion.

Petitioner testified that after completing a year of service with Respondent, corrections officers were eligible to begin requesting secondary duty. He testified that Respondent permitted corrections officers to request secondary duty at either the Metro station located at 5th and Missouri in East St. Louis or at hospitals guarding inmates receiving treatment. He testified that prior to the accident at issue, he signed up for both assignments but that Respondent more frequently offered secondary duty at the Metro station in East St. Louis. He testified that secondary duty was not mandatory and was offered to

corrections officers when available. He testified that he would sign up for secondary on a sheet of paper back at the Sheriff's Department, and that he would pick days he was able to work and if the "scheduled worked" then corrections officers would be assigned to the requested secondary. He testified that the secondary assignments were completely up to the discretion of Lieutenant Lay and later Major Wagner. He admitted that he was not guaranteed any particular secondary shift he signed up for.

Petitioner testified that there were various officers and security guards who worked at Metro facilities and trains. He testified that Respondent had officers who were assigned to the Metro detail as well as corrections officers who volunteered for secondary assignments at the Metro station. He testified that the supervisor of the Metro detail would also serve as the supervisor for the corrections officers working the secondary assignments. He also testified that Metro employed its own security guards who were not affiliated with Respondent.

Petitioner testified that while assigned to Metro secondary duty, he would wear his Sheriff's Department uniform, badge, and service weapon, all provided to him and required to be worn by Respondent. He testified that while on secondary duty, he would typically work with another officer from Respondent who volunteered for that secondary assignment through the same procedures as Petitioner. He testified that when reporting to secondary duty he would call back to Respondent's dispatch to let them know he was reporting for his shift. He testified that if he had to miss a secondary shift, he would contact another officer to cover his shift and that he had the option of picking up another officer's shift if he wanted the extra hours. He testified that if he ever had to leave during the middle of his secondary shift, he would contact the shift supervisor to let them know he was leaving. He testified that any disciplinary measures were taken by Respondent in the event that an officer violated department policy while working secondary duty.

Petitioner testified that his secondary duties included patrolling the landing, watching for illegal activity, assisting passengers with directions and ensuring passenger safety. He testified that if there was an incident on the landing that required an arrest, he would do so and later complete a police report for Respondent. He testified that after an arrest was made, he would either call the East St. Louis Police Department or an officer from Respondent to pick up the arrested subject. He testified that he would not leave the 5th and Missouri station while on secondary duty.

Petitioner testified that only employees of Respondent were eligible to sign up for secondary duty at the Metro station. He testified that employees of Metro, such as their own security guards, could not sign up for those assignments. He also testified that employees of Respondent could not accept any concurrent employment unless the Sheriff himself permitted them to do so. Furthermore, he testified that Respondent controlled all of his job duties as a corrections officer and all of his job duties on secondary assignments.

Petitioner testified that he earned $16.50 per hour working his secondary assignments. He testified that while he was working light duty for Respondent, Respondent would not permit him to sign up for any secondary shifts due to his restrictions. He testified that he did not work a secondary assignment since he was given light duty restrictions on April 29, 2015. He testified that he received a termination letter from Respondent on May 2, 2016, but that he did not receive a termination letter from Metro at any time. When asked whether correctional officers were currently allowed to perform secondary duty, Petitioner testified "As far as I heard about three or four months ago, I talked with a fellow officer, they said they weren't. I do not know."

The medical records of Dr. Donald Johnston were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The records reflect that Petitioner was seen on December 18, 2013 for a chief complaint of right shoulder pain. It was noted that Petitioner sustained an injury at work on November

11, 2013, that he was a corrections officer and that he was trying to get through the doorway in which there was a large metal security door. It was noted that the door closed on Petitioner while his left arm was across his body and that this caused a compaction injury to the shoulder. It was noted that after a few seconds, the door was opened and Petitioner was able to be freed. It was noted that Petitioner was currently on light duty and performing office work at work, that he rated his pain as a 7/10 and that he described it as a dull and aching quality of pain that became sharp and throbbing with activities. It was noted that Petitioner denied any previous surgeries or fractures involving the shoulder, that he was right-hand dominant, that there was no numbness, tingling or radicular complaint and that Petitioner stated that there was occasionally a tingling of the right little finger but that it was transient and mild. The impression was noted to be that of (1) right shoulder pain; (2) impingement syndrome, right shoulder; (3) acromioclavicular joint arthritis, right shoulder; (4) fluid-filled cyst, right shoulder. Treatment options were discussed and Petitioner indicated his consent to proceed with an injection into the right subacromial region. Petitioner was prescribed Mobic, and it was noted that he was to have proper warm-up prior to activities and ice after activities. Petitioner was also placed on work restrictions. (PX1).

The records of Dr. Johnston reflect that Petitioner was seen on January 9, 2014, at which time it was noted that he stated that the injection was beneficial. It was noted that Petitioner was pleased with his progress and that he requested that he go back to full duty. It was noted that Petitioner was starting to increase his activities regarding weight training and that the Mobic occasionally made his stomach upset. The impression was noted to be that of (1) right shoulder pain; (2) impingement syndrome, right shoulder; (3) acromioclavicular joint arthritis, right shoulder; (4) fluid-filled cyst, right shoulder. Petitioner was instructed to continue with the home exercise program. It was noted that additional injections or other measures were possibilities pending Petitioner's progress. At the time of the February 6, 2014 visit, it was noted that Petitioner stated that his symptoms were improving, that he had intermittent pain that was worse with contact and movement and that he still had occasional nighttime pain. It was noted that Petitioner was taking Mobic with good results, that he had lost 5 pounds from cardiovascular activities and that he had no numbness or tingling. The impression was noted to be that of (1) impingement syndrome, right shoulder; (2) acromioclavicular joint arthritis, right shoulder; (3) fluid-filled cyst, right shoulder. It was noted that treatment options were discussed and that Petitioner indicated his desire to proceed with a second subacromial injection, which was performed. Petitioner was instructed to continue his home exercise program as well as Mobic. It was noted that a third injection and/or surgery were other possibilities pending his progress. (PX1).

The records of Dr. Johnston reflect that Petitioner was seen on March 5, 2014, at which time it was noted that the injection was beneficial but that the pain had increased in severity. It was noted that Petitioner had been with increased activities and performing a cardiovascular workout and was not lifting weights. It was noted that the pain woke him at night occasionally, that his symptoms were intermittent, and that he was tolerating the Mobic without problems. The impression was noted to be that of (1) impingement syndrome, right shoulder; (2) acromioclavicular joint arthritis, right shoulder; (3) fluid-filled cyst, right shoulder. It was noted that Petitioner wished to proceed with a third subacromial injection, which was performed. Petitioner was instructed to continue with his home exercise program as well as proper lifting techniques, as well as to continue the Mobic. It was noted that surgery was a possibility if Petitioner had continuing symptoms. At the time of the April 3, 2014 visit, it was noted that Petitioner stated that his symptoms were not improving, that it was a burning as well as throbbing quality of pain, that his symptoms were constant and that pushing and pressure exacerbated the pain. The impression was noted to be that of (1) impingement syndrome, right shoulder; (2) acromioclavicular joint arthritis, right shoulder; (3) fluid-filled cyst, right shoulder. Petitioner was instructed to continue the Mobic. It was noted that Petitioner had exhausted the amount of injections. Petitioner was instructed to continue with the home exercise program and proper lifting techniques, and that if he desired surgery he was to call to schedule. (PX1).

The records of Dr. Johnston reflect that Petitioner was seen on May 15, 2014, at which time it was noted that he stated that the pain was persistent in severity and frequency and that he had continued pain despite non-operative measures. The impression was noted to be that of (1) impingement syndrome, right shoulder; (2) acromioclavicular joint arthritis, right shoulder; (3) fluid-filled cyst, right shoulder. It was noted that Petitioner wished to proceed with right shoulder arthroscopy with possible repair. At the time of the June 10, 2014 visit, it was noted that Petitioner was 12 days status post right shoulder arthroscopy with debridement and acromioplasty. It was noted that Petitioner was doing well and that there were no other reported problems or complaints. Petitioner was noted to be making good progress. It was noted that Petitioner was to work on range of motion and was to avoid any heavy lifting or carrying. Work restrictions were issued. At the time of the July 1, 2014 visit, it was noted that Petitioner stated that he was reaching and using the right arm at work. It was noted that Petitioner had restrictions of no use of the right arm. It was noted that there were no other problems or complaints and that Petitioner still had pain with range of motion. It was noted that Petitioner was to work on range of motion exercises and was to avoid any heavy lifting or resistance exercises. (PX1).

The records of Dr. Johnston reflect that Petitioner was seen on August 5, 2014, at which time it was noted that he reported that there was still soreness, that he was tolerating light duty restrictions and that he had no radicular complaints. It was noted that Petitioner was making satisfactory progress. Petitioner was instructed to initiate physical therapy in addition to home exercises. Petitioner was placed on Celebrex. Work restriction slips placing Petitioner under light duty work restrictions were issued on July 1, 2014, August 5, 2014 and September 4, 2014. At the time of the September 4, 2014 visit, it was noted that Petitioner was doing well and was making progress in physical therapy. It was noted that there was still soreness with range of motion. It was noted that Petitioner was to continue with physical therapy and the home exercise program as well as proper lifting techniques. It was noted that Petitioner wanted to return to weight training but was instructed to hold off secondary to continued symptoms. At the time of the October 2, 2014 visit, it was noted that Petitioner still had pain and was "tired of hurting." It was noted that Petitioner's symptoms were worse with movement and that physical therapy had been adjusted with improving results. The impression was noted to be that of (1) right shoulder pain; (2) status post right shoulder arthroscopy. It was noted that Dr. Johnston thought that Petitioner would benefit from a subacromial injection in addition to the physical therapy and Celebrex, and the injection was performed on that date. A work slip placing Petitioner under light duty work restrictions was also issued at that time. (PX1).

The records of Dr. Johnston reflect that Petitioner was seen on October 31, 2014, at which time it was noted that the injection was beneficial for 1-2 weeks and that the pain was now increased with severity and frequency. It was noted that the physical therapy notes had demonstrated improvement of range of motion but that Petitioner still had limitation secondary to pain, which bothered him at night and was worse with activities. It was noted that Petitioner did not feel safe for his occupation, in which altercations were frequent. The impression was noted to be that of (1) right shoulder pain; (2) status post right shoulder arthroscopy. Petitioner was recommended to undergo an MRI to assess the subacromial space as well as the rotator cuff. Petitioner was instructed to continue the Celebrex and discontinue formalized physical therapy while continuing with the home exercise program and proper lifting techniques. A work slip placing Petitioner under light duty work restrictions was also issued at that time. At the time of the December 3, 2014 visit, it was noted that Petitioner stated there was still severe pain located anterior in the shoulder, was not located in the posterior shoulder girdle and was worse with range of motion as well as activities. The impression was noted to be that of (1) continued residual shoulder pain, right shoulder; (2) status post right shoulder arthroscopy with acromioplasty and debridement of the glenohumeral joint and inferior clavicle spur. Petitioner was recommended to undergo a second opinion consultation with Dr. Galatz at Barnes. A work slip placing Petitioner under light duty work restrictions was also issued at that time. (PX1).

The medical records of Mid America Imaging were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The interpretive report of an MRI of the right shoulder performed on November 29, 2013 reflected that the films were interpreted as revealing (1) partial tear supraspinatus tendon, (2) mild cuff tendonitis; (3) subdeltoid bursitis; (4) multiloculated fluid collection along the posterior margin of the scapula inferior to the scapular spine measuring 3.4 x 1.5 x 0.7 cm; ganglion is possible; paralabral cyst is most likely; (5) arthritic changes acromioclavicular joint with medial arch encroachment. An MRI of the right shoulder performed on November 19, 2014 was interpreted as revealing (1) very small partial thickness bursal surface tear of the distal supraspinatus; associated supraspinatus and infraspinatus tendinosis; (2) small effusion of the subacromial-subdeltoid bursa suggesting bursitis; (3) post-operative signal changes at the anterior margin of the acromion; (4) posterior labral tear with no significant change in the posterior paralabral cyst as described; no suspicious atrophy or edema of the infraspinatus, but please correlate to exclude suprascapular nerve impingement; (5) mild degenerative changes in the glenohumeral and acromioclavicular joints. (PX2).

The medical records of Dr. James Hitchcock were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on November 20, 2013, at which time it was noted that he was trying to go through a gate at work (police station), that the door was too heavy and that it pushed on his right shoulder while it was crossed over his upper body and caused a hyperabduction-type motion. It was noted that Petitioner had a lot of pain and spasm in the right shoulder. The assessment was noted to be that of (1) insomnia; (2) joint pain, localized in the right shoulder. Petitioner was recommended to undergo an MRI and was instructed to work light duty. (PX3).

The medical records of St. Elizabeth Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen at Urgent Care on November 12, 2013, at which time it was noted that he stated that he got caught in a gate yesterday morning at work, injuring his right shoulder. It was noted that Petitioner stated that he had decreased range of motion of the shoulder because of pain and that he had normal use of his hands, forearm and elbow without pain. The primary impression was noted to be that of shoulder pain and the additional impression was noted to be that of sprain of shoulder. Petitioner was advised to rest, ice and take Advil for pain. It was noted that Petitioner was to follow up with his primary care physician as soon as possible. The records reflect that Petitioner underwent x-rays of the right shoulder on November 12, 2013 as well, which were interpreted as revealing no evidence of fracture or dislocation; bones are of anatomic alignment. Included within the records was the Operative Report dated May 29, 2014, which noted that Petitioner underwent (1) arthroscopy, right shoulder, with subacromial decompression and acromioplasty; (2) debridement of glenohumeral joint and inferior clavicle spur, right shoulder for pre-operative and post-operative diagnoses of (1) impingement syndrome, right shoulder; (2) partial rotator cuff tear, right shoulder; (3) mild acromioclavicular joint arthritis, right shoulder. Also included within the records was the interpretive report for x-rays of the right shoulder performed on July 1, 2014, which were interpreted as revealing humeral head rests within the glenoid; no acute fracture or dislocation; acromioclavicular arthritis. (PX4).

The records of St. Elizabeth Hospital reflect that Petitioner underwent physical therapy for the timeframe of August 18, 2914 through October 17, 2014. The records further reflect that Petitioner underwent additional physical therapy for the timeframe of May 19, 2015 through October 27, 2015, although the specific physical therapy notes were not included. Petitioner was also seen in the Emergency Department on February 5, 2016, at which time it was noted that he reported "extreme right shoulder pain." It was noted that Petitioner stated that he went to the Work Center for an evaluation yesterday and that he woke up with worse pain. It was noted that Petitioner denied any new injury and that it was just an increase of his normal pain due to physical activity and the shoulder evaluation. It was noted that x-rays of the right shoulder performed on that date were interpreted as revealing degenerative hypertrophic spurring at the acromioclavicular joint; downward slope to the lateral margin of the

acromion; mild spurring of the glenoid and humeral head; metallic density superimposing the proximal diaphysis of the humerus with benign-appearing periosteal reaction likely representing post-operative change; no acute fracture or dislocation. The primary impression was noted to be that of rotator cuff injury and the additional impression was noted to be that of rotator cuff dysfunction. Petitioner was instructed to rest from the offending activity, take Tylenol/Ibuprofen for pain relief and ice the shoulder. It was noted that Petitioner was recommended to get in to see his orthopedist at Barnes Jewish sooner, if possible, or otherwise follow up with his primary care physician for further pain management. (PX4).

The medical records of Dr. Jay Keener were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on February 9, 2015, at which time it was noted that he was a 43-year-old prison guard who had a shoulder injury in November of 2013. It was noted that Petitioner was squeezing through a tight door space when they closed the door on him and it jammed his arm across his body. It was noted that Petitioner felt immediate searing pain in his shoulder and that prior to that, his shoulder was normal. It was noted that Petitioner was eventually referred to Dr. Johnston, that he underwent an arthroscopy surgery on his shoulder and that the provisional diagnosis, according to Petitioner, was a torn labrum and a cyst in his shoulder. It was noted that Petitioner's shoulder pain never really improved, that he had gone through several months of therapy and that he had one subacromial injection after the surgery which did take away a lot of the pain but only lasted for about a week or two. It was noted that Petitioner had daily pain, that it hurt at night, that it was aggravated with motion particularly prolonged driving or abduction above 90 degrees and that he localized pain along the anterolateral shoulder with minimal radiation. The impression was noted to be that of persistent right shoulder pain status post arthroscopy in a 43-year-old prison guard. It was noted that the etiology of the pain was unknown but that his exam suggested a cuff-based pain generator. It was noted that Petitioner's outside MRI was inconclusive for the presence of a rotator cuff tear, and that he may have a posterior labral tear as well that was not related to his current symptoms. Petitioner was recommended to undergo a repeat MRI and to obtain an arthrogram. Petitioner was placed under light duty restrictions. X-rays of the right shoulder performed on the same date were interpreted as revealing mild right acromioclavicular osteoarthritis. (PX5).

The records of Dr. Keener reflect that Petitioner was seen on March 2, 2015, at which time it was noted that his symptoms were unchanged and that he had rather significant and sharp "twingey" pain along the anterolateral aspect of the shoulder. It was noted that Dr. Keener opined that Petitioner's symptoms were probably related to his SLAP tear and degenerative labral cyst and that he may have a band of scar in the subacromial space that was catching based on the examination performed. It was noted that Petitioner would best benefit from a repeat arthroscopy with a posterosuperior labral repair and open subpectoral biceps tenodesis and a revision debridement of the subacromial space, which he thought would have about an 80% chance of significantly improving his symptoms. Included within the records was the interpretive report for an MRI arthrogram performed on March 2, 2015, which was interpreted as revealing (1) tear of the majority of posterior labrum centered at the posterior superior aspect with 2.6 x 2.5 cm multiloculated posterior superior paralabral cyst; (2) articular-sided partial thickness tear with mild supraspinatus tendinopathy and normal supraspinatus muscle bulk. The Operative Report dated April 30, 2105 noted that Petitioner underwent (1) right shoulder arthroscopic SLAP repair; (2) right shoulder arthroscopic posterior labral repair; (3) open subpectoral biceps tenodesis for pre-operative diagnoses of (1) right shoulder SLAP tear; (2) right shoulder spinal glenoid notch cyst and post-operative diagnoses of (1) right shoulder SLAP tear; (2) right shoulder posterior labral tear; (3) right shoulder spinal glenoid notch cyst. (PX5).

The records of Dr. Keener reflect that Petitioner was seen on June 8, 2015, at which time it was noted that overall he was doing well, that he had been continuing to have some pain, that he had been seeing a therapist twice a week and that he had been using his arm a little bit around the house. It was noted that Petitioner was doing well following arthroscopic SLAP repair and open subpectoral biceps

tenodesis. Petitioner was instructed to extend physical therapy. Petitioner was also allowed to return to work light duty. At the time of the July 13, 2015 visit, it was noted that Petitioner was going to therapy twice a week and remained off work. It was noted that Petitioner stated that he felt like he was making progress with his shoulder but that it was very slow and that he continued to have a lot of pain in therapy when they were stretching him. It was noted that Petitioner had a clinical exam consistent with a mild frozen shoulder. Petitioner was recommended to undergo a fluoroscopic-guided glenohumeral steroid injection and to continue therapy. It was noted that his restrictions were unchanged. At the time of the September 2, 2015 visit, it was noted that Petitioner felt like his range of motion was a little better and that he still had a lot of sharp, stabbing pain in the shoulder when he tried to elevate the arm. It was noted that additional physical therapy had not been approved and that he remained of work as he had a restriction of no inmate contact. Petitioner was given an injection into the right subacromial space and was recommended to continue therapy to work on cuff strengthening. Work restrictions were continued at that time. (PX5).

The records of Dr. Keener reflect that Petitioner was seen on September 30, 2015, at which time it was noted that he continued to have pain. It was noted that Petitioner felt like he was slowly making improvements with range of motion and strength, but that the pain would not leave. It was noted that the subacromial injection given at the last visit gave Petitioner no relief, even temporarily. It was noted that most of the pain was located along the lateral acromion, was worse when Petitioner tried to lift his arm against gravity and that he was a little frustrated by his continued symptoms. It was noted that the source of Petitioner's pain remained "a little bit elusive" to Dr. Keener. It was noted that there was no objective evidence of a recurrent tear, that the biceps tenodesis was healing well and that there was no evidence of subscapular nerve impingement from a spinal glenoid cyst. Petitioner was recommended to continue strengthening exercises. Work restrictions were issued at that time. At the time of the November 25, 2015 visit, it was noted that Petitioner continued to describe a constant low-grade aching in his shoulder and that the ache was aggravated with motion, particularly sustained positions like driving or elevation. It was noted that most of the pain was anterior, radiated to some degree and that Petitioner had some pain at night. It was noted that Tramadol did not help. The impression/diagnosis was noted to be that of persistent right shoulder pain following surgery, uncertain pain generator. Petitioner was recommended to undergo an MRI arthrogram. Work restrictions were issued at that time. (PX5).

The records of Dr. Keener reflect that Petitioner was seen on January 6, 2016, at which time it was noted that his symptoms were unchanged and that his pain was about the same and maybe a little worse. It was noted that it ached fairly constantly and was aggravated with certain motions, and that Petitioner had been trying to strengthen his shoulder on his own at home. It was noted that Petitioner did not feel like he had enough mobility and strength to protect himself at work, that he had remained off work and that he continued to localize the pain in the anterolateral shoulder. The impression/diagnosis was noted to be that of unexplained right shoulder pain status post arthroscopic posterior labral repair, open subpectoral biceps tenodesis and subacromial decompression. It was noted that Petitioner was at maximum medical improvement and that Dr. Keener saw no obvious explanation for the ongoing pain in Petitioner's shoulder on the MRI. It was noted that Petitioner had exhausted conservative management and multiple image-guided steroid injections to help ease out where his pain generators were, and that it was time for him to undergo an FCE. Work restrictions were continued at that time. At the time of the February 23, 2016 visit, it was noted that Petitioner had finished the FCE and was at maximum medical improvement. It was noted that Dr. Keener's opinion was that Petitioner was able to perform most of the job duties according to his job description and that he qualified as a heavy-level physical demand and that the job description required a medium-heavy physical demand. It was noted, however, that Petitioner had restrictions that would specifically influence the job he had as a corrections officer and that specifically, he had some residual weakness in the shoulder that may make it difficult for him to defend himself in an altercation and had limited overhead strength. It was noted that it was Dr. Keener's opinion that Petitioner should have a permanent restriction in overhead lifting of 10 pounds and that he should not

return to work as he did not feel comfortable taking care of himself against a violent inmate nor did he feel comfortable discharging a firearm, specifically a shotgun. Petitioner was discharged at that time. (PX5).

The medical records of Dr. George Paletta were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner underwent an IME on March 30, 2015, at which time it was noted that he was seen for a chief complaint of right shoulder pain with an onset of symptoms dating back to an incident which Petitioner reported as having occurred on November 11, 2013. It was noted that Petitioner was passing through what he described as a gate, which was a narrow opening for a mechanical door. It was noted that Petitioner stated that he passed through the door somewhat sideways, and that he was leading with the left shoulder as he passed through. It was noted that Petitioner had his right arm up across his body with the forearm just under chin level in a slightly adducted position and that as he was passing through the door, the gate started to close from behind. It was noted that it was a mechanical door that was very heavy and could not be pushed back against any resistance and that the door hit him on the back of his right elbow and right upper arm, forcing it across his body in an adducted position. It was noted that Petitioner had immediate pain in the shoulder. It was noted that the impression was that of persistently symptomatic posterior superior labral tear status post previous arthroscopy with subacromial decompression, bursectomy and acromioplasty. It was noted that Dr. Paletta agreed with Dr. Keener's recommendation for surgery, and that he recommended arthroscopy of the right shoulder with decompression and excision of the paralabral cyst, labral debridement versus labral repair and subpectoral tenodesis, as well as a revision subacromial decompression without revision formal acromioplasty or distal clavicle excision. (PX6).

The medical records of Dr. Adam Labore were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner was seen on August 10, 2015 for a fluoroscopically-guided right glenohumeral injection as part of conservative therapy for pain with adhesive capsulitis. The records reflect that Petitioner underwent a right shoulder injection prior to MR arthrography on January 6, 2016. The MRI arthrogram performed on January 6, 2016 was interpreted as revealing (1) new full-thickness chondrosis in the right posterosuperior glenoid; (2) intact right posterosuperior labral repair; (3) biceps tendinotomy and tenodesis; (4) unchanged partial-thickness undersurface tear of the posterior supraspinatus. (PX7).

The medical records of The Work Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records reflect that Petitioner presented for an FCE on January 13, 2016 to determine his current functional abilities to return to the occupation of Corrections Officer. Due to blood pressure elevation greater than safe testing parameters, the FCE was not completed on that date. Petitioner returned on February 4, 2016, at which time it was noted that he provided maximal effort. It was noted that Petitioner's performance during the FCE supported employment on a full time basis within the heavy physical demand level, and that the demonstrated function within the heavy physical was completed at or below shoulder level. It was noted that Petitioner's demonstrated level of function met the required demand level for usual and customary employment as a Corrections Officer, but that return to work might be given considerations of quantifying or simulating forces needed to restrain or move an inmate in an emergent situation were not feasible for simulation in a testing environment, that Petitioner had limiting right overhead reaching and that performing overhead lifting was not successful with 10 pounds. (PX8).

The Sheriff's Department Termination Letter was entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The letter dated March 22, 2016 indicated that Respondent could not accommodate Petitioner's permanent restrictions of no lifting greater than 10 pounds above shoulder height and no inmate contact. (PX9).

The Photograph of Petitioner taken June 5, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 11.

The W-2 from Bi-State (Metro) was entered into evidence at the time of arbitration as Petitioner's Exhibit 12. The W-2 was issued by Bi-State Development Agency in the amount of $11,385.00 for 2013. (PX12).

The Wage Statement was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The Payroll History Report for the timeframe of November 2, 2012 through November 15, 2013 noted that Petitioner's gross earnings were that of $49,445.31, of which $148.82 represented overtime pay. (RX1).

The TTD Payout was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The TPD Payout was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The Medical Payout was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The Corrections Officer Pay Scale was entered into evidence at the time of arbitration as Respondent's Exhibit 5.

The Financial Reimbursement Intergovernmental Agreement was entered into evidence at the time of arbitration as Respondent's Exhibit 6. The Agreement was dated May 26, 2015 and noted that the County and Sheriff contracted with Bi-State to provide police services upon Metro Link trains and properties. The Agreement noted that the parties agreed that it was necessary and proper for the Transit District to reimburse the County and Sheriff for the self-insured retention costs associated with worker's compensation claims of the sworn deputy sheriffs performing work upon the Metro Link to ensure the continued viability of the arrangement providing for sworn deputy sheriffs performing work upon the Metro Link. (RX6).

CONCLUSIONS OF LAW

The parties stipulated at the time of arbitration Petitioner sustained an accident on November 11, 2013, that arose out of and in the course of his employment with Respondent and that Petitioner's condition of ill-being is causally related to the accident. (AX1).

With respect to disputed issue (G) pertaining to earnings, the Arbitrator finds that the applicable average weekly wage in this case is that of $1,202.92.

The Arbitrator notes that Respondent claims the average weekly wage is $949.92 based on earnings in the 52 weeks prior to the date of accident of $49,395.70. (AX1). Respondent's Exhibit1 shows earnings for the 52 weeks prior to the injury as $49,445.31, of which $148.82 represents time paid at an overtime rate. Respondent deducted the premium of $49.61 (*i.e.*, $148.82 reduced by 1/3) from the $49,445.31 and lists the difference, *i.e.*, $49,395.70, as its proposed yearly earnings. The Arbitrator notes that Respondent's calculation is essentially consistent with Respondent's Exhibit 5, which is the Corrections Officer Pay Scale. (RX5).

The Arbitrator notes that Petitioner testified that he worked weekly extra hours over and above his work as a corrections officer in the year before he was injured and claims that his additional work with Bi-State Development Agency (*i.e.*, Metro Link) should be considered concurrent employment and therefore included in the average weekly wage. Respondent, on the other hand, claims that because no employer/employee relationship existed between Petitioner and Metro Link, Petitioner's secondary duties with Metro Link do not constitute concurrent employment and therefore his earnings should not be factored into the calculation of the average weekly wage.

The Arbitrator notes that Petitioner established at the time of arbitration that Respondent effectively controlled all facets of his work activities with Metro Link despite the fact that he was issued a W-2 by Metro Link for his additional earnings. (PX12). Furthermore, Respondent provided evidence showing that Metro Link was reimbursed by Respondent for those wages. (RX6). That said, the Arbitrator finds that it would be proper for Petitioner's additional earnings while working secondary duty at Metro Link – which, the Arbitrator notes, were not specifically delineated and referenced in the Wage Statement entered into evidence at the time of arbitration as Respondent's Exhibit 1 – to be included in the average weekly wage for the underlying claim. As the evidence reflects that in the 45 weeks before he was injured Petitioner earned $11,385.00 while working for Metro Link, this results in concurrent earnings of $253.00 per week over and above Petitioner's earnings as a corrections officer with Respondent. This, then, results in a combined average weekly wage of $1,202.92.

With respect to disputed issue (K) pertaining to temporary total disability, temporary partial disability and maintenance benefits, the Arbitrator finds that, with respect to the issue of temporary total disability and maintenance benefits, Petitioner was entitled to temporary total disability and maintenance benefits for the timeframes of May 29, 2014 through July 1, 2014 and April 29, 2015 through June 1, 2016 (with the specific timeframe for maintenance benefits having been that of February 24, 2016 through June 1, 2016) at the rate of $801.95 per week. Related thereto, Respondent shall be given a credit of $47,875.90 for temporary total disability benefits paid as stipulated by the parties at the time of arbitration. (AX1).

With respect to the issue of temporary partial disability, the Arbitrator notes that the evidence reflects that Respondent did not pay temporary partial disability benefits until June 1, 2016. (RX3). Petitioner testified that he worked light duty for Respondent from July 1, 2014 to April 29, 2015, a period of 43 2/7 weeks. He also testified that he was not allowed by Respondent to work his other position while he was on light duty restrictions and confirmed that he did not work for Metro Link during that timeframe. As a result thereof, the Arbitrator finds that Petitioner was entitled to temporary partial disability benefits for the timeframe of July 1, 2014 through April 29, 2015 at the TPD rate of $168.67 per week (*i.e.*, 2/3 of $253.00). The Arbitrator notes that the parties stipulated at the time of arbitration that all appropriate temporary partial disability benefits were paid from June 1, 2016 to the hearing date of March 30, 2017. Furthermore, Respondent shall be given a credit of $12,440.97 for temporary partial disability benefits paid as stipulated by the parties at the time of arbitration. (AX1).

With respect to disputed issue (L) pertaining to nature and extent, the Arbitrator finds that Petitioner's injuries have resulted in his being partially incapacitated from pursuing his usual and customary lines of employment. The parties stipulated at the time of arbitration that had Petitioner remained in the employ of Respondent, he would have earned $24.99 per hour, or $54,586.38 per annum (*i.e.*, $1,049.74 per week). The parties further stipulated that Petitioner has found suitable employment as a boat dock security guard, earning $13.00 per hour or $520.00 per week. The record is clear that Petitioner is unable to return to his occupation as a corrections officer and is therefore entitled to benefits under Section 8(d)1.

The Arbitrator notes that Petitioner testified that he was not aware of whether corrections officers were still permitted secondary duty with Metro and admitted that he did not believe they were any longer. That said, the record is clear that Petitioner's potential future earnings in the full performance of his duties in his occupation as a corrections officer would be $24.99 per hour or $1,049.74 per week, and that he is currently earning $13.00 per hour or $520.00 per week in his current suitable employment. As a result, the Arbitrator finds that Petitioner is entitled to 2/3rds of $529.74 (*i.e.*, $1,049.74 - $520.00), or $353.16/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.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Christina Gieselmann,
Petitioner,

vs. NO: 13 WC 30843

State of Illinois / Menard Correctional Center,
Respondent.

18IWCC0080

DECISION AND OPINION ON REVIEW

Respondent appeals the decision of Arbitrator Nowak filed on March 17, 2016, following hearing held on May 20, 2015. Notice has been given to all parties. The Arbitrator found that Petitioner sustained bilateral carpal tunnel syndrome (CTS) due to work-related repetitive trauma and accordingly awarded medical expenses (including for bilateral carpal tunnel release surgeries done in summer 2013) and compensation for permanent partial disability representing 12.5% loss of use of each hand.

On review, the Commission, after considering issues including accident, causal connection, medical expenses, and permanent disability, and being advised of the facts and law, hereby reverses the Arbitrator's decision, attached hereto. Particularly, the Commission finds that Petitioner did not prove the existence of CTS (notably, electrodiagnostic studies done in 2009 and 2013 were negative for any neuropathy), nor did she prove that her current condition of ill-being was caused by her employment. Further, assuming for the sake of argument that she did have CTS, she failed to give proper notice to Respondent insofar as manifestation of any purported CTS occurred well more than 45 days in advance of the incident report she submitted on July 11, 2013 (and well in advance of the manifestation date of May 28, 2013 alleged in her Application for Adjustment of Claim). All benefits are denied.

The Commission's decision is discussed further below.

18IWCC0080

BACKGROUND

Petitioner, 43 as of the asserted date of loss (May 28, 2013), began employment as a correctional officer at Menard Correctional Center in March 1999. In early 2007, she was transferred from the maximum security unit to the more modern medium security unit, where she remained. (Tr. 23). After this transfer, and in the years leading up to the instant claim, she sustained two other work-related accidents, both of which purported to give rise (or otherwise were soon occasioned by) symptoms in her upper extremities, including numbness, tingling, and pain in her hands and arms. Both of these prior accidents were the subjects of claims against Respondent and both claims resulted in compensation for Petitioner, as described below.

First prior accident (thoracic outlet syndrome): Regarding the first claim, case no. 09 WC 17388, Petitioner reported symptoms suggestive of a repetitive use injury to Dr. David Brown of the Orthopedic Center of St. Louis, who evaluated her on April 1, 2009. Dr. Brown wrote:

> "Ms. Gieselmann is a 39-year-old right hand dominant correctional officer at Menard. She presents for evaluation and treatment for a problem with both her upper extremities. She explains to me she's worked at Menard since 1999.... Her job entails opening cell doors with Folger-Adams keys throughout the day. She'll open gates. She'll type on the computer. She explains to me that she has about a year history of progressive numbness and tingling in both her hands, aching in both her hands. She could recall no specific traumatic injury."

(RX 22 at 1). Dr. Brown ordered nerve conduction studies to determine the cause of her symptoms, after his physical examination findings that day were negative for carpal or cubital tunnel syndrome. (RX 22 at 1). These objective studies' results as well were normal, that is, as Dr. Brown indicated on April 3, 2009, "***there was no electrodiagnostic evidence for a peripheral compression neuropathy such as carpal tunnel syndrome or cubital tunnel syndrome***." (emphasis added) (RX 22).

However, the neurologist who performed the studies -- Dr. Daniel Phillips of Neurological & Electrodiagnostic Institute -- had expressed concern that Petitioner's symptoms might be connected to thoracic outlet syndrome. This concern arose from her "subjectively positive Adson's maneuvers." (PX 5 at 7). Thus, Dr. Brown sent Petitioner to see a specialist in treating thoracic outlet syndrome, Dr. Robert Thompson of Washington University/Barnes Hospital. (RX 22 at 3). Dr. Thompson first saw Petitioner on April 8, 2009. (RX 17). Dr. Thompson performed bilateral thoracic outlet surgery -- first on her right side, and then the left side -- on June 16, 2009 and August 31, 2009, respectively. (RX 2 at 4-5). Afterwards, Petitioner underwent intensive physical therapy for several months. In all, for this repetitive use injury, Petitioner was off-work from March 31, 2009 until February 1, 2010. (Tr. 78-79).

In June 2010, a hearing to determine nature and extent of injury only was held before Arbitrator Dibble. In his decision filed July 13, 2010, Arbitrator Dibble noted that "[Petitioner's] job entails opening cell doors with Folger Adams keys, opening gates, typing on the computer, and using her arms in lifting and carrying heavy objects. While performing these job duties she began noticing progressive numbness and tingling in her hands and arms." (RX 17). Arbitrator Dibble then briefly referenced Petitioner's evaluations and treatment with Dr. Brown, Dr. Phillips, and Dr. Thompson -- the latter testified that Petitioner's symptoms – i.e., the aforementioned numbness and tingling in her hands and

arms -- were due to thoracic outlet syndrome brought on by her repetitive work activities. As to the ultimate determination, the decision reads:

> "The Arbitrator finds that as a result of her repetitive work activities, the parties stipulated Petitioner contracted thoracic outlet syndrome... [The bilateral thoracic outlet surgery] improved Petitioner's condition sufficiently enough to allow her to return to work... At Arbitration, Petitioner credibly testified that she has difficulty lifting anything overhead or carrying any weight for any length of time. She has difficulty doing household chores including laundry and overhead dusting or cleaning. Activities of daily living such as washing her hair also give her trouble. She can no longer engage in motorcycle riding and has her motorcycle for sale. She has difficulty driving as her neck gets knotted and stiff and she attends massage therapy once or twice a month because of stiffness in her neck."

(RX 17). Petitioner was awarded compensation representing loss of use of 25% of the body as a whole. Significantly, there is no mention of further numbness and tingling in her hands and arms as comprising any part of her permanent partial disability.

Second prior accident (cervical spine injury): Regarding the second accident, the subject of case no. 12 WC 15647, it was alleged that Petitioner fell on ice on Respondent's premises on January 23, 2011, thereby sustaining injury that eventually necessitated 2-level cervical disc replacement surgery, performed on December 12, 2012.

Notably, Petitioner's complaints immediately after the slip-and-fall of January 23, 2011 were of pain in the neck and left shoulder area. However, by February 1, 2011 her complaints were now including symptoms going down her left arm. These left upper extremity symptoms would come to be reported as numbness and tingling in the hand and pain radiating down the left arm. These complaints are documented in the medical records of primary care physician Dr. Mark Preuss of Steeleville Clinic, who began treating Petitioner the day after the slip-and-fall. (RX 10).

As noted in Dr. Preuss's records, over the next few months Petitioner's neck pain improved, but not her left arm complaints. By May 20, 2011, Dr. Pruess raised the possibility that her persistent left arm complaints could be symptoms of a cervical radiculopathy or carpal tunnel syndrome. (RX 10 at 9). To determine the origin of her left arm symptoms, an EMG study was done by Dr. Amar Sawar on June 10, 2011. (RX 12). The results were negative for both cervical radiculopathy and cubital tunnel syndrome. There was, however, some evidence of a mild left median neuropathy at the wrist, i.e., carpal tunnel syndrome. (RX 10 at 27; RX 12 at 5). Dr. Preuss reviewed these EMG results and, possible mild CTS notwithstanding, believed that there was no further warrant for Petitioner to continue her absence from work (records suggest that Petitioner had not been at work for some time, perhaps since the slip-and-fall). On June 20, 2011, Dr. Preuss wrote:

> "I told Christina at this point I feel she could return to work, obvious care taken to avoid further neck troubles. She should make sure she doesn't do work above shoulder, lifting above shoulder.... I told her ultimately her carpal tunnel may become an issue. If it becomes more symptomatic wear a cockup splint at night at this point."

(RX 10 at 11). At any rate, Dr. Preuss' notes indicate that throughout the remainder of 2011 and into early 2012, Petitioner's neck pain and left arm symptoms continued to evolve. By early 2012, she also had been experiencing near-daily nausea and headaches for some time. In March 2012, Dr. Preuss referred her to Dr. Matthew Gornet. (RX 10 at 13-14).

As mentioned above, Dr. Gornet performed cervical disc replacement (at C5-6 and C6-7) in December 2012. For this cervical spine injury, Petitioner would receive, via settlement contract, compensation representing 21% loss of use of the person.[1]

Current alleged accident (bilateral CTS): While she was still off-work following Dr. Gornet's cervical spine surgery, Petitioner was examined by Dr. Nathan Mall, on March 29, 2013. On her intake questionnaire, Petitioner reported "pain, numbness in arms," especially at the wrist and elbows, which pain was made worse "by opening doors, chuck holes." She indicated the date of January 23, 2011 as the date of onset. (PX 3). Significantly, according to Dr. Mall's notes, during the visit, Petitioner related that she had a "nerve conduction study in the past, which demonstrated carpal tunnel syndrome prior to her thoracic outlet syndrome surgery by Dr. Thompson."[2] (As mentioned above, that study – done by Dr. Phillips 4 years earlier, in spring 2009 – was negative for CTS and cubital tunnel syndrome.)

Dr. Mall's physical examination of her was positive for Tinel's bilaterally, positive Tinel's at the left elbow, and positive Phalen's bilaterally. Dr. Mall assessed bilateral carpal tunnel syndrome and left-sided cubital tunnel syndrome and ordered a new nerve conduction study. (PX 3 at 1). Again, it was Dr. Phillips who was called upon to perform this study. Again, the EMG/NCS (done on April 2,2013) did not disclose evidence of carpal or cubital tunnel syndrome. (PX 5).

Nevertheless, on April 5, 2013, Dr. Mall administered diagnostic injections into the carpal tunnel in her wrists, after which Petitioner reported significant but temporary improvement. Dr. Mall proceeded to perform carpal tunnel release surgeries on the left, then right side, on May 28, 2013 and June 20, 2013. Dr. Mall noted good recovery. About three weeks after her second CTS surgery (and, curiously, on the virtual eve of her scheduled return to work after Dr. Gornet's cervical spine surgery; the return-to-work date was July 15, 2013), Petitioner notified Respondent for the first time of her alleged CTS. (Tr. 41). On July 11, 2013, she submitted an incident report, wherein she indicated June 20, 2013 as the date of loss (this was the date of final carpal tunnel surgery done by Dr. Mall.) The narrative portion of this incident report was completed by her husband (and fellow correctional officer) Jeff Gieselmann, who wrote:

> "On the above date this reporting officer had been referred to Dr. Nathan Mall for symptoms relating to carpal tunnel, which had been ongoing since a prior work-related

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[1] The settlement contract was approved on January 12, 2015 by Arbitrator Nowak. The settlement contract indicated that her return-to-work date was July 16, 2013.

[2] Dr. Mall's April 5, 2013 note also states that she related "she had initial injury in March 2009 in which she felt a pinch in her back while opening a trap door, suffered a fractured rib and was diagnosed with thoracic outlet syndrome for which she had surgery by Dr. Thompson." (RX 3 at 4). This is not consistent with Arbitrator Dibble's July 2010 decision, wherein he noted the parties' stipulation that Petitioner's thoracic outlet syndrome was developed through repetitive activity (not acute incident).

> injury. Dr. Mall sent this reporting officer for a nerve conduction test conducted by Dr. Phillips. The results of this testing [were] reviewed by Dr. Mall [who] concluded in order to be sure, he would do injections in both wrists. The results from injections concluded surgery would relieve the repetitive motion/work related injury; left and right carpal tunnel were operated on 5/28/13 and 6/20/13. This reporting officer was already off work since 9/25/12 for a work-related injury prior to this date. This reporting officer is currently still off work from a work-related injury."

(PX 16).

At hearing in the instant matter, Petitioner alleged that the thoracic outlet surgery of June and August 2009 improved certain complaints to her neck and shoulder – but not her hand symptoms, which, it is now claimed, apparently persisted. (Tr. 34). (This claim of persistent hand symptoms, including tingling, is made despite the fact that these same, CTS-like symptoms were what prompted the thoracic outlet surgery in the first instance, and this surgery was touted as effective during the permanency hearing before Arbitrator Dibble.) Yet, she did not seek evaluation for these allegedly continuing hand symptoms until her attorney sent her to Dr. Mall in March 2013. She could provide no explanation for the nearly 4-year gap between her thoracic outlet surgery and presentation to Dr. Mall, other than she was "still dealing with problems in her neck" -- presumably from the January 2011 slip-and-fall. (Tr. 22). This testimony leaves unaddressed the fact that about a year and a half passed between her thoracic outlet surgery and the January 2011 fall, without her seeking any treatment for her hand symptoms.

Petitioner testified that after Dr. Mall's carpal tunnel release surgeries, she got "a whole bunch of relief." Most of the numbness and tingling went away. Her hands still go to sleep once in a while and she does not have the same strength in her hands as she did before. (Tr. 35-36). At the time of hearing, Petitioner had been on leave for about a year due to non-CTS reasons (including emphysema). (Tr. 36).

EXPERT OPINIONS

Expert medical opinions in the instant case included evidence deposition testimony provided by Dr. Nathan Mall and Dr. Anthony Sudekum, as discussed below.

A. Dr. Nathan Mall (treating physician April 2013 – August 2013)

Dr. Mall treated Petitioner from April to August 2013. He was deposed on February 13, 2014. (PX 13). He proffered opinions favorable for Petitioner regarding CTS diagnosis and causation. According to Dr. Mall, his CTS diagnosis was based on Petitioner's subjective complaints and physical examination findings. He further cited Petitioner's reports of improvement after diagnostic carpal tunnel injections and of great relief after the release surgeries as supportive of the correctness of his CTS diagnosis.

As for Dr. Phillips' negative electrodiagnostic results -- in both 2009 and 2013 -- Dr. Mall demurred that these tests are not 100% accurate. A major theme of Dr. Mall's testimony is that CTS is "a clinical diagnosis and a clinical diagnosis only." (PX 14 at 7-8). On cross-examination, however, he admitted that the Clinical Practice Guidelines on the Diagnosis of Carpal Tunnel Syndrome, published by the American Academy of Orthopedic Surgeons, states that CTS cannot be diagnosed primarily on clinical grounds. (PX 14 at 36). Dr. Mall further admitted the Guidelines state that clinical tests for

CTS by themselves do not reliably diagnosis CTS, and that good response to surgery does not confirm a diagnosis of CTS. (PX 14 at 37-38). Prior to his treatment of Petitioner, Dr. Mall did not have (and apparently never did have) the 2009 records of Dr. Brown, Dr. Phillips, or Dr. Thompson regarding her thoracic outlet syndrome and surgery. (PX 14 at 33).

B. Dr. Anthony Sudekum, Section 12 examiner

Dr. Sudekum, board-certified hand surgeon, examined Petitioner at Respondent's request on June 17, 2013. He authored a narrative report and was deposed on April 14, 2014. (RX 6; RX 7). Dr. Sudekum's opinion was that Petitioner's work at the medium security unit did not involve any activity that would be significant in terms of causation or aggravation of CTS (again, Petitioner was transferred to the medium security unit in early 2007). (RX 7 at 35). He opined that Petitioner did not describe any symptoms of carpal or cubital tunnel symptoms while working at the maximum security unit, and it is likely she did not have those problems as a result of her work at the maximum security unit. (RX 7 at 78). He disagreed with Dr. Mall's diagnosis of CTS, citing the fact that there was no objective evidence of CTS (that is, multiple EMG tests had disclosed no CTS), and he questioned the propriety of Dr. Mall basing his decisions on Petitioner's subjective responses to physical examination tests for CTS (including her subjective report that the diagnostic wrist injections gave her relief), especially in light of her history. He did not feel that the CTS surgeries were indicated.

DISCUSSION

Whatever the nature and cause of Petitioner's condition of ill-being, the Commission finds that neither the nature nor cause thereof has been proven to be what Petitioner alleges them to be. That is, the Commission finds that Petitioner: (1) has not proven that her current condition of ill-being is carpal tunnel syndrome (or any peripheral compression neuropathy); and (2) has not proven that her condition is causally connected to her employment. Further, she has failed to provide timely notice to Respondent, even assuming *arguendo* that her condition is CTS (or other peripheral compression neuropathy) brought on by work-related repetitive use.

Regarding her failure to prove that any condition of her ill-being was CTS, the Commission assigns great significance to Dr. Phillips' electrodiagnostic studies from 2009 and 2013, which were both negative for carpal tunnel syndrome or any peripheral nerve compression. It is true that Dr. Sawar's test in June 2011 indicated that there was evidence of mild left CTS; however, Dr. Pruess did not consider this finding meaningful and had even returned Petitioner to work upon receiving Dr. Sawar's report.

Further, whatever her true condition is, she has failed to prove that this condition was brought on by repetitive use activity on the job or was otherwise work-related. In this regard, the Commission finds the opinions of Dr. Sudekum persuasive. That Petitioner has already been compensated for repetitive-activity-induced thoracic outlet syndrome – asserted at the time to have given rise to the same numbness and tingling in her arms and hands – suggests that her current claim of CTS is akin to an act of "double dipping."

Finally, even assuming *arguendo* that Petitioner had a current condition of CTS (and that it was work-related), her claim fails for her untimely notice to Respondent. As already mentioned, Petitioner testified that her first notification to Respondent of her asserted work-related CTS was through the incident report dated July 11, 2013. At hearing, Petitioner claimed that she became aware of her alleged CTS when Dr. Mall advised her of it, either during the first visit to Dr. Mall (March 29, 2013) or when Dr. Mall administered wrist injections (April 5, 2013). (Tr. 83). It should be noted that the date of manifestation as reflected in her hearing testimony is inconsistent with the dates proffered in her incident report (June 20, 2013, the date of her second CTS surgery) and in her Application for Adjustment of Claim (May 28, 2013, the date of her first CTS surgery). (Arbitrator Nowak found that May 28, 2013 date was an appropriate manifestation date and that proper notice to Respondent had been provided.)

The date of manifestation for repetitive trauma injuries is the date on which the claimant became aware of the condition and reasonably should have known it may be work-related. *Peoria County Bellwood Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524 (1987). The Commission finds that all proffered manifestation dates described above are invalid. The Commission further finds that Petitioner became aware of her condition, and reasonably should have known that it was work-related, likely by June 10, 2011. As mentioned above, Dr. Sawar performed an EMG study that day. This study disclosed some evidence of mild left carpal tunnel syndrome. At hearing, Petitioner claimed that Dr. Sawar never told her that she had carpal tunnel syndrome and/or he never advised her the CTS was work-related. (Tr. 40). This testimony strains credulity[3]. However, even were it to be believed that Dr. Sawar did not advise her of her test results, the Commission finds that Dr. Preuss advised her of those results on June 20, 2011, as indicated in his medical records (and as discussed above). Ultimately, with regard to the notice issue, her claim that she did not understand that her hand numbness and tingling – dating as far back as 2008 – were symptoms of CTS and/or that the CTS was work-related until March or April or May of 2013– is simply not believable.

IT IS THEREFORE ORDERED BY THE COMMISSION that the decision of Arbitrator Nowak filed March 17, 2016, is hereby reversed as discussed above. Benefits denied.

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[3] She also professed ignorance or inability to recall references to hand numbness, tingling, and carpal tunnel syndrome contained in the records of Dr. Brown and Dr. Phillips in 2009. Also, Dr. Mall's record of March 29, 2013 contained the notation that Petitioner related that Dr. Thompson advised her that she had a "significant chance of developing symptoms relating to carpal tunnel syndrome following her thoracic outlet surgery." She denied this at hearing. (Tr. 55, 57-59, 76-77).

18IWCC0080

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 the alleged accidental injury.

DATED: FEB 5 - 2018

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

o-12/06/17
jdl/ac
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GIESELMANN, CHRISTINA
Employee/Petitioner

Case# **13WC030843**

STATE OF ILLINOIS/MENARD CORR CTR
Employer/Respondent

18IWCC0080

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:

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
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

MAR 17 2016

Ronald A. Rascia, Acting Secretary
Illinois Workers' Compensation Commission

18IWCC0080

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

Christina Gieselmann
Employee/Petitioner

v.

State of Illinois/Menard Corr. Ctr.
Employer/Respondent

Case # **13** WC **30843**

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 **May 20, 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 **May 28, 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 **$57,425.00**; the average weekly wage was **$1,104.33**.

On the date of accident, Petitioner was **43** years of age, ***married*** with **0** dependent child(ren).

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

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

Respondent shall be given a credit of $- 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 the reasonable and necessary medical services of $24,793.10, pursuant to the medical fee schedule, as provided in § 8(a) and § 8.2 of the Act.

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

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, Respondent shall pay Petitioner the sum of $662.60/week for 47.5 weeks, because the injuries sustained caused the 12.5% loss of the right (23.75 weeks) and left hands (23.75 weeks), as provided in § 8(e) of the Act.

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

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

Michael K. Nowak, Arbitrator

2/16/16
Date

FINDINGS OF FACT

Petitioner began her career with Respondent in March of 1999 as a Correctional Officer (CO) in the Menard Correctional Center maximum security facility. She worked for 7 1/2 years in the maximum security facility performing the same job duties. (T.15).

The record contains an extensive amount of evidence regarding Petitioner's job duties. Both parties offered into evidence a CorVel Job Site Analysis procured at Respondent's request. (PX9, RX4) Both parties also offered a DVD produced at Respondent's direction which depicts the job duties of a CO. (PX10, RX5) In addition, Respondent offered a "position description" pertaining to a Menard CO. (RX8) Petitioner's Job Description was also admitted into evidence. (PX15)

The Correctional Officer DVD depicts various job tasks, assignments, areas, equipment and mechanisms demonstrated by a variety of Correctional Officers. (PX10). Depictions included the armory, shakedown officer, bar rapping, double gate door, double gate walkway, opening cell doors, turning gallery cranks, receiving control house, control room, receiving door, shower door segregation, shower door, segregation unit, segregation door, chuckholes, double gate, and tower. *Id.* Each area required opening and closing multiple doors and using multiple keys, including Folger Adams keys. *Id.* Bar rapping is conducted on the 7-3 and 3-11 shifts. *Id.* Officers perform bar rapping at the beginning of each shift on the gallery where they are assigned. *Id.* There are 55 cells per gallery. *Id.* The officer in the DVD held a metal bar with his right hand and struck the bars of the cell approximately 60 times to demonstrate bar rapping on 1 cell (5 to 6 bars vertically in 12 separate sections, each bar struck 1 time). Some galleries have half solid doors and half open bars, but Correctional Officers may also be assigned to more than one gallery per day. *Id.* Both hands are used to complete tasks. *Id.*

Petitioner testified that she reviewed Respondent's DVD, and stated that it did not accurately depict the duties of a Menard Correctional Officer in that:

> Well, it doesn't tell you the pace that an officer works. Anybody can go by a cell and unlock it for anybody but for them to line out for chow, the library or wherever you're just going and turning the keys and getting everybody off deadlock, the whole gallery, and you do the same thing back, you shut the gates, you pull and make sure they're locked after you get everybody out, get everybody back on deadlock so it's – it depends on which house you're in. (T.16).

Respondent's "Demands of the Job" form indicates that Petitioner uses her hands for gross manipulation (grasping, twisting, handling) for 2 to 4 hours per day, and fine manipulation (typing, good finger dexterity) for up to 2 hours per day. (RX1 at 10)

The CorVel Job Site Analysis classifies the strength demands of a Menard Correctional Officer as medium. (PX9; RX4). According to the analysis, Correctional Officers engage in frequent lifting and/or carrying up to 25 pounds; frequent being defined as 2.5 to 5.5 hours per day, 34% to 66% of a day, or between 33 to 200 repetitions per day. *Id.* Correctional Officers are required to frequently pull open doors from 2 ½ hours to 5 ½ hours per day, up to 66% of the time, or up to 200 times per day. *Id.* This includes pulling open chuckhole doors as needed during lockdowns for dining, and cuffing and uncuffing residents. *Id.* Wrist turning is required 34-66% of the time, 2 ½ hours to 5 ½ hours per day, or 33 to 200 times per day. *Id.*

Petitioner testified that she reviewed the CorVel Job Site Analysis and the "Demands of the Job" form generated by Respondent and agreed with the information they contained. (T.15, 16).

Petitioner testified that doors at Menard are opened by using a Folger Adams key. (T.17). She testified that turning Folger Adams keys requires grip force and strength because the lock mechanism has to disengage or push up a bar in the ceiling, which in turn allows the door to be opened. (T.17). Petitioner also testified that Respondent's locks do not always work, and when she cannot open a lock with her best effort using both hands, she has to find someone who can open it for her. (T.17). Petitioner testified that the heavy sliding steel doors at Menard also require force to open. (T.18). She testified, "They're heavy because you have to put all your weight and just pull it back." (T.18). Petitioner testified that every 30 minutes, wing checks are performed, which involves pulling on doors to make sure they are secure. (T.69). She testified that Respondent's chuckholes were also difficult to open, because they stick due to the fact that inmates sabotage or damage them with "whatever they can put in there" including bodily waste and gum. (T.21). She testified that when a chuckhole does not close properly, she has to "bang on it" to get it closed. (T.21). Petitioner testified that she also performed bar rapping. (T.19). In addition to turning thousands of keys, opening thousands of doors, and rapping thousands of bars, Petitioner also performed shakedowns and searched cells top to bottom for contraband. (T.19, 20). This required that she lift property boxes, some of which Petitioner testified she could not pick up. (T.20, 21). Petitioner also cuffed and uncuffed inmates. (T.26). Petitioner testified that her hands were tired and tingling at the end of her shift. (T.22).

After 7 1/2 years at Respondent's maximum security unit, Petitioner transferred to the medium security unit and continued working as a Correctional Officer. (T.23). She testified that most of her time, approximately 80 percent, was spent as a wing/gallery officer. (T.24, 26). The chuckholes at the medium security unit were also opened with a Folger Adams key, and inmates had to be manually keyed out for insulin or of the facility was on deadlock or lockdown. (T.24, 25). Petitioner continued to perform shakedowns and property box checks, cuff and uncuff inmates. (T.25, 26). Petitioner entered a job description of outlining her duties as a Correctional Officer in the medium security unit as Petitioner's Exhibit 14. (PX14). Respondent's witness, Major Rees testified that Petitioner's testimony and written description as to her duties on the medium security unit is accurate. (T.88, 89).

Petitioner testified that she did not seek evaluation for hands because she was dealing with problems in her neck. (T.22). Petitioner sustained accidental neck and back injuries on January 23, 2011 when she slipped and fell on ice. Petitioner was treated by Dr. Gornet for her neck condition which ultimately required surgery. Petitioner also developed thoracic outlet syndrome which required surgery. Petitioner testified that her neck, shoulder and upper back complaints improved markedly as a result of her treatment. (T.28) Petitioner was off work from September 21, 2012 until July 15, 2013 due to these injuries. The symptoms in her hands persisted while she was off work for the aforementioned injuries and treatment. (T.29).

On March 29, 2013 Petitioner sought treatment with Dr. Nathan Mall. Petitioner testified that prior to her visit with Dr. Mall she had never been diagnosed with work-related carpal tunnel or cubital tunnel syndrome. (T.29). Petitioner testified that she knew her condition was work-related when she was so advised by Dr. Mall on March 29, 2013. (T.52, 53). Dr. Mall's physical examination revealed a positive flexion compression test at the wrist bilaterally, positive Tinel's bilaterally at the wrist, and positive left elbow Tinel's. (PX3, 3/29/13). Dr. Mall believed Petitioner suffered from bilateral carpal tunnel syndrome and left cubital

tunnel syndrome. *Id.* Dr. Mall noted that Petitioner's 14 years of employment with Respondent was a contributing factor in the development of these conditions, especially given that Petitioner had no repetitive or intensive hobbies outside of work that would contribute. *Id.* He recommended nerve conduction studies which were negative. (PX3, 4/5/13). Yet, Petitioner's physical examination remained markedly positive for bilateral carpal tunnel syndrome and left cubital tunnel syndrome. *Id.* Dr. Mall noted that EMG/NCS are not always 100% accurate in diagnosing carpal and cubital tunnel syndrome. He therefore recommended using carpal tunnel injections as another diagnostic test, as well for their therapeutic effects. *Id.* Dr. Mall wrote "I do think that this is a work related injury and that her job entailing multiple opening and closing of doors and locks has contributed and caused her bilateral carpal tunnel syndrome." *Id.* His plan was to "wait and see her response to the injections. If she gets no response to these then I am not sure how to explain her symptoms. If she does get a good response from these injections, this is a good indication that she will get a good response from a carpal tunnel release." *Id.*

Petitioner reported almost complete relief of her symptoms with the carpal tunnel injections. (PX3, 4/27/13). Dr. Mall indicated that this positive outcome proved that Petitioner was suffering from carpal tunnel syndrome and was a good indication that Petitioner would benefit from carpal tunnel releases if her symptoms returned. *Id.* Dr. Mall recommended physical therapy with stretching and strengthening of her forearm musculature and prescribed anti-inflammatory medication. *Id.* When Petitioner returned on May 20, 2013, the carpal tunnel injections had worn off and Petitioner's symptoms returned. (PX3, 5/20/13). Dr. Mall also noted symptoms of medial epicondylitis. *Id.* Dr. Mall recommended bilateral carpal tunnel releases and injection into the elbows. *Id.*

Dr. Mall performed surgery on her left wrist on May 28, 2013 and her right wrist on June 20, 2013. Following surgery Dr. Mall referred Petitioner for therapy. (PX3, 6/14/13; 7/3/13; PX7). Petitioner was much improved following surgery and was released to full duty work on July 31, 2013. (PX3, 7/31/13). When she returned for follow up on August 28, 2013 Petitioner reported that while her numbness and symptoms dissipated significantly, she had aches and pains with the performance of job duties such as pulling heavy doors shut. (PX3, 8/28/13).

Petitioner attended a §12 examination with Dr. Anthony Sudekum on June 17, 2013. (RX6) Dr. Sudekum did not feel that Petitioner's conditions were related to her employment with Respondent. (RX6). He did not believe that Petitioner suffered from carpal tunnel syndrome, cubital tunnel syndrome, or epicondylitis on either side; and he did not believe the surgical procedures were indicated. *Id.*

Dr. Sudekum testified that a clinical examination for both carpal and cubital tunnel syndrome would include both Tinel's and Phalen's tests. (RX7, p.10-12). He testified that these tests are used to diagnose both carpal tunnel syndrome and cubital tunnel syndrome. *Id.* He noted that Petitioner's examination by Dr. Phillips in 2009 was benign for carpal or cubital tunnel syndrome. *Id.*, at 16, 17. He further indicated that Dr. Mall's physical examination revealed "very significant abnormalities in [Petitioner's] bilateral hands. *Id.* at 20.

Dr. Sudekum testified that the duties of a Correctional Officer in the maximum security unit of Menard CC were potentially an aggravating factor in the progression of carpal tunnel syndrome. *Id.* at 30-31, 35-36. He testified that bar rapping and the heaviness of the doors were provocative factors. *Id.* at 35-36. He did not believe that the duties performed at the medium security unit, however were sufficient to aggravate carpal or

cubital tunnel syndrome. *Id.* at 35. Dr. Sudekum testified that neither Petitioner's work at the maximum or minimum security facility at Menard was a factor in her condition of ill-being. *Id.* at 75. His belief that the duties performed at the maximum security facility were not factors in this case was based upon the fact that Petitioner had no symptoms while working at the maximum security facility. *Id.*, at 77-78.

Dr. Sudekum testified that he performs diagnostic injections in his practice. *Id.* at 70, 71. They can be used to determine whether a certain nerve is responsible for symptoms. *Id.* at 71. He acknowledged that Dr. Mall performed these types of injections in Petitioner's wrists for diagnostic and therapeutic reasons and he took no issue with Dr. Mall's use of this procedure. *Id.* at 71-72. He acknowledged that Petitioner responded favorably and obtained good relief from Dr. Mall's carpal tunnel injections and following her left carpal tunnel release. *Id.* at 72.

Petitioner was examined by Dr. Richard Katz on January 28, 2014 pursuant to §12 of the Act in order to obtain an impairment rating. Dr. Katz is a physiatrist and does not practice any sort of surgery. He testified that he was asked to evaluate Petitioner's neck, bilateral carpal tunnel and left sided cubital tunnel. (RX3 at 37). Dr. Katz indicated that according to the AMA Guides no impairment rating "is to be given for a focal neuropathy unless there are abnormal nerve conduction studies and EMG findings." *Id.*, at 22. In his report, Dr. Katz clearly indicated he was "rating only the neck pain today." (RX2, p. 15). Despite the fact that he was hired to provide an AMA impairment rating for Petitioner's upper extremity conditions, Dr. Katz also provided opinions regarding Petitioner's conditions (or the lack there of) and the relationship between the conditions and her employment. (RX2; RX3).

Dr. Katz's did not believe that Petitioner suffered from carpal tunnel syndrome because her electrodiagnostic testing was negative. (RX2; RX3) He believed that the Tinel's and Phalen's tests were debatably no better than "flipping a coin." *Id.* at 52. Dr. Katz opined that Petitioner's employment played no role in her condition, and attributed the success of Petitioner's surgery to a "strong placebo effect." *Id.* at 49. In his view, carpal tunnel syndrome is an "idiopathic" condition. (RX3, p.25, 26). Dr. Katz had no knowledge regarding any pertinent details about Menard Correctional Center or the conditions at the facility. *Id.* at 41-46. He had no knowledge of the Job Site Analysis, Demands of the Job form, the DVD, or the post description of a Correctional Officer. *Id.* He did not know how doors and chuckholes were opened. *Id.* at 45, 46. When asked if he would "have liked to have been provided with" more detailed information regarding Petitioner's job duties Dr. Katz replied:

> [n]o, because I was asked to do an impairment rating in terms of whether she has impairment related to carpal tunnel syndrome and ulnar neuropathy is entirely invalidated by the fact that she has no positive nerve conduction studies. If you have normal nerve conduction studies you don't end up with an impairment rating, that's all I was asked to do here. *Id.*, at 73.

Yet he indicated that none of Petitioner's work activities would cause or aggravate carpal tunnel syndrome. *Id.*, at 21-22. The Arbitrator found Dr. Katz to be evasive in his testimony.

Petitioner's surgeon, Dr. Mall, testified by way of deposition. (PX14). He regularly treats carpal and cubital tunnel syndrome. *Id.* at 5, 6. Dr. Mall explained that carpal tunnel syndrome is a clinical diagnosis which is made as a result of the effects of increased compression of the median nerve at the wrist. *Id.* at 7. He

testified that cubital tunnel is very similar, except that it involves the ulnar nerve. *Id.* at 8. When asked to explain how patients can have symptoms of carpal or cubital tunnel syndrome but have negative nerve studies, he explained that carpal tunnel and cubital tunnel syndrome are clinical diagnoses, based on the patient's history and physical examination, and nerve conduction studies are only used for confirmation. *Id.*, at 9-10. He further indicated that there is a 10 to 15 percent false negative rate with even the best electrodiagnosticians, and in those situations, "we have to try to figure out other ways to confirm the diagnosis." *Id.* Dr. Mall testified that his diagnosis was confirmed by the results of the ultrasound-guided injections that he performed into Petitioner's carpal tunnel bilaterally, as Petitioner obtained nearly complete relief of her symptoms from same. *Id.* at 10.

Dr. Mall also pointed out that even in cases where the diagnosis is not confirmed surgery is sometimes offered. He indicated there are papers published which indicate that in such cases "you have a good to excellent result rate of anywhere between 90 to 98 percent. So in that situation when the history and physical examination meet the criteria for a diagnosis of carpal tunnel syndrome, then you can pretty much go ahead and actually do surgery on them and you can expect at least 90 to 98 percent of them will get good to excellent results. *Id.* at 9-10. Dr. Mall also noted that Petitioner had almost complete resolution of her symptoms following her carpal tunnel surgeries. *Id.* at 11. He anticipated that Petitioner would have some post-operative symptoms and stated "The longer the nerves [have been] compressed, the longer it takes for them to get complete recovery." *Id.* at 12.

In terms of causal connection Dr. Mall testified that Petitioner was not obese, and whether or not female gender is an increased risk is debated in the literature. *Id.* at 12-13. He also testified that there is no history of hypothyroidism, diabetes or gout. *Id.* at 13. With regard to occupational risk factors, Dr. Mall testified that the literature states that any kind of repetitive gripping activities or heavy gripping activities in general, repetitive flexion/extension of the wrist, and repetitive supination/pronation of the wrist are considered potential risk factors. *Id.* at 14-15. Dr. Mall reviewed the materials pertaining to the duties of a Menard Correctional Officer. *Id.* at 13. He reviewed the Job Site Analysis, the Demands of the Job form the DVD, the April 2011 report and June 2011 deposition of Dr. Sudekum pertaining to the duties of a Menard Correctional Officer, and the report of Dr. Katz. *Id.* at 13-14. Dr. Mall opined that the activities described on Respondent's Demands of the Job form, use of the hands for 2 to 4 hours per day for fine and gross manipulation (4 to 8 hours total usage), "would definitely contribute to carpal tunnel syndrome." *Id.* at 17-18. He further testified that the activity delineated in Respondent's Job Site Analysis - lifting and/or carrying 25 pounds from 2.5 to 5.5 hours per day, and wrist turning for 2.5 to 5.5 hours per day - would likewise contribute to the development of carpal tunnel syndrome. *Id.* at 18-19. He testified that the bar rapping that Petitioner did while at the maximum security unit as well as the use of Folger Adams keys were also contributing factors in the development of her disease,. *Id.* at 20-21. He testified that Petitioner's employment with Respondent involved job duties which are "clearly the activities . . . noted multiple times in several papers to be the activities that place patients to be at a higher risk for the development of carpal tunnel syndrome." *Id.* at 21-22.

Consistent with the medical records, Petitioner testified that most of her symptoms resolved as a result of Dr. Mall's treatment. (T.35). Despite the improvement from surgery, however Petitioner's hands still "go to sleep once in a while," and she notices reduced strength in her hands. (T.35, 36). Dr. Mall recommended that Petitioner take anti-inflammatory medication for her symptoms. (PX3, 8/28/13).

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?

An injury is 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. Industrial Commission*, 128 N.E.2d 718, 720 (Ill. 1955); *General Electric Co. v. Industrial Commission*, 433 N.E.2d 671, 672 (Ill. 1982). In a repetitive trauma case, issues of accident and causation are intertwined. *Elizabeth Boettcher v. Spectrum Property Group and First Merit Venture*, 99 I.I.C. 0961 (1999). Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it is a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672-73 (Ill. 2003) (emphasis added). As in establishing accident, to show causal connection Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury. *Fierke v. Industrial Commission*, 723 N.E.2d 846 (3rd Dist. 2000).

In *Edward Hines Precision Components v. Indus. Comm'n*, 825 N.E.2d 773, (2nd Dist. 2005). the Court expressly stated, "There is no legal requirement that a certain percentage of the workday be spent on a task in order to support a finding of repetitive trauma." *Id.* at N.E.2d 780. Similarly, the Commission recently noted in *Dorhesca Randell v. St. Alexius Medical Center*, 13 I.W.C.C. 0135 (2013), a repetitive trauma claim, a claimant must show that work activities are a cause of his or her condition; the claimant does not have to establish that the work activities are the sole or primary cause, and there is no requirement that a claimant must spend a certain amount of time each day on a specific task before a finding of repetitive trauma can be made. *Randell* citing *All Steel, Inc. v. Indus. Comm'n*, 582 N.E.2d 240 (2nd Dist. 1991) and *Edward Hines supra.*

The Appellate Court in *City of Springfield v. Illinois Workers' Comp. Comm'n*, 901 N.E.2d 1066 (4th Dist., 2009) issued a favorable decision in a repetitive trauma case to a claimant whose work was "varied" but also "repetitive" or "intensive" in that he used his hands, albeit for different task, for at least five (5) hours out of an eight (8) hour work day. *Id.* "While [claimant's] duties may not have been 'repetitive' in a sense that the same thing was done over and over again as on an assembly line, the Commission finds that his duties required an intensive use of his hands and arms and his injuries were certainly cumulative." *Id.*

The Appellate Court recently highlighted in *PPG Indus. v. Illinois Workers' Comp. Comm'n*, A claimant's entire work history is relevant and routinely considered in repetitive trauma cases because, "[b]y their very nature, repetitive-trauma injuries may take years to develop . . ." *PPG Indus. v. Illinois Workers' Comp. Comm'n*, 22 N.E.3d 48, 51, (2014). Prior Commission decisions are consistent with this view, even when the employee was previously employed by a different employer, when the claimant switched to less intensive employment, or when the claimant retired altogether when the injuries manifested. *See Lemes v. Peko Tile, Inc.*, 07 I.W.C.C. 1545 (2007) (holding the current employer with which the injury manifested itself liable for the entire claim when both employers contributed to the development of the resulting injury); *See Rachel Vasquez v. Menard Correctional Center*, 10 I.W.C.C. 0826 (2010) (where claimant's condition did not improve after she switched to a non-repetitive job and the Commission held the previous employer liable after the termination of the employer/employee relationship); *Mastrangeli v. Illinois State Toll Highway Authority*, 12 I.W.C.C. 1371 (2012) (wherein claimant's condition worsened after retiring); *See also A.C.& S. v. Indus. Comm'n*, 710 N.E.2d 837 (Ill. App. 1st Dist., 1999); and *White v. Illinois Workers' Comp. Comm'n*, 873 N.E.2d 388 (Ill. App. 4th

Dist. 2007) (holding that repetitive injuries can manifest after the termination of the employer/employee relationship).

The Arbitrator finds that Petitioner was a credible witness. In this case, the evidence shows that Petitioner used her hands and arms extensively during the performance of her job duties for Respondent. Further, the Arbitrator finds the opinions and testimony of Mall much more persuasive than those of Dr. Sudekum and Dr. Katz in this case.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met her burden of establishing that she sustained accidental injuries which arose out of and in the course of her employment with Respondent and that her current condition(s) of ill-being are causally related to the employment.

Issue (D): What was the date of the accident?
Issue (E): Was timely notice of the accident given to Respondent?

The Workers' Compensation Act is a humane law of a remedial nature that should be liberally construed to achieve its purpose. *Hagene v. Derek Polling Const.*, 388 Ill. App. 3d 380, 902 N.E.2d 1269 (2009). Hence, the Supreme Court has established a flexible but fair standard for determining manifestation dates in repetitive trauma claims. *Durand v. Industrial Commission*, 224 Ill.2d 53, 862 N.E.2d 918 (Ill. 2007). Although the date on which the employee becomes aware that he has a condition related to work was the first method for determining a manifestation date, it is not the only permissible means for alleging or proving manifestation. The manifestation date can be set as: (a) the date the employee actually became aware of the physical condition and its relation to work through medical consultation; (b) the date the employee requires medical treatment; (c) the date on which the employee can no longer perform work activities; or (d) when a reasonable person would have plainly recognized the injury and its relation to work. *Durand v. Industrial Commission*, 224 Ill.2d 53, 862 N.E.2d 918 (Ill. 2007), *see also Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill.2d 524, 505 N.E.2d 1026 (Ill. 1987); *Oscar Mayer & Co. v. Industrial Commission*, 176 Ill.App.3d 607, 531 N.E.2d 174 (3rd Dist. 1988); *Three "D" Discount Store v. Industrial Commission*, 198 Ill.App.3d 43, 556 N.E.2d 261 (4th Dist. 1989). The method for determining the manifestation date for repetitive injuries is flexible and liberally construed depending upon the facts of the case.

Although a claimant is aware of symptoms and carries a suspicion that these are work-related, the Supreme Court has stated, "The 'fact of injury' is not synonymous with the 'fact of discovery'" *Durand,* N.E.2d at 927. Claimants are not charged with filing a claim as soon as they believe they may have a work-related condition, nor are they penalized for failing to realize a condition is work-related when the employer feels that he or she should have. The Supreme Court stated that to rely solely on a claimant's testimony concerning symptoms, without accurate knowledge of the cause of those symptoms, would essentially be asking them to "rely on 'expert' medical testimony from a layperson." *Id.* at 929. The Court also recognized that claimants would have had difficulty proving injury with a sketchy and equivocal understanding of the cause of their symptoms. *Id.* at 930. The standard that "the 'fact of injury' is not synonymous with the 'fact of discovery'" has since become a safety measure employed by all Courts to ensure that the employers do "penalize an employee who diligently worked through" his or her symptoms. *Durand v. Indus. Comm'n*, 862 N.E.2d at 927, 930. In *Durand*, the claimant was not sure her pain was from carpal tunnel syndrome, but "she believed it was work-

related" in 1997, some 3 years before her injuries manifested in 2000. *Durand v. Indus. Comm'n*, 862 N.E.2d at 929-30.

In *Oscar Mayer*, the Court embraced the "date of collapse" method of determination, setting the manifestation date on the date of surgery, or the date the employee could no longer work. Compensation was awarded to a claimant, despite his full knowledge that his condition was work-related well before he filed a claim, because the claimant diligently served his employer until he could no longer do so without intervention for his repetitive injuries. *Oscar Mayer supra.* The Court noted that no prejudice can occur in employing such a method, since it is not until the employee actually misses work for his injuries that the employer becomes adversely affected; and the notice provisions were not impugned as this flexible and fair provision in no way interfered with an employer's ability to effectively investigate the claim.

In *Three "D" Discount*, the Court held the manifestation date of claimant's injury was the date "petitioner first learned that his condition of ill-being was work related." (*Id.*, 556 N.E.2d at 265) The Court went on to caution "[a]lthough our finding that the injury in this case 'manifested itself' on July 10, rather than August 10, does not affect the Commission's ruling in petitioner's favor, we emphasize that the peculiar facts of each case must be closely analyzed in repetitive-trauma cases to be fair to the faithful employee and his employer as well as to the employer's compensation insurance carrier." (*Id.*)

The Supreme Court in *Durand* noted that the manifestation date is typically set on the date the employee requires medical treatment or the date on which the employee can no longer perform work activities. *Durand,* 862 N.E.2d at 929. The law also allows Petitioner to select a manifestation date that coincides with discovery of injury and its relation to work after medical consultation. See *Steven Beal v. Town of Normal,* 06 IL.W.C. 25261, 10 I.W.C.C. 0380 (2010); *see also White v Worker's Compensation Commissio*n, 374 Ill.App.3d 907, 873 N.E.2d 388, 392-393 (4th Dist. 2007) (holding Petitioner could select accident date); *A.C. & S. v. Industrial Commission*, 304 Ill.App.3d 875, 710 N.E.2d 837, 841-842 (1st Dist. 1999).

In this case, Petitioner testified that she knew her condition was work-related when she was advised by Dr. Mall of same on March 29, 2013. Petitioner did not allege this date as her manifestation date. Instead, she alleged a manifestation date of May 28, 2013, the date of her first surgery by Dr. Mall.

The Arbitrator finds this case analogous to *Oscar Mayer v. Indus. Comm'n*, 176 Ill.App.3d 607, 609 (4th Dist. 1988). In *Oscar Mayer*, the claimant began experiencing numbness, tingling, and burning sensations in his elbows and hands in 1981. The claimant was examined and, based on electrical diagnostic testing, diagnosed with bilateral carpal tunnel syndrome at that time. The claimant refused surgery at that time and was treated with conservative measures for the next two years. Ultimately surgery was performed on his right hand on May 12, 1983, and on his left hand on August 3, 1983. The claimant alleged the last date he worked prior to his surgery, May 11, 1983, as his manifestation date. *Id.* It was clear from the record in that case that the claimant knew of his injuries and their relationship to employment prior to his manifestation date. *Oscar Mayer v. Indus. Comm'n*, 176 Ill.App.3d 607, 609 (4th Dist. 1988). The Appellate Court held that the appropriate date of manifestation can be "where the employee's existing physical structure gives way under the stress of his usual labor and he is suddenly disabled." *Id.* The Appellate Court noted that *requiring* a claimant to give notice before an injury becomes disabling would not only prejudice the claimant, but would essentially be ineffectual for the very purpose that notice serves:

> By their very nature, repetitive-trauma injuries may take years to develop to a point of severity precluding the employee from performing in the workplace. An employee who discovers the onset of symptoms and their relationship to the employment, but continues to work faithfully for a number of years without significant medical complications or lost working time, may well be prejudiced if the actual breakdown of the physical structure occurs beyond the period of limitation set by statute. *Id.* Similarly, an employee is also clearly prejudiced in the giving of notice to the employer if he is required to inform the employer within 45 days of a definite diagnosis of the repetitive-traumatic condition and its connection to his job since it cannot be presumed the initial condition will necessarily degenerate to a point at which it impairs the employee's ability to perform the duties to which he is assigned. Requiring notice of only a *potential* disability is a useless act since it is not until the employee actually becomes disabled that the employer is adversely affected in the absence of notice of the accident. *Id., at* 609 citing *Peoria Belwood supra.* (Emphasis in original).

Accordingly, the claimant was allowed to use the time of his surgery or disablement as his manifestation date. *Id.*

Petitioner's injury required surgery on May 28, 2013 and became disabling on that date due to the surgery. The Arbitrator finds that May 28, 2013 is an appropriate manifestation date under the Act.

It is undisputed that Petitioner notified Respondent via an incident report dated June 20, 2013. (PX16). Further, the Arbitrator notes that, just as in *Steven Beal v. Town of Normal*, 10 I.W.C.C. 0380 (2010), Respondent has been following Petitioner's medical condition since her previous unrelated work accidents. Thus, Respondent had notice of Petitioner's injuries even before they became disabling and thus no prejudice could have possibly resulted.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that May 28, 2013, is an appropriate manifestation date under the Act. Petitioner has met his burden of establishing his date of accident and further has provided proper notice 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?

The Arbitrator finds that all the medical care rendered to Petitioner's wrists was reasonably sought in the quest to relieve and or cure the effects of his work-related injuries. The Arbitrator does not award the expenses related to Petitioner's epicondylitis, specifically the injections given by Dr. Mall during Petitioner's carpal tunnel surgeries which total $1,844.10 ($498.00 from Regeneration Orthopedics and $1,346.10 from St. Louis Surgical Center), as no opinion was given with regard to Petitioner's epicondylitis.

Respondent is therefore ordered to pay the medical expenses contained in Petitioner's exhibit 1 in the amount of $24,793.10 ($26,637.20 - $1,844.10 = $24,793.10) pertaining to Petitioner's carpal tunnel syndrome 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.

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 no permanent partial disability impairment report and/or opinion was submitted into evidence with regard to Petitioner's carpal tunnel syndrome. Dr. Katz stated that no impairment rating could be given. (RX2; RX3). The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of § 8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner is currently unable to work due to a non-work-related medical issue. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (iii) of § 8.1b(b), the Arbitrator notes that Petitioner was 43 years old at the time of the accident. Because Petitioner must live with her disability for a number of years, the Arbitrator gives *some* weight to this factor.

With regard to subsection (iv) of § 8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that there is no direct evidence of reduced earning power directly attributable to her bilateral carpal tunnel syndrome. 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 despite the improvement from her bilateral carpal tunnel releases, Petitioner's hands still "go to sleep once in a while," and she notices reduced strength in her hands. (T.35, 36). Dr. Mall recommended that Petitioner take anti-inflammatory medication for her symptoms. (PX3, 8/28/13). The Arbitrator therefore finds that Petitioner sustained serious and permanent injuries that resulted in the 12.5% loss of her right and left hands.

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

JENNIFER KOMORNICK,

Petitioner,

vs.

NO: 12 WC 32562

18IWCC0081

COSTCO,

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, causation, prospective medical care, 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).

The Commission affirms the Arbitrator's decision as to accident, causation, and prospective medical care. However, the Commission finds that as of Petitioner's visit to Dr. Mass on November 6, 2014, she was released to full duty, and therefore the temporary total disability benefits should cease as of that date. Respondent had additionally offered Petitioner a job within her restrictions. Although Petitioner had been advised by her treating physicians not to return to her duties as a cake decorator, she was offered the job of both a non-licensed optician, and as an outside marketer. Petitioner declined both jobs. The non-licensed optician job was not at a preferred location for Petitioner. However, the outside marketer position that was offered, was out of the Niles location where she had held her prior position.

Based on the fact that Petitioner was released to full duty, combined with the fact that there were pending job offers, the Arbitrator's award for temporary total disability benefits are modified down to terminate on November 6, 2014.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $493.00 per week for a period of 112 6/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner be awarded prospective care in the form of a return visit to Dr. Mass and a right cubital tunnel release, assuming the doctor still finds this surgery to be appropriate.

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 $55,739.00. 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 - 2018

Charles J. DeVriendt

CJD/dmm
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049

Joshua D. Luskin

DISSENT

"In a repetitive trauma case, there must be a showing that the injury is work-related and not the result of a normal degenerative aging process." *Nunn v. Industrial Commission*, 157 Ill. App. 3d 470, 478, 510 N.E.2d 502 (1987). A claimant must offer evidence to "show that claimant's work activities caused the condition complained of." *Id.* Dr. Mass's opinion is not reliable. I would afford greater weight to Dr. Carroll's opinions. Therefore, I respectfully dissent.

Petitioner testified she worked for Respondent as a cake decorator for 12 years which required her to ice and decorate cakes. T. 14-15. Petitioner testified in June/July of 2012 she began experiencing pain in her right elbow extending into her neck and shoulder. T. 19. Petitioner initially sought treatment from Dr. Remington who performed surgery on June 20, 2013 consisting of right elbow median nerve decompression; right elbow pronator tendon lengthening; and right thumb CMC injection. PX2. Due to continued hand and elbow pain, Petitioner sought treatment

from Dr. Mass who performed surgery on August 14, 2014 consisting of right carpal tunnel release and right radial tunnel release. PX3. Respondent accepted both procedures.

Dr. Mass re-evaluated Petitioner on November 6, 2014 at which time he noted Petitioner was improving well. As such, he released her to return to work and released her from medical care to return on a P.R.N. basis. PX3. On April 30, 2015 approximately six months later, Petitioner returned to Dr. Mass complaining of numbness and tingling from her mid-forearm to hand. Dr. Mass performed a physical examination and noted full range of motion in the elbow and wrist. Dr. Mass noted "no areas specifically of anatomic pain...but the numbness and tingling is in a nonanatomic distribution and appears to have a supratentorial overlay." [Doctor-speak meaning her pain is potentially psychological and not anatomical]. Dr. Mass concurred with the recommendations for an FCE as previously indicated by Dr. Carroll with a return to work and stated, "We feel like we do not have anything else to offer her, so we will see her back on an as needed basis." PX3.

On June 10, 2015, Dr. Mass re-evaluated Petitioner for a final time noting Petitioner denied any numbness or tingling in her hand and had no limitations of range of motion. Dr. Mass diagnosed right medial epicondylitis (not cubital tunnel syndrome) and recommended and MRI. PX3.

In the interim, Dr. Carroll evaluated Petitioner on two occasions at Respondent's request pursuant to Section 12 of the Act; September 26, 2014 (report-October 3, 2014) and May 5, 2015 (report-May 20, 2015) as well as authoring several addendum reports- November 10, 2014, January 6, 2015, and April 17, 2015. During the September 26, 2014 evaluation, Dr. Carroll noted Petitioner's radial, medial, and ulnar nerve function to be improved and intact as well as sensation to be intact. Dr. Carroll affirmed his opinion that the need for the radial tunnel release was related to Petitioner's job duties. He recommended further therapy as well as an FCE with MMI to be six months from the date of surgery (August 4, 2014). Thereafter on November 10, 2014, Dr. Carroll authored an addendum report diagnosing Petitioner with median and radial nerve compression at the elbow (again no cubital tunnel syndrome) and carpal tunnel syndrome with an impairment rating of 6%. On January 6, 2015, Dr. Carroll authored a second addendum report relative to work restrictions and recommended an FCE. On April 17, 2015, Dr. Carroll authored a third addendum report addressing the FCE performed on January 9, 2015 which noted sensory testing to be intact. Dr. Carroll placed Petitioner at MMI with no further treatment recommendations.

On May 20, 2015, Dr. Carroll authored another report following an evaluation of Petitioner on May 5, 2015. Dr. Carroll performed a physical examination and reviewed medical records, specifically a record purportedly from Dr. Mass dated March 19, 2015 which documents a diagnosis of cubital tunnel syndrome and an injection to Petitioner's elbow. The medical records offered into evidence at trial from Dr. Mass do not contain any such record. Dr. Mass did not testify to examining Petitioner on March 19, 2015, and Petitioner did not testify to such an examination nor an injection to her elbow. PX3, T. 37. Dr. Carroll diagnosed cubital tunnel syndrome and recommended surgery but opined such condition was not related to Petitioner's work duties.

On June 24, 2015, Dr. Mass, without evaluating Petitioner, authored a written report after reviewing Dr. Carroll's report of May 20, 2015 and altered his diagnosis of Petitioner, suddenly finding she suffers from cubital tunnel syndrome. On February 6, 2016, Dr. Mass provided his opinions via evidence deposition and again reiterated his diagnosis changed following the review of Dr. Carroll's report. PX4, p.28. Dr. Mass testified he failed to diagnosis Petitioner with cubital tunnel syndrome during her visits of April 30, 2015 and June 10, 2015 instead diagnosing epicondylitis. PX4, p. 24-27. Dr. Mass testified on direct examination, Petitioner's diagnosis of cubital tunnel syndrome was caused by her work duties and her treatment unmasked each

successive condition. PX4, p. 21. On re-redirect examination, Dr. Mass changes his opinion regarding causation instead finding Petitioner's radial tunnel syndrome was caused by her work duties, and the surgery performed for the same caused pressure on the nerve leading to the cubital tunnel syndrome. PX4, p. 39.

On May 4, 2016, Dr. Carroll provided his opinions via evidence deposition. Dr. Carroll testified he performed a physical examination and reviewed the medical records regarding Dr. Mass' treatment including a March 19, 2015 report which appears not to exist. RX4, p. 22. Ultimately, Dr. Carroll opined Petitioner suffered from cubital tunnel syndrome, but such condition was not caused by Petitioner's work duties. RX4, p. 25. Dr. Carroll reasoned the onset of Petitioner's symptoms is almost two years from when she last performed work for Respondent. Further Dr. Carroll explained the surgery performed was not near the ulnar nerve, and more importantly, there is no evidence of scarring or swelling. RX4, p. 33.

I would afford greater weight to the opinions of Dr. Carroll over those of Dr. Mass. Dr. Mass treated Petitioner for a significant period which included performing surgery, and never once did he diagnosis Petitioner with cubital tunnel syndrome during this treatment. In fact, when Dr. Mass evaluated Petitioner in April of 2015, he indicated Petitioner's pain might be psychological as opposed to anatomical. As of his deposition of February 6, 2016, Dr. Mass was uncertain of the diagnosis stating, "It may tell me that she doesn't have cubital tunnel syndrome. It may tell me that she does have cubital tunnel syndrome. It may tell me she has lateral epicondylitis, medial epicondylitis. It may tell me she is crazy." PX4, p. 36. Dr. Mass only altered his opinion as to Petitioner's diagnosis in deference to Dr. Carroll's opinion. Strangely Dr. Mass' deference only relates to diagnosis and not causation, but ultimately his causation opinion is flawed. Notwithstanding Dr. Mass's abandonment as to his opinion regarding Petitioner's underlying condition of ill-being, Dr. Mass abandons his initial opinion as to causation during the course of his deposition. In opposition Dr. Carroll provides a consistent opinion as to causation with a clear basis for the same.

Petitioner's current condition of ill-being was neither caused nor aggravated by her work duties. I would find Petitioner at MMI as of November 12, 2014 per Dr. Mass. I would deny any medical or temporary total disability benefits thereafter and remand the matter to the arbitrator for a finding of permanency, if any. Accordingly, I respectfully dissent.

L Elizabeth Coppoletti

L. Elizabeth Coppoletti

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

KOMORNICK, JENNIFER
Employee/Petitioner

Case# **12WC032562**

COSTCO
Employer/Respondent

18IWCC0081

On 11/1/2016, 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 0.50% 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:

0598 LUSAK & COBB
JOHN E LUSAK
221 N LASALLE ST SUITE 1700
CHICAGO, IL 60601

0210 GANAN & SHAPIRO PC
JOSEPH P BRANCKY
210 W ILLINOIS ST
CHICAGO, IL 60654

18IWCC0081

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)

Jennifer Komornick
Employee/Petitioner

v.

Costco
Employer/Respondent

Case # **12** WC **32562**

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 C. Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **September 13, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **August 1, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Respondent stipulated to accident and causation insofar as Petitioner's initial repetitive trauma injuries and surgeries are concerned. The Arbitrator finds that Petitioner also established accident and causation as to her claimed current right cubital tunnel condition of ill-being, for which both Dr. Mass and Respondent's examiner, Dr. Carroll, have recommended surgery.

Petitioner's average weekly wage was $739.50

On the date of accident, Petitioner was **31** years of age, ***single*** with **0** dependent children.

Petitioner did not claim any outstanding medical expenses at the September 13, 2016 hearing. Arb Exh 1. T. 5-7.

Respondent shall be given a credit of **$82,205.58** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$82,205.58**.

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

ORDER

Respondent stipulated Petitioner was temporarily totally disabled from September 8, 2012 through November 6, 2014. Arb Exh 1. T. 5-7. The Arbitrator finds that Petitioner was also temporarily totally disabled from November 7, 2014 through the hearing of September 13, 2016. Based on the stipulated average weekly wage, the temporary total disability rate is $493.00 per week.

The Arbitrator awards prospective care in the form of a return visit to Dr. Mass and a right cubital tunnel release, assuming the doctor still finds this surgery to be appropriate.

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

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

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

Molly C Mason

Signature of Arbitrator

10/31/16
Date

NOV 1 – 2016

Jennifer Komornick v. Costco
12 WC 32562

18IWCC0081

Summary of Disputed Issues

The parties agree that Petitioner, a cake decorator, sustained injuries secondary to repetitive trauma manifesting on August 1, 2012. They also agree that these injuries required surgery, which Petitioner underwent in June 2013 and August 2014. Respondent disputes accident and causation insofar as Petitioner's claimed current right cubital tunnel condition is concerned. T. 4-5. The other disputed issues include temporary total disability from November 7, 2014 through the hearing of September 13, 2016, and prospective care, with Petitioner seeking an award of right cubital tunnel surgery, as recommended by both her treating surgeon, Dr. Mass, and Respondent's examiner, Dr. Carroll. T. 6. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner testified that, as of September 8, 2012, she had worked for Respondent for twelve years. During the ten years before September 8, 2012, she worked in the cake department at Respondent's facility in Niles, Illinois, cutting, filling, icing, decorating and boxing cakes. T. 14-15. When she iced a cake, she would use a spoon to transfer buttercream frosting from a large container to the cake and then use a spatula to smooth out the tops and sides of the cake. She would then use different kinds of frosting-filled bags to pipe out the borders and decorative writing. The bags had different kinds of tips. Petitioner testified she primarily used her right hand to squeeze the bag while piping designs and writing onto the cakes. Her left hand acted more as a support or guide. T. 16.

Petitioner testified she spent between four and six hours per workday squeezing the bags while decorating cakes. T. 16.

Petitioner testified that, in June or July 2012, she began noticing that her right hand would lock up, with her fingertips pointing down towards her palm, while she was squeezing the bags. This would happen three or four times per workday. She would have to massage her right hand and wait for it to "kind of pop back into place." When the locking occurred, she would experience pain radiating from her right elbow up her right arm to her shoulder and into the right side of her neck. T. 19.

Petitioner testified she reported the locking and related symptoms to her supervisor, Victoria. [Notice is not in dispute].

On August 1, 2012, Petitioner saw Dr. Garces at Concentra Medical Center. The doctor noted an injury date of August 1, 2012. He indicated that Petitioner had worked as a cake decorator for eight years. He also indicated that Petitioner began experiencing right wrist and right thumb pain two weeks earlier, with this pain worsening to the point where it was "radiating to the right forearm and right shoulder." Part of the note is missing but it appears,

based on subsequent notes, that the doctor ordered right wrist X-rays and prescribed Aleve, a brace and therapy. The X-rays showed no acute process. The doctor released Petitioner to light duty with brace usage and limited use of the right hand. PX 1.

Petitioner began a course of therapy at Concentra on August 2, 2012. PX 1.

On August 6, 2012, Petitioner returned to Concentra and again saw Dr. Garces. Petitioner reported some improvement with night symptoms secondary to using the brace. She complained of pain on the radial aspect of the right wrist, with the pain radiating to the right forearm and elbow. On right hand/wrist re-examination, the doctor noted a positive Finkelstein's test, decreased grip strength and a limited range of motion. He assessed Petitioner as having DeQuervain's tendinitis. He directed Petitioner to continue therapy. He released her to work with usage of the brace and limited right hand usage. PX 1.

On August 13, 2012, Petitioner returned to Concentra and saw a different physician, Dr. Lambos. The doctor noted improvement but persistent positional pain in the radial wrist and thenar eminence. He noted a full range of elbow motion and negative Tinel's bilaterally. He diagnosed wrist tenosynovitis and carpal tunnel. He described the latter as "transient" and "now resolved." He released Petitioner to work with usage of the brace and no forceful grasping or repetitive motion with the right arm. PX 1.

Petitioner saw yet another physician, Dr. Trusewych, at Concentra the following day. The doctor noted that Petitioner was performing light duty and denied improvement. He prescribed Ibuprofen and additional therapy. He released Petitioner to light duty with brace usage and no forceful gripping or squeezing of the right hand. PX 1.

Petitioner returned to Concentra on August 20, 2012 and again saw Dr. Trusewych. Petitioner reported no improvement and complained of pain in her right wrist and right thumb. The doctor noted a positive Finkelstein's test and normal grip strength bilaterally. He directed Petitioner to continue therapy and to see a hand surgeon "as soon as possible." He continued the previous restrictions. PX 1.

On August 20, 2012, Petitioner left a message for her family doctor, indicating she was "still straining wrist at work" and that the "only other full-timer is not doing decorating and she has to decorate the majority of the cakes herself." Petitioner indicated she was wearing a brace at work but still having "significant pain and swelling." The doctor referred her to Dr. Rimington, a hand specialist. RX 5.

Petitioner first saw Dr. Rimington on August 22, 2012. The doctor noted that Petitioner reported the onset of right hand symptoms in May when she returned to her cake decorator job after injuring her tailbone in a fall. He indicated that Petitioner reported these symptoms to her boss but was told to continue working. He noted that Petitioner reported decorating 34 cakes on July 31, 2012 and performing a lot of "smooshing" with her hands on that date while blending icing. He also noted that Petitioner had undergone some therapy via Concentra.

On initial right hand examination, Dr. Rimington noted some minor swelling to the radial aspect of the hand and wrist, tenderness to the first extensor compartment, tenderness at the radial styloid, positive Finkelstein's testing, limited right flexion, full pronation and supination and intact sensation. He assessed Petitioner as having right De Quervain's syndrome. He administered an injection into the extensor tendon sheath of the first dorsal extensor compartment. He released Petitioner to light duty with brace usage and no repetitive use of the right hand. He directed Petitioner to continue participating in therapy and return to him in one month. PX 2. T. 28.

Petitioner returned to Dr. Rimington on August 31, 2012 and reported performing modified work while wearing a brace on her right hand. Petitioner also reported worsening of her pain and numbness and tingling of the right hand. On re-examination, Dr. Rimington noted slightly improved tenderness over the first dorsal compartment, positive Finkelstein's testing, a mildly positive Tinel's to the right wrist and a positive Phalen's test to the right wrist. He diagnosed right wrist De Quervain's and carpal tunnel syndrome. He recommended an EMG and directed Petitioner to wear a thumb spica brace for one month. He released Petitioner to light duty with no use of the right hand for one month. PX 2.

Petitioner testified she went off work as of September 8, 2012 and, after an initial delay, began receiving temporary total disability benefits. T. 24.

On September 19, 2012, Dr. Rimington noted that Petitioner was not working and had not yet undergone the recommended EMG. He also noted that Petitioner was "noting new pain in the elbow as well as the right shoulder." On re-examination, the doctor again noted a mildly positive Finkelstein's test. He also noted mild tenderness at the SL and LT intervals, mild tenderness over the medial epicondyle, mild tenderness in the anterior aspect of the shoulder and 5/5 rotator cuff strength. He again diagnosed right wrist De Quervain's and carpal tunnel syndrome. He took Petitioner off work for one month and again recommended EMG testing. PX 2.

Petitioner underwent EMG and nerve conduction studies on January 9, 2013. Dr. Avramov conducted these studies. He described the results as "abnormal and suggestive for a right pronator syndrome." PX 2.

On January 10, 2013, Dr. Rimington noted that the EMG showed neuropathy along the median nerve proximally at the forearm, where Petitioner was most symptomatic. He injected the right CMC joint, prescribed a CMC brace to be worn during the day and directed Petitioner to remain off work for another month. PX 2.

On February 1, 2013, Dr. Rimington noted improvement secondary to the injection but new spasming of the thumb and index finger along with pain radiating up the right arm. He prescribed a repeat trial of therapy for four weeks and Naprosyn. He directed Petitioner to stay off work another month. PX 2.

On March 7, 2013, Dr. Rimington noted complaints of pain in the proximal forearm in the area of the pronator that increased with any manual activities such as gripping or lifting. He also noted that Petitioner reported experiencing finger pain and triggering during therapy. After examining Petitioner, he commented that "the biggest issue still remains the median neuropathy and pain in the area of the pronator with radicular symptoms." He recommended an MRI to evaluate the median nerve. He injected the right index finger and directed Petitioner to continue therapy and remain off work another two weeks. PX 2.

Petitioner underwent a right elbow and proximal forearm MRI on March 19, 2013. The radiologist described the results as unremarkable save for a trace amount of fluid in the elbow joint. PX 2.

On March 21, 2013, Dr. Rimington reviewed the MRI results with Petitioner. He expressed concern that Petitioner's clinical findings were "not clear cut for pronator syndrome." He indicated that surgery to release the pronator might not provide complete relief. He stated he viewed the thumb as a "separate issue." He directed Petitioner to remain off work for another two weeks and to see Dr. Baxamusa for a second opinion. PX 2.

On April 25, 2013, Petitioner returned to Dr. Rimington and reported having seen Dr. Papierski for a second opinion. [Dr. Papierski's records are not in evidence.] Petitioner complained of a lot of pain in the proximal aspect of the forearm, over the median nerve, as well as numbness and tingling extending down the arm and pain in the CMC joint. Dr. Rimington recommended median nerve decompression at the elbow and median nerve neurolysis, along with a repeat injection of the CMC joint. He noted an upcoming IME and indicated that the surgery should be performed as soon as possible since Petitioner had failed an extended course of conservative care. PX 2.

On June 20, 2013, Dr. Rimington performed the following surgical procedures: 1) right elbow median nerve decompression; 2) right elbow pronator tendon lengthening; and 3) right thumb CMC joint injection. PX 2.

According to records in PX 2, Petitioner sought Emergency Room care on June 23, 2013, secondary to an allergic reaction to skin adhesive used during the surgery.

Records in PX 2 reflect Dr. Rimington spoke with Petitioner via telephone on June 25, 2013, with Petitioner reporting increased hand pain, along with "complete numbness in the fingers and thumb," since the injection. The doctor told Petitioner he felt these symptoms were due to carpal tunnel rather than the injection. He also told Petitioner she might require a carpal tunnel release. He recommended she reduce her Aleve intake and wear a brace. PX 2.

Dr. Rimington also examined Petitioner on June 25, 2013, noting extensive swelling and blistering secondary to the allergic reaction. He prescribed a Medrol Dosepak, Norco and wound care. PX 2.

Petitioner testified that, following the surgery, some of her pain went away but she continued to experience "clenching," or locking, of her right hand when she performed certain manual tasks, such as cutting an apple. T. 31. She tried running her right hand under hot water to try to loosen it up. T. 33.

Petitioner returned to Dr. Rimington on July 2, 2013. The doctor noted that the allergic reaction had calmed down. He also noted that Petitioner was experiencing forearm pain and pain when flexing and extending her fingers. He recommended occupational therapy. PX 2.

Petitioner saw Dr. Rimington again on July 29, 2013, with the doctor noting improvement of the elbow pain but complaints of pain radiating down the thumb and up the arm on the lateral aspect of the forearm. On examination, he noted persistent swelling at the forearm and elbow and mild tenderness at the CMC joint. He prescribed extensive occupational therapy to decrease the swelling and address the pain. He continued to keep Petitioner off work. PX 2.

On August 26, 2013, Petitioner returned to Dr. Rimington and reported pain along the dorsum of the hand and radial nerve distribution. She also reported being unable to clean her apartment or perform other significant tasks. On examination, the doctor noted swelling in the forearm and wrist, tenderness at the thumb CMC joint and along the superficial radial nerve, no obvious Tinel's and grip weakness on the right. He prescribed additional therapy and Mobic. He continued to keep Petitioner off work. PX 2.

On September 26, 2013, Dr. Rimington noted persistent complaints relative to the elbow, dorsal aspect of the forearm and base of the thumb. He also noted that additional therapy had been denied. He offered another forearm injection, which Petitioner declined. He directed Petitioner to stay off work another two weeks and then undergo a functional capacity evaluation. PX 2.

Petitioner underwent a functional capacity evaluation on October 4, 2013. The report concerning this evaluation is not in evidence. According to Dr. Carroll, Respondent's Section 12 examiner (see further below), the evaluator found Petitioner capable of medium duty but unable to resume her cake decorator job. Carroll Dep Exh 2.

Petitioner returned to Dr. Rimington on October 7, 2013. Petitioner denied improvement and indicated she experienced a lot of pain following the functional capacity evaluation. She also reported being unable to perform some of the lifting activities during the evaluation due to an inability to grip with her index finger and thumb. On examination, the doctor noted some tenderness in the proximal dorsal forearm at the area of the supinator and along the course of the radial nerve. He also noted decreased grip strength on the right. Based on the evaluation, he recommended Petitioner return to light duty with no lifting over 20 pounds. He also recommended repeat EMG testing specific to the radial nerve and two more weeks of therapy. PX 2.

On November 4, 2013, Dr. Rimington noted that Petitioner was participating in work conditioning even though workers' compensation had not approved it. He also noted that Petitioner reported feeling worse rather than better. On re-examination, he noted tenderness with CMC grind testing, mild catching of the flexor tendons at the MP joints of the index and middle fingers and decreased grip strength on the right. He diagnosed pronator syndrome, thumb CMC joint sprain and trigger finger. He indicated he was uncertain whether the triggering was the exact cause of Petitioner's inability to work and participate in work conditioning. He recommended additional work conditioning and again recommended a repeat EMG. He noted an upcoming independent medical evaluation. PX 2.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Carroll on November 18, 2013. In his report of that date, Dr. Carroll opined that the pronator syndrome treatment was reasonable, necessary and causally related to Petitioner's cake decorator work activities. He believed Petitioner required a new EMG and care for a radial nerve condition. He found Petitioner capable of medium duty but unable to perform any forceful twisting with her right forearm. Carroll Dep Exh 2.

On December 2, 2013, Dr. Rimington noted that Petitioner had undergone an IME but that the report was not yet available. He also noted complaints of significant hand and arm pain, triggering in the index and middle fingers, pain up the forearm into the shoulder and thumb pain. On re-examination, he noted tenderness with resisted wrist extension, positive Tinel's testing along the radial nerve and limited right grip strength. He directed Petitioner to remain off work another two weeks, indicating he wanted to review the IME report. PX 2.

Petitioner underwent repeat EMG and nerve conduction studies on January 2, 2014. Dr. Tuttle performed these studies. He notes symptoms of numbness and tingling in the right arm, below the elbow, following pronator release surgery. He found the results of the studies consistent with a mild carpal tunnel syndrome. PX 2.

On January 16, 2014, Dr. Rimington noted bruising of the right arm secondary to the EMG, tenderness in the forearm and radial tunnel, tenderness at the CMC joint and over the metacarpal heads of the index and middle finger, mild catching of the middle finger and decreased right grip strength. He reviewed the EMG, noting that Dr. Tuttle did not specifically examine the radial nerve, as he had requested. He recommended another EMG specifically looking at the radial nerve, noting that the IME physician, Dr. Carroll, also recommended this. He directed Petitioner to remain off work. PX 2.

Petitioner underwent another EMG on February 11, 2014. According to Dr. Carroll, this EMG did not show any radial nerve damage or entrapment. Dr. Carroll indicated that this "is not uncommon with a clinical diagnosis of radial nerve entrapment at the elbow." Carroll Dep Exh 3.

On February 18, 2014, Dr. Rimington noted the recent repeat EMG, along with complaints of pain along the dorsum of the right wrist and in the right thumb. He indicated that Petitioner reported experiencing severe pain when opening a jar or lifting a heavy glass. He informed Petitioner that the repeat EMG showed no significant radial nerve abnormality and that he did not believe there was one specific surgery that could relieve all of Petitioner's pain. He recommended that Petitioner return to light duty with no lifting over 20 pounds and no repetitive use of the right arm. He recommended that Petitioner return to him in one month, indicating she might need permanent restrictions if she could not tolerate this light duty. He also recommended that Petitioner seek a second opinion from a specialist such as Dr. Mass. PX 2.

On March 18, 2014, Dr. Rimington noted that Petitioner remained symptomatic, was awaiting a second opinion and had not returned to work. He described Petitioner as "continuing to have significant pain while doing simple activities of daily living." He continued the previous work restrictions and again recommended that Petitioner see Dr. Mass. PX 2.

Petitioner testified she chose Dr. Mass based on recommendations from both her attorney and Dr. Rimington. T. 35.

Petitioner first saw Dr. Mass on May 29, 2014. On that date, she completed a "hand surgery intake" form, describing her job, injury, treatment to date and current symptoms. She indicated that she was currently experiencing 6/10 pain from her "fingers to shoulder." PX 3.

In his initial note, Dr. Mass recorded a consistent history of Petitioner's job history and treatment to date. On examination, he noted tenderness to palpation over the lateral condyle of the elbow, as well as distally along the lateral aspect of the forearm over the radial tunnel. He recommended both a radial tunnel release and a carpal tunnel release. He opined that the two procedures should be performed at the same time since radial and carpal tunnel syndrome "are hard to differentiate." He further opined that the radial tunnel syndrome resulted from the pronator surgery "as these nerves are only a centimeter apart." He went on to state: "therefore, the new diagnosis and treatment necessary are directly or indirectly related to [Petitioner's] work." PX 3.

On August 4, 2014, Dr. Mass operated on Petitioner, performing a right carpal tunnel release and a right radial tunnel release. In his operative report, he described the transverse carpal ligament as very thick. PX 3.

On August 20, 2014, Dr. Mass noted post-operative improvement but indicated Petitioner was still experiencing some tingling and numbness over the dorsum of her right hand as well as some forearm soreness with lifting exercises. He recommended therapy for strengthening and scar massage. He continued to keep Petitioner off work. PX 3.

On September 23, 2014, Dr. Mass noted post-operative improvement but indicated Petitioner was still experiencing intermittent right hand numbness and pain in her "index and

long finger trigger fingers." He recommended therapy for strengthening and scar massage. He indicated Petitioner could resume light duty but stated she could not perform any cake decorating. PX 3.

At Respondent's request, Dr. Carroll re-examined Petitioner on September 26, 2014. In his report of that date, he noted the recent surgery by Dr. Mass. On re-examination, he noted stiffness in the right wrist, improved radial, median and ulnar nerve function, intact sensation and grip strength of 5 pounds on the right and 15 pounds on the left. He reiterated his previous opinion that the carpal tunnel release was not needed as there was no evidence of active carpal tunnel syndrome. He opined that the radial nerve surgery was reasonable and necessary, as well as causally related to the job activities. He found no evidence of symptom magnification. He found Petitioner capable of light duty, with no lifting over 20 pounds, no cake decorating and varied job tasks. He described these restrictions as "temporary" and indicated they could likely be changed in three to six months. He recommended a week or two of additional therapy, four to six weeks of work conditioning and a functional capacity evaluation. He anticipated that Petitioner would reach maximum medical improvement six months after the August 4, 2014 surgery. Carroll Dep Exh 4.

On November 6, 2014, Dr. Mass wrote to an adjuster at Liberty Mutual, indicating that Petitioner reported feeling a lot better but was "still having some difficulty with tedious tasks with her right hand." He noted that he had released Petitioner to light duty at the last visit but that Petitioner "has not been able to get back to work as of yet due to her work not getting her back." He stated that, from his viewpoint, Petitioner was "okay to work" but needed additional therapy. He released Petitioner from care on a PRN basis. PX 3.

Petitioner returned to Dr. Mass on December 16, 2014 but the note of that date is not in evidence.

Dr. Carroll issued an addendum on January 6, 2015, in order to address Petitioner's work capacity. He opined that Petitioner could perform certain cake-related tasks, including mixing, fingering and layering, but could not squeeze frosting or dough out of a tube. He indicated "this particular activity would be difficult to perform given the residual sensitivity in [Petitioner's] right hand and right elbow. He saw no need to restrict Petitioner's hours. He placed no restrictions on usage of the left arm. He recommended that Petitioner vary her job activities. Carroll Dep Exh 6.

Petitioner underwent a functional capacity evaluation on January 9, 2015. The evaluation report is not in evidence. According to Dr. Carroll, the evaluator found Petitioner capable of medium level duty and expressed some concern about sub-maximal effort but concluded Petitioner "could do constant fine and gross hand manipulation [with] the left hand only." RX 2. Carroll Dep Exh 7. In a supplemental report dated April 17, 2015, Dr. Carroll opined that Petitioner could return to medium level duty but could only occasionally use her right hand for object handling, fingering and grasping. He stated that, if Petitioner were to resume cake-related duties, she should still avoid squeezing dough or frosting out of tubes. He

did not recommend any restrictions relative to the left arm or the number of hours worked per week. He saw no need for additional surgery. Carroll Dep Exh 7.

According to Dr. Carroll, Dr. Mass re-evaluated Petitioner on March 19, 2015 and noted evidence of right cubital tunnel syndrome for which he administered an injection. Carroll Dep Exh 8. Dr. Mass's March 19, 2015 note is not in evidence.

On April 30, 2015, Dr. Mass wrote to an adjuster at Liberty Mutual, indicating Petitioner no longer had radial or carpal tunnel symptoms, following the surgery, but was now complaining of numbness and tingling from her right mid-forearm through her hand, along with occasional tingling in her anterior right shoulder. Dr. Mass noted he had been unable to find specific areas of anatomic pain on examination. He described Petitioner's current symptoms as "of unclear origin." He recommended a functional capacity evaluation and return to work. PX 3.

Dr. Carroll examined Petitioner again on May 4, 2015. He noted that Petitioner complained of "sensitivity on the medial elbow" and numbness and tingling in the right ring and small fingers. He noted positive Tinel's testing over the ulnar nerve and positive elbow flexion testing on the right elbow. He noted a grip strength of 20 pounds on the right and 60 pounds on the left. He concurred with Dr. Mass's diagnosis of right cubital syndrome but did not find this condition to have stemmed from the injury of August 1, 2012, given the passage of two years between that date and "the onset of symptoms around Christmas of 2014." He recommended that Petitioner consider surgery to release the ulnar nerve but reiterated that he did not link the need for this surgery to the accident or Petitioner's cake decorator job duties. He reiterated that Petitioner could return to cake decorating so long as she performed only occasional squeezing with her right hand. He linked the need for this restriction to the ulnar nerve condition, which he did not view as work-related. Carroll Dep Exh 8.

On June 1, 2015, Dr. Mass addressed Petitioner's work capacity as follows:

> "As far as I can interpret the FCE, Jennifer has reached a median [sic] level function but the FCE does not really stress repetitive use which is what she has to do to put icing on cake and do cake design because her right hand is 50% weaker than her left hand. Therefore, I do not think this FCE adequately fits to the broad category of medium level of work for her return to work. Therefore, I cannot change her off work status at this time. I have requested her ability to go to work and work for an hour and then increase it on a weekly basis if she can tolerate it because that would be a true test of what she could do, but this has not been approved.
>
> She has not reached MMI. She needs gradual return to work."

PX 3.

On June 10, 2015, Dr. Mass noted that Petitioner complained of increased right forearm pain secondary to coloring while babysitting the previous day. The doctor also noted that Petitioner had recently been re-examined by Dr. Carroll.

On examination, Dr. Mass noted a negative Tinel's, an equivocal forced elbow flexion test, exquisite tenderness in the medial epicondyle, no evidence of atrophy and the ability to make a full fist. His impression was "right medial epicondylitis and elbow pain." He recommended a right elbow MRI and addressed causation as follows: "I feel that the reason she has not been able to return to work is the therapy has flared her medial epicondylitis." PX 3.

On July 7, 2015, a general manager at Respondent's Schaumburg location sent Petitioner a letter offering her a full-time "non-licensed optician" job at that location. In the letter, the general manager indicated the job would be modified so as to allow Petitioner to "self-monitor and modify [her] body mechanics by using [her] left hand for any simple grasping and fine manipulation that exceeds [her] restrictions on [her] right hand." The general manager also indicated Respondent would provide "return to work job coaching." He asked Petitioner to contact him by July 15, 2015 if she did not believe she could perform this accommodated position. He informed Petitioner that, if she failed to respond by that date, Respondent might move forward with separating her employment, given she had exceeded her leave of absence. He also informed Petitioner that her disability benefits could be affected if she declined the position. RX 1.

Petitioner attended another job assessment meeting on August 12, 2015. Under cross-examination, Petitioner acknowledged signing a document (RX 2) outlining the results of that meeting. RX 2 also bears the signature of general manager Daniel LaVigne, who testified at the hearing. RX 2 references Dr. Carroll's report of April 17, 2015, in which he referenced the January 9, 2015 functional capacity evaluation and opined that Petitioner could perform unrestricted duty with her left hand but could perform only occasional squeezing of dough or icing with her right hand.

RX 2 focuses on a full-time position entitled "outside marketer." The document reflects that this position (without any accommodations) involved, among other tasks, pulling orders for shoppers, with potential lifting of over 40 pounds below waist and over 30 pounds above waist. The document reflects that Respondent agreed Petitioner could "self monitor and obtain assistance" with the required lifting. The document also reflects that Petitioner "noted a concern with the driving required of the position" and that Respondent "clarified that [the driving] varies daily and the estimate time to drive to the farthest location is approximately 20 minutes one way." Notations on the third page of the document reflect that Petitioner declined the offer and agreed to continue to receive job postings. RX 2.

Dr. Mass testified by way of evidence deposition on February 16, 2016. Dr. Mass testified he is a professor of orthopedic surgery at the University of Chicago. He specializes in hand and upper extremity surgery. PX 4 at 5. He is board certified in orthopedic surgery and has advanced certification in hand surgery. PX 4 at 6.

Dr. Mass testified he first saw Petitioner on May 29, 2014. Petitioner told him she formerly worked as a cake and pastry decorator at Respondent. She indicated she developed right wrist and forearm pain in 2012. Eventually, this pain became so debilitating that she stopped working. In June of 2013, she underwent a pronator tunnel release and lengthening of some muscles in the elbow. Pronator syndrome is compression of the median nerves at the elbow. PX 4 at 8.

Dr. Mass testified Petitioner primarily complained of pain in her right wrist and the top of her right forearm. Petitioner also indicated she was experiencing pain and weakness with wrist and finger extension as well as some triggering of the fingers. PX 4 at 8-9.

Dr. Mass testified that Petitioner's pre-operative EMG showed pronator tunnel syndrome. This is unusual because compression of the median nerve at the pronator usually cannot be demonstrated "until the symptoms are so bad that you actually lose function." In most cases, pronator tunnel syndrome is masked by carpal tunnel syndrome. Usually, a hand surgeon performs a carpal tunnel release before discovering a pronator tunnel problem but, in Petitioner's case, the first EMG was positive for pronator tunnel syndrome. PX 4 at 33. A second EMG performed following the surgery showed mild carpal tunnel syndrome but no radial nerve symptoms. PX 4 at 9.

Dr. Mass testified he operated on Petitioner on August 6, 2014. On that date, he performed a release of the right carpal and radial tunnels. He recommended therapy postoperatively. PX 4 at 10. It "became obvious" that Petitioner developed cubital tunnel symptoms, or compression of the ulnar nerve at the elbow, whether due to the therapy or the original problem. Overall, Petitioner improved "except for the last nerve at the elbow." PX 4 at 11.

Dr. Mass testified that, as of December 16, 2014, Petitioner was experiencing numbness and tingling in her right hand and forearm, more on the ulnar side. Her household activities were limited and she reported experiencing pain when she did too much. She exhibited a full range of motion and he was "not clear as to why she was having pain on that day." As of that visit, Petitioner's complaints did not match his examination findings and he had not yet made a diagnosis. PX 4 at 11-12. He recommended a functional capacity evaluation. Petitioner underwent this evaluation on January 19, 2015. The evaluator found Petitioner capable of performing at a medium physical demand level, meaning she could occasionally lift 40 pounds below waist level and 20 pounds from waist to shoulder. Petitioner did not appear to have an inflammatory response following the evaluation. PX 4 at 12-13.

Dr. Mass testified he has reached a definitive diagnosis of right cubital syndrome. Cubital tunnel syndrome is compression of the ulnar nerve at the "funny bone." The ulnar nerve originates in the lower part of the cervical spine and goes around the elbow as it runs from the back to the front of the arm. PX 4 at 14. The activities Petitioner performed at her cake decorator job, i.e., lifting and squeezing, compress the ulnar nerve. PX 4 at 14. Petitioner has to squeeze frosting out of a "bag tube." This creates "a lot of stress on the hand" and to be delicately done in order to create artistic designs. The activity is continuous throughout the workday. PX 4 at 15.

Dr. Mass addressed causation as follows:

> "I thought because her right hand was 50 percent weaker than her left hand and her right hand is her dominant hand, that . . . the problem was now the cubital tunnel. I think that we unmasked it by releasing the other nerves and it was directly related to the work that she did."

PX 4 at 15. Petitioner's wrist was in a slightly bent position while she squeezed the tube, with the fingers "grabbed tightly." "That pinches the nerve up at the elbow because that is where the muscles start." PX 4 at 16.

Dr. Mass testified he has released Petitioner to work within the parameters set by the functional capacity evaluator. Respondent and its carrier have not given him approval to perform the cubital tunnel release. PX 4 at 16. He does not know whether his bill has been paid. PX 4 at 16. If Petitioner underwent the surgery he has recommended, she would have to regain strength in her right hand via therapy. In her case he "would actually allow work to be part of her therapy." All in all, Petitioner would require four to six weeks of therapy following the surgery. PX 4 at 17. The goal would be for Petitioner to resume her former cake decorator job. PX 4 at 17.

Under cross-examination, Dr. Mass testified that Petitioner had both radial tunnel and carpal tunnel syndrome. Radial tunnel syndrome is caused by compression of the radial nerve at the elbow. There are five areas in the elbow where the nerve can be compressed. Some people have a "particularly thick band" in their elbows where the never can be compressed. That is a purely anatomic factor. PX 4 at 19. Petitioner's job required supination and that can cause compression. After he released the radial nerve, Petitioner's finger pain and weakness completely resolved. PX 4 at 18. He performed a carpal tunnel release because, at that point, the only positive finding on EMG was carpal tunnel syndrome. There was nothing about Petitioner's job that would have caused carpal tunnel syndrome. The surgery was prophylactic in nature. PX 4 at 19.

Dr. Mass testified that Petitioner had no risk factors for radial tunnel syndrome with the exception of the existence of the thick band in the forearm. Petitioner does not smoke.

Petitioner is a large woman but obesity has not been shown to be a factor for radial tunnel syndrome. Diabetes can be a risk factor but a family history of diabetes is not. PX 4 at 19-20.

Dr. Mass testified it was after the April 2015 visit that he observed symptoms of cubital tunnel syndrome. PX 4 at 20. It is his understanding that Petitioner last worked as a cake decorator in September 2012. While there was a gap between September 2012 and April 2015, Petitioner underwent surgery and therapy during that time. Moreover, Petitioner had "multiple nerve compression syndromes" and that is an unusual problem. You have to tackle one nerve problem at a time. As you tackle each one, you unmask a different one. Therapy, too, is a "type of work activity" that can make the next nerve problem more obvious. PX 4 at 21. All three syndromes, i.e., pronator, radial and now cubital, involve the elbow. All stem from the original work activity. PX 4 at 21.

Dr. Mass testified that the symptoms of cubital tunnel syndrome include forearm pain, numbness and tingling in the ring and small fingers, an impaired ability to spread the fingers apart and pinch in grip and a positive Tinel's at the elbow. If you tap on the elbow of a person who has cubital tunnel syndrome, it causes a sensation akin to hitting the "funny bone." PX 4 at 22.

Dr. Mass testified he examined Petitioner's hands. Initially, Petitioner complained of diffuse hand weakness and an inability to straighten her fingers. It was pretty obvious to him that Petitioner had pronator tunnel syndrome. PX 4 at 22. When he first saw Petitioner, he did not document whether he examined the cubital tunnel. If Petitioner had exhibited cubital tunnel symptoms, he would have noted that. PX 4 at 23. When he later examined Petitioner, on April 30, 2015, he noted a complaint of numbness and tingling from the mid-forearm through the hand. These symptoms are not associated with radial tunnel syndrome. They could be associated with carpal, pronator or cubital tunnel syndrome. He also noted anterior shoulder pain. "Any of the nerve compression syndromes can cause anterior shoulder pain." The pain is "referred." PX 4 at 23-24. On that date, he described Petitioner's symptoms as non-anatomic because he could not explain them. Petitioner's symptoms were to diffuse or widespread at that point to cause him to diagnose cubital tunnel syndrome. By the time Petitioner returned, she had thought about where her symptoms were and he was then able to make the diagnosis. PX 4 at 24-25. He cannot remember whether he diagnosed right medial epicondylitis and elbow pain on June 10, 2015. It appears he examined Petitioner on that date but he cannot find his note. He recommended a right elbow MRI to look for pathology associated with medial epicondylitis. PX 4 at 26. Petitioner had just undergone an examination by Dr. Carroll, who believed she had cubital tunnel syndrome. The epicondyle and cubital tunnel are a centimeter apart from one another so there is a "lot of overlap between those two problems." He felt an MRI would help distinguish. He did not note any cubital tunnel symptoms on June 10, 2015. At the request of Petitioner's counsel, he issued a report dated June 24, 2015, responding to Dr. Carroll's examination. What caused him to change his mind, diagnosis-wise, was his review of Dr. Carroll's opinions. PX 4 at 28. He has not seen Petitioner since June 10, 2015 and thus cannot state with certainty that she currently has cubital tunnel syndrome. PX 4 at 28.

Dr. Mass acknowledged he did not view any videos of Petitioner's job. He does, however, have a basic understanding of cake decorating. Petitioner told him she spent her entire workday, other than breaks, squeezing bags of frosting while creating designs. Petitioner did not bake the cakes. She simply frosted and decorated them. PX 4 at 30.

Dr. Mass testified that Petitioner either has a chronic pain syndrome or a diagnosable problem. Dr. Carroll's examination was "pretty specific" even though his own was not. He believes that cubital tunnel syndrome potentially explains Petitioner's continued symptoms. As for whether he can state this "for sure," it "would have been nice to have seen [Petitioner] in the last seven months." PX 4 at 30. The onset of symptoms in Petitioner was not typical. The typical onset for cubital tunnel syndrome is either a blow to the elbow in a young person or certain positions/activities, such as sleeping with the hands curled up, talking on the phone a lot or leaning on the elbows, in an older person. PX 4 at 31. He knows it can be positional, sleep-wise, because patients "wake up with their ring and little fingers asleep." PX 4 at 31. In Petitioner's case, "it took a second outside examiner to probably unmask" the cubital tunnel syndrome. PX 4 at 32. He cannot say for sure that Petitioner's work activity caused the syndrome but the mechanics of that activity provide a good explanation for all of the syndromes Petitioner has experienced. Petitioner has been off work a while and now primarily performs only activities of daily life but the symptoms of cubital tunnel syndrome, in particular, "will go up and down in terms of function and usage." PX 4 at 32.

Dr. Mass testified that, in Petitioner's case, he would likely recommend a slow return to work following four to six weeks of therapy following a cubital tunnel release. He might start Petitioner out at two hours of work per day and then have her build up to four hours, etc. Therapy, which typically consists of working with weights, "is not the same thing as squeezing bags [of frosting]." PX 4 at 34.

Dr. Mass testified that, the fact the functional capacity evaluator did not note an inflammatory response, or swelling, after the evaluation, does not mean the problem does not exist. PX 4 at 35.

On redirect, Dr. Mass reiterated it would be helpful for him to be allowed to see Petitioner again. A return visit would allow him to determine whether she has cubital tunnel syndrome or another condition. It might also tell him Petitioner "is crazy." PX 4 at 36. His note reflects that it was Helmsman Management Services that referred Petitioner to him. When he issued his report, it was his thinking that the pronator release could have caused the radial tunnel syndrome. If the surgeon retracts too forcefully, he can cause damage to the radial nerve. Since that time, he has given causation more thought and now believes the radial tunnel syndrome was "more directly related to" Petitioner's work. The work involved rotation and twisting of the arm. The surgery could have indirectly contributed to the radial tunnel syndrome. He does not know whether the carpal tunnel syndrome stems from Petitioner's work. In his practice, he almost always releases the carpal tunnel when he releases the pronator tunnel. It is "just the way" he does things. PX 4 at 39.

Records in PX 3 reflect that Petitioner returned to Dr. Mass on March 9, 2016. The records concerning this visit are incomplete. They reflect that the doctor released Petitioner to work "as defined in previous note" as of March 10, 2016. PX 3.

Dr. Carroll testified by way of evidence deposition on May 4, 2016. Dr. Carroll testified he completed fellowship training in hand surgery in 1988. He is board certified in orthopedic surgery with added qualification in hand surgery. RX 4 at 5-6.

Dr. Carroll testified he has no independent recollection of Petitioner. He first examined Petitioner on November 18, 2013. RX 4 at 6. As of that date, he believed Petitioner had received reasonable care for pronator syndrome and was at maximum medical improvement with respect to that condition. RX 4 at 7-8. He also believed Petitioner had radial nerve entrapment and required more care for that condition. He did not diagnose any other conditions at that time. RX 4 at 8. He saw no evidence of carpal or cubital tunnel syndrome. RX 4 at 8-9.

Dr. Carroll testified he issued a supplemental report on March 15, 2014, after reviewing an EMG. The EMG showed evidence of carpal tunnel syndrome but Petitioner "did not have physical symptoms consistent with" that condition. He did not believe Petitioner required active care for that condition. RX 4 at 10. In his opinion, the carpal tunnel syndrome was idiopathic. Since the condition was not clinically present, he could not attribute it to any particular activity. RX 4 at 11. Carpal tunnel syndrome can be caused by wrist fractures or dislocations, forceful and repetitive grasping and twisting activities and working in awkward postures. It can be observed with certain diseases, such as diabetes or thyroid disorders, and is more common in women than men. RX 4 at 11-12.

Dr. Carroll testified he re-examined Petitioner on September 26, 2014. He issued a report concerning this re-examination on October 3, 2014. RX 4 at 12-13. As of the re-examination, Petitioner was still in therapy, following the August 4, 2014 radial nerve release, and was still symptomatic. Her forearm had improved but she was still having some difficulties with her hand. RX 4 at 13. When he re-examined Petitioner, he saw no evidence of cubital tunnel syndrome or ulnar nerve entrapment. RX 4 at 14. He conducted an AMA impairment rating, utilizing the Sixth Edition of the Guides, based on the following diagnoses: median nerve entrapment, pronator syndrome, radial nerve issues at the elbow and right carpal tunnel syndrome. He relied in part on his examination findings, which included loss of motion and strength. He also relied on the EMG. He used a Grade 1 modifier. He reached an upper extremity rating of 6%, rounding up from 5.5%, and converted this to 4% of the person as a whole based on the conversion table. RX 4 at 17-19.

Dr. Carroll testified he examined Petitioner again on May 4, 2015. In connection with this re-examination, he reviewed a functional capacity evaluation and records from Dr. Mass. RX 4 at 21-22. Petitioner had developed numbness, tingling and pain on the medial side of her elbow, as opposed to where she had her surgery. These symptoms radiated into her ring and

small fingers. She was utilizing an elbow pad. She reported having difficulty using her fingers and performing routine household activities. RX 4 at 22.

Dr. Carroll testified that he noted Dr. Mass had diagnosed right cubital tunnel syndrome and was contemplating further surgery. He also noted that Petitioner had not worked since September 2012. On re-examination, he noted evidence of ulnar neuritis on elbow flexion testing. He also noted a positive Tinel's at the elbow. Ulnar nerve compression testing was also positive. He did not find a chronic radial neuropathy or median nerve compression at the elbow. RX 4 at 23. Petitioner's forearm, wrist and hand examination was otherwise benign. RX 4 at 24. Her strength was decreased at 20 pounds on the right versus 60 pounds on the left. Her X-rays were negative. There was some evidence of subluxation of the right thumb metacarpal. RX 4 at 24.

Dr. Carroll agreed with the diagnosis of right cubital syndrome but was unable to link that diagnosis to the accident or subsequent surgeries. Petitioner "had not worked in a number of years when the symptoms manifested" and had not undergone surgery in the area where she was symptomatic. If Petitioner had developed right cubital syndrome within three or six months of the accident, he "might have come up with something different" but that was not the case. RX 4 at 24-25.

Dr. Carroll testified that, as of May 4, 2015, Petitioner was at maximum medical improvement for her work-related conditions but was not at maximum medical improvement for the right cubital syndrome. RX 4 at 26.

Dr. Carroll opined that cubital tunnel syndrome can be caused by trauma to the elbow or repetitive flexion or extension with force to the elbow. It can also be caused by diabetes or thyroid disease. It is more common in women than men and excess weight can play a role. It can also be caused by chronic posturing, including leaning the elbow on objects while working. It can be related to vibration or forceful gripping and grasping. RX 4 at 26-27. It is common for patients to report symptoms due to sleeping with their elbows bent. RX 4 at 27. In some patients, sleeping in this position might cause the syndrome. In other patients, "it may just be a manifestation phenomena." RX 4 at 27.

Dr. Carroll testified he did not note any radial nerve entrapment on May 4, 2015. RX 4 at 27. He conducted another impairment rating on that date. Because Petitioner's overall function had improved, he arrived at a lower percentage than he had previously arrived at. RX 4 at 29-30.

Under cross-examination, Dr. Carroll testified he tries to rely primarily on objective findings when conducting an impairment rating. He gives some consideration to subjective components as well but he tries to stay as objective as possible. RX 4 at 30. He does not view Petitioner's cubital tunnel syndrome as work-related, but if he were to assume it is work-related, that diagnosis would bump up his impairment rating by a percentage or two of the person as a whole. RX 4 at 30-31.

Dr. Carroll testified he is aware of the requirements of Petitioner's former cake decorator job. It is possible that squeezing bags of frosting to create designs could cause carpal tunnel syndrome. RX 4 at 31. He does not believe, however, that this activity could have caused the cubital tunnel syndrome. It would be "more likely to cause a pronator syndrome." RX 4 at 32. Cubital tunnel syndrome can be caused by forceful gripping but in combination with elbow flexion. RX 4 at 32. He does not believe that the surgeries Petitioner underwent caused the cubital tunnel syndrome. RX 4 at 32-33. Surgeries on the medial side of the elbow could cause the syndrome but Petitioner's surgeries were performed "at a distance from that." RX 4 at 33. There was no evidence of swelling or scarring that went to the posterior aspect of Petitioner's right elbow. He can never say never but, in his opinion, the surgeries did not cause the cubital tunnel syndrome. RX 4 at 33. He humbly disagrees with Dr. Mass's causation opinion. RX 4 at 33-34. Petitioner's cubital tunnel syndrome could be gender-related or could have come from postures she did after work. The syndrome did not manifest until a number of years after she last worked so he was hard pressed to say it stemmed from her work. RX 4 at 34-35. He does not believe the other syndromes "masked" the cubital tunnel because cubital tunnel specifically involves the ring and small fingers while Petitioner's other syndromes involve the thumb, hand and index and long fingers. RX 4 at 35. Again, he can never say never, but he does not see the causal link as to the cubital tunnel syndrome. RX 4 at 35-36. In his opinion, Petitioner's treatment was reasonable. He did not review any therapy records but he does not see any causal link between the therapy and the cubital tunnel syndrome. RX 4 at 36-37. He disagrees with Dr. Mass's opinion that the therapy Petitioner performed could have caused her cubital tunnel syndrome symptoms to become more obvious. RX 4 at 37. Cubital tunnel can come on spontaneously. It can result from leaning on the elbow or driving with one's arm out the door all the time. He saw no evidence of this in Petitioner. Diabetes can also be a factor but Petitioner does not have diabetes. In Petitioner's case, the best diagnosis might be idiopathic cubital tunnel, based on the timing of the onset of symptoms. RX 4 at 38.

Petitioner denied injuring her right wrist, arm, elbow or shoulder at any point after August 1, 2012. T. 38.

Petitioner testified she has no strength in her right arm. She has difficulty using her right hand and arm to lift objects. She is able to lift a gallon container a couple of times in a row but, by about the fourth repetition, she experiences a "jolt going up" arm and feels as if she is likely to drop the container. T. 39. She has dropped a can of pop on her herself, while drinking from the can. She has also dropped a tray at a Subway store. T. 39. She was using both hands to carry the tray but her right arm abruptly became numb and "opened," causing her to lose her grip. T. 39-40. She has difficulty sleeping because of numbness and tingling in her right arm. She tries to position the arm so as to avoid these sensations but still experiences shock-like "jolting" going from her fingertips to her right elbow and up to her right shoulder. T. 41.

Petitioner testified she last saw Dr. Mass about four months before the hearing. [As noted below, the last records in evidence are incomplete notes dated March 9, 2016. PX 3.] Dr. Mass wants to operate on her but Respondent's carrier has not authorized the surgery. T.

42. When she last saw Dr. Mass, he injected the base of her right thumb. T. 42-43. The injections she has undergone to date have not relieved her pain. T. 44.

Petitioner testified she received temporary total disability benefits through approximately August 2015. She has not returned to any kind of gainful employment. T. 44. At one point, she spoke with two Respondent employees, both of whom were named Julie, about returning to work. She also spoke with Dan, the warehouse manager at Respondent's Niles location. T. 45. She worked at the Niles location throughout her twelve years with Respondent. T. 45. To date, Respondent has not placed her in any kind of alternative job. T. 45. She believes she could perform the duties of a greeter. At a meeting held in June 2015, she asked to be placed in a greeter job and was told no such job was available. T. 51. Despite being told she did not have to make herself available to work at any location other than her regular Niles location, she informed Respondent she would also be willing to work at the Melrose Park and Mount Prospect locations. T. 52. After she expressed this willingness, one of the two women named Julie sent her job openings, via E-mail, and she applied for an outside marketer job. This job was multi-faceted. It would have required her to drive to various businesses for the purpose of setting up booths and trying to promote Respondent memberships. It also entailed working in the warehouse, pulling items for disabled customers who are physically unable to shop for themselves. T. 54. The job involved driving up to 100 miles per day. At that time, she was not able to drive such a distance. If she drove for more than 30 minutes, her right elbow would become extremely painful and the pain would travel down into her right middle, ring and small fingers. T. 55-56. At other times, her right hand would "lock up" while she was driving. T. 56.

Petitioner denied injuring her right elbow in any manner other than while performing her cake decorator duties for Respondent. T. 56.

Petitioner testified she is not currently taking any pain medication. She scheduled a return visit to Dr. Mass but then cancelled it due to the hearing and due to the doctor telling her she should return to him once the surgery had been approved. T. 56-57. Dr. Mass told her there was no point in her returning to see him unless she had secured approval for the surgery. T. 57-58.

Under cross-examination, Petitioner acknowledged losing time from work due to other medical problems prior to August 1, 2012. T. 58. In 2009, she requested a leave of absence due to a left finger condition. In approximately 2011, she requested another leave after injuring her coccyx in a non-work-related fall. T. 60. [See coccyx-related records in RX 6.] After the August 1, 2012 accident, Respondent allowed her to work as a greeter until approximately September 8, 2012. T. 61. She went off work thereafter. Her pain stayed the same after she stopped working. T. 61. She underwent two functional capacity evaluations. After the October 4, 2013 evaluation, she underwent work conditioning to try to increase the amount of weight she could lift. While attending work conditioning, she felt as if she was going to lose her grip and drop objects onto her feet. She informed her therapist of this and he advised her to stop increasing the load she was lifting. T. 63. She does not recall whether Dr. Mass released her to regular

duty in November 2013. She saw Dr. Carroll in 2013 and 2014, at Respondent's request. T. 63-64. She underwent a second functional capacity evaluation in January 2015. She saw both Dr. Mass and Dr. Carroll thereafter. T. 64.

Petitioner testified she first attended a job assessment meeting on May 5, 2015. At that time, the job under consideration was her regular cake decorator job. Respondent was not able to offer that job to her within her restrictions. T. 65. In July 2015, she received a letter from the general manager at Respondent's Schaumburg store, offering her a "non-licensed optician" job at that store. She found this offer very confusing because she had never met this general manager. At a job assessment meeting held on August 12, 2015, she told Dan and the two women named Julie about the letter. They told her to disregard the letter because Schaumburg was not one of her selected locations and because they were unsure as to how the general manager at Schaumburg had learned of her restrictions. T. 67. She was living in Franklin Park at the time she received the letter. T. 67. At the August 12, 2015 meeting, Dan and the two women named Julie presented her with a document offering her a job as an outside marketer. She declined this offer because the job required lifting up to 40 pounds and Dr. Mass had restricted her to lifting 10 pounds at that point. She was also concerned about the amount of driving the job required. T. 69. Dan and the two women asked her to sign the written job offer. T. 69. She identified her signature on RX 2, the offer letter. T. 70. On September 11, 2015, she applied for a front end assistant job at Respondent's Melrose Park location. T. 71. She believes this job involved assisting customers who were checking out and lifting up to 40 or 50 pounds. T. 71. She asked the two women named Julie whether there would be any negative repercussions from declining the outside marketer job and one responded, "it's fine – I will be E-mailing you other jobs." T. 72. Because she worked primarily in the bakery department, she was not familiar with the demands of other jobs at Respondent stores. T. 72. She met with the Melrose Park store manager concerning the front end assistant job. Once she learned of the lifting requirements of this job, she called Dr. Mass's office and explained the situation to the doctor's nurse. The nurse put her on hold. When she returned to the line, she quoted Dr. Mass as saying, "absolutely not, [you are subject to a] 10-pound limit." T. 75-76. She last saw Dr. Mass on March 9, 2016, at which time he injected her right thumb. T. 76. He did not release her from care. He told her she would not improve unless she underwent the previously recommended surgery. She complained of thumb pain and numbness/tingling in her middle, ring and small fingers. T. 80. Some of her pain improved after her first surgery. After her second surgery, she did not start therapy right away, due to lack of approval, and her hand felt "almost worse than before." T. 79. She was still experiencing triggering and her right elbow hurt when she rested her arm on a chair or table. T. 80. She denied having right arm problems before 2007. She is now married but still uses the last name "Komornick." T. 81. She last worked anywhere in September 2012. She has not looked for formal employment since that time. She has, however, baked cupcakes once every six months or so to bring in some income. She has also decorated or painted a few items that she has sold to friends. She does this about once a month. T. 82. She tries to sleep on her left side with her right arm by her side. T. 83.

On redirect, Petitioner testified the items she sold to her friends were flower pots. She received money for these items. T. 84. The last restriction Dr. Mass imposed was a 10-pound lifting restriction. She applied for a front end assistant job without knowing the physical requirements of this job. Respondent told her to apply for jobs, indicating they could possibly be modified to fit her needs. T. 85. The manager she met with told her she would basically be a "front end assistant [who] would need an assistant." Ultimately, she was told the front end assistant job could not be modified for her. T. 86. She has never worked in an optical department at Respondent. She did deal with customers in the bakery department, in terms of directing them to products, but she never dealt with eyeglasses. T. 88. Dan told her to ignore the written offer of the optical job because it was at a location other than the three she designated and because he was not sure where the letter originated. T. 89. The fall that led to the coccyx injury occurred at home, not work. She was off work for a month or so after that fall. She did not injure her right arm when she fell. T. 89-90.

Under re-cross, Petitioner testified she is not sure how long she worked between the time she returned to work after the coccyx injury and her accident of August 1, 2012. T. 90. She believes Dan told her to "dismiss" the offer of the optical department job at the Schaumburg location. T. 90.

Daniel LaVigne testified on behalf of Respondent. LaVigne testified he has worked for Respondent for eighteen years. T. 111. He currently works as the general manager at Respondent's Niles location. T. 93. He oversees 240 employees there, managing everything from sales to member services to finances. T. 93. One of his duties is to help place injured employees who have work restrictions. T. 93. Respondent's policy is to submit an injured worker's permanent restrictions to the "leave department" and arrange a job assessment meeting with the worker to see whether his current job can be modified in such a way as to meet the restrictions. T. 94, 99.

LaVigne testified he is familiar with Petitioner. He and Petitioner never worked together but he met her "through the job assessment process." T. 95. He first met with Petitioner on May 5, 2015. At that meeting, he and Petitioner agreed that, given Petitioner's restrictions, Respondent could not accommodate her via her previous cake decorator position. T. 95.

LaVigne testified that, at some point, Respondent offered Petitioner a "non-licensed optician" position at its Schaumburg location. He indicated he is "somewhat" familiar with the requirements of this position. It is his understanding that a non-licensed optician helps customers select and order eyeglass frames and also fits those frames to the customer's nose and ears. T. 96. The fitting is done while the optician is seated. T. 97.

LaVigne acknowledged he does not recall discussing the "non-licensed optician" job offer with Petitioner. If Petitioner testified that he told her to ignore this offer, that would not make sense to him. T. 98.

LaVigne testified that an injured worker who is subject to restrictions can sometimes be accommodated at a location other than his original location if he "requests to have an expanded job posting notification." Petitioner requested such a notification. It is his recollection, based on his review of the minutes of the job assessment meetings, that Petitioner asked to be notified of job possibilities at Respondent's Melrose Park, Mount Prospect and Schaumburg locations. T. 100-101. When he met with Petitioner, he would not have discussed offers at other locations. T. 101. He would have focused on the job he was offering. T. 101.

LaVigne testified he recalls meeting with Petitioner on August 12, 2015. At that meeting, he offered Petitioner a full-time outside marketer job at the same rate of pay Petitioner earned as a cake decorator. T. 102. An outside marketer travels to various businesses within a 5-mile radius of a Respondent warehouse to review the benefits of a Respondent membership with business owners and their employees. T. 102. An outside marketer might drive to as many as three businesses within that radius on any given workday. It is also possible that an outside marketer would have no appointments and do no driving on a particular day. The following exchange then occurred between Respondent's counsel and LaVigne:

> "Q: Would it have required driving 100 miles a day?
>
> A: I can't imagine, but I would never say never. I would think exceedingly rare, if ever."

T. 103. LaVigne testified that the outside marketer job he offered to Petitioner was based at the Niles facility. T. 103-104.

LaVigne testified he maintains a record of any job assessment meeting he holds. He identified RX 2 as a signed summary of the minutes of the meeting he had with Petitioner on August 12. 2015 meeting. He read and signed this summary but did not create it. T. 105. It is recollection that Petitioner declined the offer of the outside marketer job. When she declined the offer, she "referenced something about driving." T. 105.

LaVigne testified he believes Petitioner attended a third job assessment meeting at Respondent's Melrose Park location. Petitioner had expressed interest in a job at that location and then met with the general manager. He does not know what job Petitioner expressed interest in. T. 106.

LaVigne testified he is familiar with a Respondent job known as "front end assistant." This job is classified as medium to heavy duty. A front end assistant helps customers place their purchases on a conveyor belt and also helps them load scanned items back into their carts. T. 106. Respondent's policy is that any item weighing over 15 pounds stays in the cart. T. 107. A front end assistant job is one that a restricted employee can be accommodated into. T. 107.

LaVigne testified he believes the third job assessment meeting took place on September 11, 2015. He identified RX 3 as the minutes of that meeting. An outside party would have typed up these minutes and then submitted them to the Melrose Park general manager and Petitioner for their signatures. T. 108.

LaVigne testified he is not familiar with the restrictions Petitioner presented to the Melrose Park general manager at the September 11, 2015 meeting. T. 108.

Under cross-examination, LaVigne acknowledged he did not attend the September 11, 2015 meeting. Petitioner was not offered a front end assistant position at that meeting. T. 109. A front end assistant would be regularly required to lift items exceeding 10 pounds in weight. T. 109. If a customer happened to place an item weighing more than 15 pounds on the belt, a Respondent employee, meaning either the cashier or the front end assistant, would offer to return that item to the customer's cart. T. 110.

LaVigne testified Petitioner would not be required to drive up to 100 miles a day as an outside marketer. T. 111. LaVigne acknowledged he has never worked as an outside marketer. T. 111. It would not refresh his memory if Petitioner testified he told her to ignore an offer of a job at the Schaumburg location because Schaumburg was not one of the locations she selected. T. 111. He does not know whether Petitioner worked as a greeter for a few weeks after being placed on restrictions. He was not working at the Niles location at that time. T. 112-113. A greeter falls into the "member service" job category. A "member service" employee would rarely, if ever, have to lift anything but might have to lift an item to check underneath it. T. 115. If such a job was posted and Petitioner responded to the post, Respondent would have brought her in for a job assessment meeting. T. 115. Petitioner would have learned of every job that was posted and would have had the first opportunity to post for those jobs. Once Petitioner posted, the job would be "frozen" until a job assessment meeting was held. T. 116.

Petitioner was called in rebuttal. Petitioner testified that, when she first told LaVigne about the offer at the Schaumburg location, he told her to ignore the offer, indicating he did not know how anyone at that location could have obtained her information. T. 120. LaVigne also told her that an outside marketer might have to drive up to 100 miles per day. T. 120-121. LaVigne also told her that, if she was required to lift more than 10 pounds while performing a job, Respondent would provide her with an assistant to perform that lifting. When she met with the general manager at the Melrose Park location, he told her he would not have someone available all the time to help her with this. This is why the general manager did not offer her the front end assistant job. T. 124. She asked Respondent to place her in a greeter job. She E-mailed one of the women named Julie to ask whether there were any available jobs as a greeter or a clothes folder and Julie responded that no such jobs were available. T. 125. Petitioner acknowledged she was aware she had to post for job openings. Julie would send her a list of available jobs at the Niles, Melrose Park and Mount Prospect locations. Julie told her to apply for any of these jobs that she wanted to, subject to a job assessment meeting that would then be held to determine whether the job could be accommodated to meet her restrictions. T. 126. It was after Julie E-mailed her a list of openings at the three locations that she

expressed interest in the front end assistant job. Later, Julie told her there were no jobs within her restrictions and stopped sending her listings. T. 126.

Arbitrator's Credibility Assessment

Respondent maintains that Petitioner's credibility is undermined by her pre-accident records (RX 5), which document treatment for work-related anxiety, among other conditions. While it is clear that Petitioner's job was causing her some degree of stress, the Arbitrator does not view that as a valid basis for questioning Petitioner's motivation, especially given Respondent's limited stipulations to accident, causation and a period of temporary total disability.

Petitioner provided a detailed and credible description of her cake decorator duties. Petitioner also credibly testified that she primarily used her dominant right hand to squeeze the frosting bags so as to create words and designs. Respondent did not refute Petitioner's testimony that she spent four to six hours per workday squeezing these bags. This testimony is bolstered by Dr. Rimington's initial history, which reflects that Petitioner reported being required to decorate 34 cakes in a single shift on July 31, 2012.

None of the physicians who treated or examined Petitioner noted symptom magnification. Dr. Mass testified there was only one occasion on which he was unable to explain Petitioner's symptoms. He was later able to arrive at a diagnosis, i.e., right cubital tunnel syndrome.

The Arbitrator finds credible Petitioner's testimony that, per Respondent, she could have opted to look for accommodated positions only at her original location in Niles. That Petitioner opted to venture outside that location so as to include locations in Mount Prospect and Melrose Park weighs in her favor.

Respondent's witness, general manager LaVigne, candidly acknowledged he did not recall Petitioner's restrictions. He also conceded that the outside marketer job that was offered to Petitioner might have involved driving up to 100 miles in a single day, although he went on to state that this would be rare. He admitted he has never worked as an outside marketer. He did not refute Petitioner's testimony that the outside marketer position also involved pulling items from the warehouse. Nor did he refute Petitioner's testimony that she could have opted to apply only to jobs at her regular Niles location. He did not directly refute Petitioner's testimony that he told her to ignore the offer of a job at a location [Schaumburg] she had not selected. He conceded he had no recollection of discussing that offer with Petitioner. T. 98. He also conceded that Respondent did not offer Petitioner a modified version of her original job and that the front end assistant position Petitioner applied for was outside Petitioner's restrictions. Ultimately, LaVigne bolstered Petitioner's claim rather than Respondent's defense.

Arbitrator's Conclusions of Law

Did Petitioner establish a right elbow/arm injury secondary to repetitive trauma manifesting on August 1, 2012? Did Petitioner establish causation as to her claimed current right elbow and arm condition of ill-being?

Respondent concedes Petitioner sustained injuries secondary to repetitive trauma manifesting on August 1, 2012. Respondent also concedes that these injuries gave rise to the need for surgery performed in 2013 and 2014. T. 4-5. The issue is whether Petitioner's cake decorator duties also caused a right cubital tunnel condition. Respondent's examiner, Dr. Carroll, acknowledged Petitioner requires surgery for this condition but he does not view the condition as work-related.

The Arbitrator finds that Petitioner established accident/repetitive trauma and causation insofar as her current right cubital tunnel condition is concerned. In so finding, the Arbitrator relies on the following: 1) Petitioner's detailed and credible testimony that she primarily used her dominant right upper extremity in performing her cake decorator duties; 2) the written job description that appears in one of Respondent's exhibits, which describes Petitioner as having to frequently perform "power grasping" exceeding 8 pounds of force and "repetitive hand motions"; 3) the fact that right elbow complaints are documented (by Dr. Garces of Concentra) as early as August 6, 2012 (PX 1); 4) the fact that Petitioner's first surgeon, Dr. Rimington, initially, and reasonably, focused on the pronator tunnel syndrome, based on the earliest EMG results; 5) Dr. Mass's testimony that different nerve-related disorders can exist simultaneously and can be "unmasked" as they are treated; 6) the fact that Dr. Carroll, Respondent's examiner, diagnosed right cubital tunnel syndrome requiring surgery and, ultimately, could not completely rule out Petitioner's work activities as a cause of that condition; 7) Petitioner's credible denial of any post-accident right elbow injuries; and 8) the fact that Petitioner has no left-sided impairment. The Arbitrator believes that, if Petitioner's cubital tunnel syndrome was in fact idiopathic or positional, as Dr. Carroll theorized, it would be bilateral.

The Arbitrator acknowledges that Petitioner has presented different symptoms at different times. The Arbitrator notes Dr. Mass's testimony that, of the various nerve syndromes, cubital tunnel, in particular, can vary in its presentation. PX 4 at 32. Dr. Mass did not view Petitioner's relative inactivity while off work as a reasonable basis for doubting the diagnosis.

The Arbitrator views Petitioner's current right elbow condition of ill-being as multi-factorial. As Dr. Mass testified, it could be that the therapy and work conditioning Petitioner performed over time contributed to the development of right elbow symptoms or caused those symptoms to become more noticeable. The fact that treatment for an undisputed condition might contribute to the development of another condition does not make that second condition non-compensable. Under Illinois law, a claimant need only show that work activity was a cause of her condition. She need not exclude all other potential contributing factors. Sisbro v. Industrial Commission, 207 Ill.2d 193 (2003).

Is Petitioner entitled to temporary total disability benefits from November 7, 2014 through September 13, 2016?

Respondent focuses primarily on Dr. Mass's note of November 6, 2014 and its allegation that Petitioner improperly declined job offers in arguing that it is not liable for temporary total disability benefits from November 7, 2014 through the hearing.

The Arbitrator, having considered Respondent's arguments and the evidence as a whole, finds that Petitioner is entitled to temporary total disability benefits during the disputed period, November 7, 2014 through the hearing. The Arbitrator does not view Dr. Mass as releasing Petitioner to unrestricted work as of November 6, 2014. When the November 6, 2014 note is placed in context, it is clear that the doctor was referring to his prior light duty release when he indicated Petitioner could return to work. He emphasized that he had previously found Petitioner capable of light duty but that Petitioner was still off work because no light duty had been offered to her. In his previous note, he had stated Petitioner could perform light duty but no cake decorating. In his November 6, 2014 note, he did not find Petitioner capable of cake decorating.

This interpretation is bolstered by subsequent notes, in which the doctor recommended right cubital surgery and re-addressed work capacity. The Arbitrator views Dr. Mass as having offered a reasonable alternative which Respondent declined to pursue. In his note of June 1, 2015, Dr. Mass expressed criticism of the most recent functional capacity evaluation, indicating it did not really replicate Petitioner's repetitive duties, but offered an alternative, i.e., a very gradual return to work, with Petitioner initially attempting to resume cake decorating for only one hour per day and building up duration as tolerated. Respondent could have availed itself of this option at any time, while continuing to dispute causation, but opted not to do so. Respondent's witness, Daniel LaVigne, readily conceded that Respondent declined to refashion Petitioner's cake decorator job so as to accommodate her restrictions. RX 1 shows that Respondent responded to Dr. Mass's suggestion of a gradual return to work by offering Petitioner a non-bakery job that would require "self-monitoring" in order to meet the existing restrictions and at a location other than the three Petitioner designated. The Arbitrator views this offer as disingenuous.

Moreover, Respondent's own examiner, Dr. Carroll, indicated on September 26, 2014 that Petitioner required more treatment and work restrictions (for her undisputed post-operative condition) and would not reach maximum medical improvement for another six months.

In awarding temporary total disability benefits, the Arbitrator also relies on Interstate Scaffolding v. IWCC, 236 Ill.2d 132 (2010) and Sunny Hill of Will County v. IWCC, 2014 Ill.App.3d LEXIS 454 (3rd Dist. 2014). In Interstate Scaffolding, the Supreme Court emphasized that the "dispositive" issue in determining entitlement to temporary total disability benefits is whether the claimant's condition has stabilized. In Sunny Hill, the Appellate Court held that a claimant's ability to return to work in some capacity is but one factor to consider in determining whether

the claimant's condition has stabilized. As of November 6, 2014, Dr. Mass was still recommending treatment, i.e., therapy, for the conditions he had previously addressed surgically. He had not yet diagnosed, or recommended surgery for, right cubital tunnel syndrome. He testified he arrived at this diagnosis with the help of two individuals: Dr. Carroll and Petitioner, who, at a return visit, had less diffuse symptoms and was able to hone in on what was bothering her.

Is Petitioner entitled to prospective care?

Based on the foregoing findings as to accident and causation, the Arbitrator grants Petitioner's request for prospective care. The Arbitrator awards prospective care in the form of a return visit to Dr. Mass along with a right cubital tunnel release, assuming the doctor still finds that surgery to be appropriate.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gerald T. Morsovillo,

Petitioner,

vs.

NO: 10 WC 14721
12 WC 17526

FE Moran Fire Protection,

18IWCC0082

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 employment relationship, accident, notice, causation, temporary total disability, medical expenses, and penalties, and being advised of the facts and law, reverses the Decision of the Arbitrator in case 12 WC 17526 and modifies the decision in case 10 WC 14721, as stated below. The Commission further remands case 12 WC 17526 to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Findings of Fact

The Commission hereby incorporates by reference herein the statement of facts contained in the Arbitration decisions in claims 10 WC 14721 and 12 WC 17526, and notes the following:

Petitioner testified that he worked as a sprinkler fitter for 39 years and that his job involved installing pipes, valves, fire pumps, dry pipe systems, and control valves for fire protection systems. (A.23,26).[1] He indicated that the size of the pipes ranged from one to ten-

[1] The Commission notes that for purposes of this decision, pages from the hearing held on 2/27/14 will be designated by the letter "A"; pages from the 3/25/14 hearing by "B"; pages from the 4/25/14 hearing by "C"; pages from the 7/14/14 hearing by "D"; and pages from the 9/3/14 hearing by "E."

inches in width and from a foot to twenty-feet in length. (A.24-25). He stated the weight of these pipes varied and could weigh as much as 250 pounds. (A.27). He also noted that these pipes would typically be installed in the ceilings of buildings, and that he would use wrenches and drills to mount the hangers for the pipe. (A.27-28). He indicated that the drills he used weighed between 20 and 25 pounds and that the wrenches were heavier. (A.28). He noted that his duties as a sprinkler fitter remained basically the same during the 39 years that he worked, although he noted that the industry is now using some plastic systems that he never installed himself. (A.24).

Petitioner described the process of installing pipes as involving getting the pipe in the building, laying it out on the floor based on the print designs, and installing the hangers, Victaulic and screw fittings. (A.31-32). He noted that the pipes were installed with the fittings on them, and that to get the pipes in the air they would use a lift or man lift. (A.32-33). He indicated that the first thing that goes up are the cross mains, which come off the fire pump or the city supply, using the man lift. (T.33). He stated that once they get the pipe at the elevation called for in the blueprint "... you still have to lift the pipe to get it up into the hangers", which he would do by lifting it up off the man lift onto his shoulders. (A.33-34). He indicated that he would then "catch" a ring on the pipe on a rod hanging from the ceiling using his arms, shoulders and legs, and then go on to the next piece of pipe. (A.34). He noted that he would have to balance the heavier pipes on his shoulder and lift with his legs, and that he "... sometimes actually put [his] head underneath it and lift[ed] it to catch the ring onto the rod." (A.35). When using his head in this fashion, Petitioner stated that he would "... get my body directly underneath the pipe, get ahold of the ring. It has a button on it that's threaded. I lift with my head and catch it with a channel lock." (A.35). He explained that he would use his head because he "... just needed that extra half an inch" to keep the pipe in place while he used his hands to catch the ring on the rod and hold the channel lock. (A.35-36). He agreed that once the pipe is installed he would begin the process all over again. (A.38).

Petitioner testified that during the period of January to March of 2009 he noticed that he "... was getting pain generating up my neck causing me to get headaches. I was getting weakness in my shoulders and arms." (A.50). He indicated that he would notice these symptoms when "[d]riving, taking ladders and power machines out of the truck. Going up the ladders, any movement with my arms, with like working with a wrench", particularly while working overhead and "taking the pipe up." (A.50). Petitioner testified that he would notice these symptoms "[e]very day." (A.51).

Petitioner testified that he was let go by Respondent in March of 2009 as part of a layoff, and that he then decided to retire. (A.54). When asked why he decided to retire at that time, Petitioner stated that "I noted that the trade was getting slow, so instead of trying to get another job with another company, I retired. And my neck was bothering me more, so I just retired." (A.55). Petitioner noted that during the last thirteen (13) years of his career he worked as a sprinkler fitter foreman for FE Moran Fire Protection, the Respondent herein. (A.38). He noted that as a foreman he continued installing pipes performing the same installation process he previously described. (A.39-40). He also indicated that as a foreman he would have to supervise young apprentices and actually show them the way to do things. (A.40). He noted that during the last six months of his employment he worked in the service department doing "freeze-ups" – when client's pipes freeze due to standing water -- and other service calls. (A.39).

Petitioner filed two (2) Applications for Adjustment of Claim – the first filed on 4/16/10 alleged a date of accident of 4/7/10 (10 WC 14721) while the second filed on 5/18/12 alleged a date of accident of 5/26/09 (12 WC 17526). Petitioner represented on both Application forms that the employer was notified in writing of the respective claimed accident.

Petitioner testified that he had a "general" recollection of having conversations in the period around March of 2009 regarding his neck complaints with Scott Massoglia, whom he claimed was his superintendent, or the guy "... who lets me know where I am working at." (A.51-52). Petitioner reiterated his claim that Mr. Massoglia was his supervisor at the hearing held on 9/3/14. (E.11). For his part, Mr. Massoglia claimed that Petitioner never reported to him and that he never acted as the latter's supervisor. (C.9). In any event, Petitioner testified that in general he "[j]ust mentioned [to Mr. Massoglia] that my neck was bothering me" and that "[i]n conversation I just said, my neck is bothering me today." (A.52). Petitioner stated that he did not relate these complaints to any of his activities at that point, and that he "[j]ust kept on working." (A.52).

Petitioner later testified that he specifically told Mr. Massoglia about his work in relation to his neck hurting. (E.12). He indicated that "I would tell Scott when I finished the project that we were doing that my neck was bothering me. It was three or four times because I didn't work with him all the time. In service there's times I worked by myself." (E.14). Petitioner acknowledged that he did not ask to fill out an accident report with respect to these complaints at that time even though he was aware that one needed to be filled out and that he had in fact filled out one before. (E.14-15).

The record shows that Petitioner visited Dr. William Farrell on 5/26/09 (12 WC 17526). In a report on that date, Dr. Farrell recorded that "[f]or 6 months, [Petitioner] has been having cervical spine pain to the point where he made an appointment to see me. There is no history of injury. He retired not long ago as an iron worker. His job clearly has contributed at least in part to his back condition and to now his neck condition. He denies any arm pain. There is no numbness or tingling to account for these symptoms. He has restriction with respect to rotation to both sides. His symptoms are primarily in the midline able to affect both traps and will create the secondary headaches. Resting will tend to quiet it down, but the minute he is active, will have reproduction of his symptoms. He denies any recent injurious event. His symptoms are worse with certain weather as well." (PX4). X-rays taken on that date revealed "... evidence of disk narrowing consistent with mild degenerative joint disease but no acute changes noted." (PX4). Dr. Farrell recommended outpatient physical therapy and a follow-up appointment in one month. (PX4).

Seven months later, in a follow-up note dated 12/22/09, Dr. Farrell recorded that Petitioner "... has no degenerative arthritis of the cervical spine. He has chronic pain in that area with intermittent episodes of worsening. While he denies any significant arm pain, he does have referred pain to the shoulders, like through the trapezius. The patient denies any numbness in the upper extremities at present..." (PX4). Petitioner was to continue with his medication and exercises and was instructed to "... make the appropriate appointments in the event his situation worsens." (PX4).

On 4/7/10, Petitioner visited Dr. Anthony Rinella (10 WC 14721). On that date, Dr. Rinella recorded that Petitioner was "... a 62-year-old sprinkler fitter that was injured at work on March 10, 2009. He does not recall a specific injury. Over a 4-6 month period he developed progressive pain in his neck that caused occipital headaches and bilateral trapezial pain. He stated his job regularly involves lifting heavy pipes up to high levels. At times when he was unable to lift with his shoulder due to the height of the pipe, he would lift the pipe with his head. He worked with the same company for many years and feels as though this is a repetitive injury as opposed to a specific event. He saw Dr. Farrell in March of 2009, right after the injury and cervical radiographs were taken. He has since retired due to the pain. He rates his pain at 5/10 on a 10-point visual analog scale mostly in the posterior-inferior neck on the left side in trapezial areas. He has radiating symptoms more distally." (PX1). Following his examination and review of imaging studies, Dr. Rinella's impression was "[c]ervical spondylotic radiculopathy – work related." (PX1).

At the hearing held on 2/27/14, when asked when he first realized that his neck condition might be related to his work activities, Petitioner responded: "I want to say December." (A.53). When reminded about his testimony as to his conversations with Mr. Massoglia in March, Petitioner stated that he believed he realized his neck pain might be related to his work activities "[i]n March – sorry, in February." (A.53).

At the hearing held on 9/3/14, Petitioner testified that he first became aware that his neck problems were the result of his work activities when he saw Dr. Rinella on 4/7/10. (E.10). He agreed that at that time Dr. Rinella informed him the problem he was having with his neck was the result of his work as a sprinkler fitter. (E.10-11). He also indicated, once again, that before he left Respondent's employ he told Mr. Massoglia "[p]robably three or four times" that he was having neck pain, and that "[a]fter I performed the duty I was doing, I would say to him when I got finished with it: The area I've been in really hurt my neck." (E.11).

Also at the hearing held on 9/3/14, Petitioner agreed that he had previously testified that when he saw Dr. Farrell in May of 2009 he believed his neck pain was secondary to his work as a sprinkler fitter. (E.19). He likewise agreed that it was fair to say that his position here today is that his work activities in 2009 caused his neck pathology. (E.20-21). In addition, Petitioner noted that Dr. Farrell informed him at that time that his work activities were the cause of his neck pain. (E.24).

In a report dated 4/19/10, Dr. Faris Abusharif of Pain Treatment Centers recorded that the patient presented with "... cervical pain which radiates to the bilateral shoulder and occasionally to the upper extremities... Patient states pain is located in neck, the head. Duration of the symptoms since one year ago. The patient was employed as a pipe fitter for many, many years which involved hours daily of having his head in the extended position. This will likely contribute to facet arthropathy and cervical stenosis. Pain just started, no reason. Injury occurred from repetitive activity..." (PX2). Following his examination and review of imaging studies, Dr. Abusharif's assessment was cervical intervertebral disc displacement. (PX2).

At the time of his deposition, board certified orthopedic surgeon Dr. Rinella testified that he believed Petitioner had retired due to neck pain, and that his diagnosis at the time of his first

visit on 4/7/10 was "... work-related cervical spondylotic radiculopathy or a pinched nerve." (PX6, p.7). In addition, he noted that it was his understanding that the document entitled "Sprinkler Fitter Job Elements" for sprinkler fitters Local 281 reflected the work activities that were described to him by Petitioner. (PX6, p.8). As a result, Dr. Rinella felt that Petitioner's work activities as a sprinkler fitter caused or contributed to the diagnosis of cervical spondylitic radiculopathy, noting that Mr. Morsovillo "... placed heavy emphasis on lifting things to shoulder height and above, which is listed here, but that was one of the more particularly difficult maneuvers for him to perform." (PX6, pp.8-9). Dr. Rinella also agreed that this initial visit on 4/7/10 was the first time he informed the patient that his cervical radiculopathy was related to his work activities. (PX6, p.9).

The Local 281 "Sprinkler Fitter Job Elements" referred to by Dr. Rinella show that the job involved installing pipe and various devices for automatic fire protection systems. (PX7). The normal work day was 7:00 a.m. to 3:30 p.m. with a half hour lunch break, Monday through Friday. (PX7). It was noted that "[t]hey work at various jobsites both inside and outside, and are subject to heights, noise, dampness, heat or cold. Within a day, they use pipe threading machines, electric drills, hammers, chisels, pipe wrenches; all of which require firm grasping and repetitive motions. They spend 30% of their time walking or standing and 70% working on ladders or scaffolds. While performing their job, they may be required to twist, stoop, bend, squat, kneel, climb stairs, lift objects over their head, or walk on uneven surfaces." (PX7).

Furthermore, this job description noted that "[w]hen installing pipe, they bend over, pick up one piece (average length 12 feet), hold it overhead, align the thread with the fitting firmly grasping and rotating until hand tight. A hanger is then attached to the building structure, and a pipe wrench 18 or 24 inches in length is used to tighten sufficiently to hold 200 p.s.i. of water pressure. This task is repeated 80 to 125 times in an average day[']s work. Because of the above requirements, there are no light duty or restricted jobs for a sprinkler fitter." (PX7).

Board certified orthopedic surgeon Dr. Joseph T. Monaco examined Petitioner on 3/10/11 at the request of Liberty Mutual and Respondent #1 (10 WC 14721). (R#1X6, pp.4-9). Dr. Monaco noted that Petitioner informed him the pain in his neck developed after he retired. (Id., p.18). However, Dr. Monaco noted that when Petitioner saw Dr. Farrell in May of 2009 Mr. Morsovillo informed the latter that his pain had been going on for four to six months, with no specific injury having occurred at work. (Id., p.18).

Following his examination and review of the medical records, Dr. Monaco testified that he was of the opinion "... to a reasonable medical certainty that I saw no proximate cause of Mr. Morsovillo's neck and radicular pain related to his work for F.E. Moran Fire Protection." (Id., p.26). He agreed that this would be based on the fact that Petitioner reported no specific trauma. (Id., pp.26-27). Dr. Monaco also noted that "... it is my opinion to a reasonable medical certainty considering medical evidence and Mr. Morsovillo's specific history that there is not support for repetitive injury at F.E. Moran Fire Protection as the cause of the subsequent neck pain following retirement." (Id., p.27). Dr. Monaco noted that "... there are many other factors that are more likely to have contributed to his neck pain developing at 63. Age is the most significant thing ..." (Id., p.31). He later testified that "... this was a[n] age-related degenerative condition that pre-existed the onset of his complaints, is my opinion." (Id., p.36).

Dr. Monaco also indicated that "... the history [Petitioner] gave me was not consistent with the history in the medical records. The history he gave me was the pain started after he retired; however, the medical records seem to indicate that it was there for, I would say, three, at least three to four months while he was working before he retired." (Id., pp.32-33).

On cross examination, Dr. Monaco agreed that the degenerative changes seen on Petitioner's imaging reports weren't symptomatic. (Id., p.42). However, when asked whether Petitioner had symptomatic complaints of pain that were consistent with the objective findings on the imaging studies, Dr. Monaco stated that "... he had complaints and he had findings on an MRI, and you could try to correlate the two. I mean, you can't say that every – in other words, every individual with that kind of finding is not going to have neck pain and everybody with neck pain doesn't have to have any, you know, specific findings. It's you correlate the two. You never look – you don't want to look at them separately." (Id, pp.42-43). He went on to state that "... there was no smoking gun on those imaging findings." (Id., p.43).

However, Dr. Monaco agreed that if the history did show that Mr. Morsovillo had complaints of symptomatic neck pain prior to his retirement then he would be of the opinion that the work activities could have caused or contributed to that neck pain. (Id., p.44). He also agreed, despite earlier statements on direct, that there is medical literature in peer-reviewed journals that suggest overhead lifting and repetitive activities can cause or contribute to degenerative changes in the neck, although he added that "[t]here's also evidence that contradicts that." (Id., p.45). Dr. Monaco also did not know whether his review of the medical records included the description of Petitioner's job activities and the fact that his neck pain predated his retirement as contained in Dr. Rinella's records. (Id., p.47). He also conceded that his report does not mention that Dr. Abusharif had noted Petitioner had complaints of neck pain over a year ago and that the pain had started from repetitive activities. (Id., pp.47-48). While Dr. Monaco agreed with the recommendation for surgery, he noted that he does not perform spine surgery himself. (Id., p.58). On re-direct, Dr. Monaco agreed that this was age-related degenerative findings about the cervical spine that were unrelated to his work for F.E. Moran. (Id., p.63).

On re-cross, Dr. Monaco reiterated that "[i]t is my opinion that in this case that the degenerative changes, which were mild in nature, were not caused by his work-related activity." (Id., p.64). He indicated this opinion is based on "... the history given to me that he had not developed pain until after retirement." (Id., p.65). However, he noted that "... if you change the information, I might change my opinion." (Id., p.65). Dr. Monaco also stated that "... I put more credence in the history he gave Dr. Farrell than the history he gave me." (Id., p.67). He went on to state that "... I can't eliminate the history he gave me, and I used that information to make my opinion; but I'm aware in my mind it's information that he gave Dr. Farrell, you know, within two months after he retired is more credible than what he gave me a year later." (Id., pp.67-68). Furthermore, Dr. Monaco agreed that work activities are one of many multi-factoral reasons that cause neck pain, and that he believed Petitioner's work activities, such as overhead lifting, was one of the factors that contributed to the neck pain that he ultimately sought treatment for with Dr. Farrell. (Id., p.70). On further redirect, Dr. Monaco agreed that once you remove work as a factor in neck pain, then it ceases to be a factor. (Id., p.71). Thus, since Petitioner last worked in March of 2009, Dr. Monaco agreed that it would cease to be a risk factor after that date. (Id., p.71).

At the request of Respondent #2 (12 WC 17526), Petitioner was examined by board certified orthopedic surgeon Dr. Alexander J. Ghanayem on 4/8/13. (R#2X3, p.5). Dr. Ghanayem recorded a history of neck pain starting 4/7/10 due to long-term lifting as a sprinkler fitter, having retired in 2009. (Id., p.8). Dr. Ghanayem noted that he reviewed the records and found "[f]rom a structural standpoint, the MRI showed multiple levels of cervical spondylosis. My review of that MRI scan revealed that it was age appropriate. That for a guy between 60 and 70, to show this degree of arthritis, it was not excessive. He didn't distinguish himself in a negative or positive way. He just had standard old-guy spondylosis." (Id., pp.11-12). As a result, Dr. Ghanayem did not believe there was a causal connection "... between [Petitioner's] work and his soft tissue neck symptoms and his arthritis." (Id., p.13). He indicated that it "makes sense" if Petitioner gave a history of his symptoms progressing over the past year even though he was not working during that time, noting that "... the fact it is getting worse over the past year as he is getting older with his problem is kind of typical. It's not a surprise." (Id., pp.13-14).

On cross, Dr. Ghanayem noted that he could not specifically recall whether he reviewed any records from Drs. Farrell or Rinella. (Id., p.21). He also noted that he could not recall if he reviewed a job description in this case, but that he has seen a job description for a sprinkler fitter before. (Id.). He noted that "[o]bviously a lot of the work is done overhead because you don't put sprinklers in floors, but you put them in ceilings." (Id., p.22). He indicated that he did not know how long Petitioner worked as a sprinkler fitter, or how long he worked for F.E. Moran. (Id., pp.22-23). He also did not recall whether he asked Petitioner to describe his job duties or job activities or if Petitioner did so himself. (Id., p.24).

When asked whether his opinions would change if he learned the neck pain developed before Petitioner retired, Dr. Ghanayem testified that "[i]f he had pain in his neck while at work, you could have soft tissue pain while at work depending on the job you have." (Id., pp.26-27). Dr. Ghanayem indicated that Petitioner had "radiographic spondylosis", but did not have symptomatic spondylosis. (Id., p.28). He noted that "[i]f the sprinkler fitter job is going to aggravate his condition, the type of aggravation you will have is when working overhead and causing extension-type problems to the cervical spine, you will reproduce radiculopathy from a neuro-compressive lesion. That's the type of aggravation you could get from sprinkler fitting type of work." (Id., pp.34-35).

Conclusions of Law

An employee seeking benefits for gradual injury due to repetitive trauma must meet the same standard of proof as a petitioner alleging a single, definable accident. *Three "D" Discount Store v. Industrial Commission*, 144 Ill.Dec.794, 797, 556 N.E.2d 261, 264 (Ill. App. 4 Dist. 1989). The Petitioner must prove a precise, identifiable date when the accidental injury manifested itself. "Manifested itself" means the date on which both the fact of the injury and the causal relationship of the injury to the petitioner's employment would have become plainly apparent to a reasonable person. *Three "D" Discount Store*, 144 Ill.Dec.at 797; citing *Peoria County Belwood Nursing Home v. Industrial Commission (1987)*, 115 Ill. 2d 524, 505 N.E.2d 1026. The test of when an injury manifests itself is an objective one, determined from the facts and circumstances of each case. *Luttrell v. Industrial Commission (1987)*, 154 Ill.App.3d 943, 507 N.E.2d 533.

"By their very nature, repetitive-trauma injuries may take years to develop to a point of severity precluding the employee from performing in the workplace. An employee who discovers the onset of symptoms and their relationship to the employment, but continues to work faithfully for a number of years without significant medical complications or lost working time, may well be prejudiced if the actual breakdown of the physical structure occurs beyond the period of limitation set by statute. Similarly, an employee is also clearly prejudiced in the giving of notice to the employer if he is required to inform the employer within 45 days of a definite diagnosis of the repetitive-traumatic condition and its connection to his job since it cannot be presumed the initial condition will necessarily degenerate to a point at which it impairs the employee's ability to perform the duties to which he is assigned. Requiring notice of only a potential disability is a useless act since it is not until the employee actually becomes disabled that the employer is adversely affected in the absence of notice of the accident." *Oscar Mayer & Co. v. Industrial Commission*, 126 Ill.Dec. 41, 43, 176 Ill. App. 3d 607, 611, 531 N.E.2d 174, 176 (Ill.App.4 Dist.).

Based on the above, and the record taken as a whole, the Commission reverses the decision of the Arbitrator in claim 12 WC 17526 and finds that Petitioner proved by a preponderance of the credible evidence that he sustained accidental repetitive trauma-type injuries arising out of and in the course of his employment as of 5/26/09. The Commission notes that while Petitioner's testimony is admittedly confusing as to the date he first equated his neck complaints to his work activities, the record shows that he did not seek treatment and was not informed by a physician that his condition was likely due to his work activities until he visited Dr. Farrell on 5/26/09. At that time, Dr. Farrell recorded that Mr. Morsovillo's job "... clearly has contributed at least in part to his back condition and to now his neck condition." (PX4). Likewise, Dr. Abusharif, in his report dated 4/19/10, recorded that Petitioner's neck complaints had begun a year earlier, that he had been "...employed as a pipe fitter for many, many years which involved hours daily of having his head in the extended position" and that the "[i]njury occurred from repetitive activity..." (PX2).

More importantly, the evidence shows that Petitioner's job as a sprinkler fitter over the course of 39 years entailed the frequent and repetitive use of his arms, shoulders and neck overhead while installing and securing heavy pipes in the ceilings of buildings. Furthermore, there is no evidence to suggest that Petitioner had any symptoms relative to his neck prior to January of 2009, when he claimed he started noticing same, or that he sought treatment for any such complaints before his initial visit to Dr. Farrell on 5/26/09. As a result, the Commission finds that Petitioner proved by the preponderance of the evidence that he sustained accidental injuries arising out of and in the course of his employment, and that said injuries manifested themselves as of 5/26/09 (12 WC 17521).

The Commission further finds that Petitioner's current condition of ill-being is causally related to the accident on 5/26/09 based upon the opinions and records of Drs. Farrell, Abusharif and Rinella. Along these lines, Dr. Rinella opined that Petitioner's work activities as a sprinkler fitter caused or contributed to the diagnosis of cervical spondylitic radiculopathy, noting that Mr. Morsovillo "... placed heavy emphasis on lifting things to shoulder height and above, which is listed [in the job description at PX7], but that was one of the more particularly difficult maneuvers for him to perform." (PX6, pp.8-9). In addition, Drs. Farrell and Abusharif also

referenced the job-relatedness of Petitioner's cervical complaints in their office notes dated 5/26/09 and 4/19/10, respectively. (PX4, PX2). Even Respondents' §12 examining physicians, Drs. Monaco and Ghanayem, seemed willing to concede that Petitioner's work activities could have contributed to his cervical injury. Indeed, Dr. Monaco agreed that if the history showed Petitioner had complaints of symptomatic neck pain prior to his retirement then he would be of the opinion that the work activities could have caused or contributed to that neck pain. (R#1X6, p.44). Similarly, Dr. Ghanayem acknowledged that "[i]f he had pain in his neck while at work, you could have soft tissue pain while at work depending on the job you have" and that "[i]f the sprinkler fitter job is going to aggravate his condition, the type of aggravation you will have is when working overhead and causing extension-type problems to the cervical spine, you will reproduce radiculopathy from a neuro-compressive lesion. That's the type of aggravation you could get from sprinkler fitting type of work." (Id., pp.26-27,34-35). And while Dr. Ghanayem ultimately did not believe there was a causal relationship between Petitioner's cervical condition and his work, he could not recall whether he had reviewed any job description in this case or even how long Petitioner had worked as a sprinkler fitter, although he did allow that "[o]bviously a lot of the work is done overhead because you don't put sprinklers in floors, but you put them in ceilings." (R#2X3, pp.21-24). As a result, the Commission chooses to place greater weight on the opinions of Dr. Rinella, Farrell and Abusharif to the effect that a causal relationship exists between Petitioner's current cervical condition and the accident of 5/26/09.

Based on the above, the Commission finds the claimed accident of 4/7/10 (10 WC 14721), or the date of his first visit to Dr. Rinella, represented a continuation of his ongoing symptoms and treatment relative to his compensable repetitive trauma injuries and not an accident per se. As a result, the Commission affirms the Arbitrator's decision in claim 10 WC 14721 to the extent that Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment on 4/7/10, and failed to prove that his current condition of ill-being is causally related to said claimed accident. Instead, for the reasons stated previously, the Commission chooses to assign liability to claim 12 WC 17526 exclusively.

Furthermore, the Commission finds that an employment relationship existed between the parties with respect to both claimed dates of accident, specifically 5/26/09 (12 WC 17526) and 4/7/10 (10 WC 14721). The Commission notes that the question of whether an employment relationship existed at the time of the accident is one of fact. *Labuz v. Ill. Workers' Comp. Comm'n*, 981 N.E.2d 14, 366 Ill. Dec. 949 (1st Dist. 2012). While both the alleged dates of accident admittedly post-date Petitioner's last day of work for Respondent, the evidence shows that the repetitive activities that formed the basis for each claim, and which ultimately resulted in the cervical injury in question, occurred during the term of Petitioner's employment with Respondent. Indeed, the Arbitrator even noted that if he had found accident and causation in claim 12 WC 17526 "... a finding of an employee/employer relationship would be appropriate." (Arb.Dec. [12 WC 17526], p.9). As a result, the Commission modifies the decisions of the Arbitrator to show that an employee-employer relationship existed between Petitioner and Respondent on both claimed dates of accident.

In addition, the Commission finds that notice cannot be used by the Respondents herein to deny compensation in this matter. The Commission notes that §6(c) of the Act requires the claimant to give notice of the accident "to the employer as soon as practicable, but not later than

45 days after the accident." 820 ILCS 305/6(c) (West 2010). §6(c) further provides that "[n]o defect or inaccuracy of such notice shall be a bar to the maintenance of proceedings on arbitration or otherwise by the employee unless the employer proves that he is unduly prejudiced in such proceedings by such defect or inaccuracy." Id. A claim is only barred if no notice whatsoever has been given. *Silica Sand Transport, Inc. v. Industrial Comm'n*, 197 Ill. App. 3d 640, 651, 554 N.E.2d 734, 742, 143 Ill. Dec. 799 (1990).

In the present matter, the Commission notes that both Respondents claimed a credit pursuant to §8(j) of the Act for medical bills paid totaling $49.90. (See Arb.Ex.#1 & #2). The record shows that this amount corresponds to a bill that was paid by Blue Cross/Blue Shield on 6/12/09 for services provided by Dr. Farrell at Parkview Orthopedics on 5/26/09, the claimed date of accident in 12 WC 17526. This payment by Respondent's group insurer results in the tolling of the statute pursuant to §8(j) of the Act, and evidences effective notice on the part of Respondents, including the workers' compensation carriers and their insureds herein. In this respect, the Commission notes that the insurance carrier may be made a party to the proceedings to which the employer is a party, pursuant to §4(g) of the Act. (See also *Equitable Casualty Underwriters v. Industrial Com.*, 322 Ill. 462, 153 N.E. 685 (Ill. 1926). By extension, the Commission finds that the group carrier in this case had notice of the injury, as evidenced by the payment of Dr. Ferrell's bill, and that said notice imputes to all party opponents, including the employer and its workers' compensation carriers. Furthermore, there is no evidence to suggest that either Respondent or the workers compensation carriers were unduly prejudiced in the defense and/or investigation of these claims by reason of any deficiencies in said notice. As a result, the Commission modifies the decisions of the Arbitrator to find that adequate notice was provided by Petitioner to the employer/carriers in both claims.

The Commission also finds, based on the above findings as to accident et al, that Petitioner is entitled to reasonable and necessary medical expenses as set forth in PX10 through PX19, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act, with a credit to Respondent for any and all amounts paid on account of the injury.

In addition, the Commission finds that Petitioner is entitled to temporary total disability benefits from 4/12/12, the date of the first office note referencing the imposition of work restrictions, through the last hearing date at arbitration on 9/3/14, for a period of 125 weeks. The Commission notes that while the evidence shows Petitioner did in fact retire from F.E. Moran effective 4/1/09, with his last day of work occurring on 3/16/09, Petitioner credibly testified that he was let go by Respondent in March of 2009 as part of a layoff and that he subsequently decided to retire thereafter due to the slowness of the trade and his ongoing neck complaints. (A.55). Dr. Rinella likewise indicated, in an office note dated 4/7/10 as well as at his deposition, that Mr. Morsovillo had retired due to neck pain. (PX1; PX6, p.7). However, the record is devoid of any reference to any restrictions being imposed upon Petitioner by any of his medical providers with respect to his cervical condition until Dr. Rinella's office note dated 4/12/12 wherein he ordered Mr. Morsovillo to "... continue his current work restrictions and follow-up with me in the near future. (PX1). Similarly, Dr. Farrell's and Dr. Abusharif's records are silent as to Petitioner's ability to work following the accident, noting only that he was retired. (PX2, PX4). Petitioner eventually underwent surgery at the hands of Dr. Rinella on 6/18/14 in the form of an anterior cervical discectomy at C5-C6, C6-7 and anterior cervical fusion at the same levels.

(PX1). Thereafter, in an office note dated 7/3/14, Dr. Rinella's physician assistant, Douglas Stevens, recorded that Petitioner "... will remain off work at this time." (PX1). There is no indication that Dr. Rinella has released Petitioner to return to work with or without restrictions since. As a result, the Commission finds that Petitioner was temporarily totally disabled from 4/12/12 through 9/3/14, for a period of 125 weeks.

The Commission also corrects the Arbitrator's decisions to find that Respondent is entitled to a credit for TTD paid in the amount of $132,369.08 (not $132,902.40) given the parties' stipulation, made at the time of the 7/14/14 hearing, to amend the Request for Hearing forms (Arb.Ex.#1 & #2) to reflect said amount. (D.7).

Finally, the Commission declines to award penalties in this matter given that legitimate issues of law and fact existed between the parties, especially with respect to Petitioner's burden of proof as to accident, notice and causation, as discussed above. Accordingly, Petitioner's request for additional compensation pursuant to §19(k) and §19(l) and attorneys' fees pursuant to §16 of the Act is hereby denied.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision in claim 12 WC 17526 is reversed, and the decision in claim 10 WC 14721 dated April 4, 2017 is hereby modified, as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner in claim 12 WC 17526 the sum of $1,135.00 per week for a period of 125 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner in claim 12 WC 17526 reasonable and necessary medical expenses as set forth in PX10-PX19, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this matter (12 WC 17526) 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, in claim 12 WC 17526.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury pursuant to §8(j) of the Act; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers for which Respondent is receiving credit under this order.

18IWCC0082

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 8 - 2018
o:12/12/17
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

DISSENT

I respectfully dissent from the Majority's opinion reversing the Arbitrator's decision. I find Arbitrator Huebsch's decision to be thorough and well reasoned. Particularly persuasive are the arbitrator's detailed findings regarding causation and Petitioner's credibility. I give great weight to Arbitrator Lammie's contemporaneous observations of Petitioner at trial and his analysis based on Petitioner's numerous medical records and histories. I would affirm and adopt this decision.

Kevin W. Lamborn

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

MORSOVILLO, GERALD T
Employee/Petitioner

Case# **10WC014721**

12WC017526

F E MORAN FIRE PROTECTION
Employer/Respondent

18IWCC0082

On 8/2/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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G. T. Morsovillo v. F. E. Moran, etc., 10 WC 014721

18IWCC0082

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)

Gerald T. Morsovillo
Employee/Petitioner

v.

F.E. Moran Fire Protection
Employer/Respondent

Case # **10 WC 014721**

Consolidated cases: **12 WC 017526**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Milton Black, and Jeffrey Huebsch, Arbitrators** of the Commission, in the city of **Chicago**, on **02/27/2014, 03/25/2014 and 04/25/2014, 07/14/2014 and 09/03/2014, respectively.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☒ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What 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

18IWCC0082

FINDINGS

On the date of accident, **4/7/10**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondent.

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

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

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

In the year preceding the injury, Petitioner earned **$88,529.22**; the average weekly wage was **$1,702.49**.

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 **$132,902.40** for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of **$132,902.40**.

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

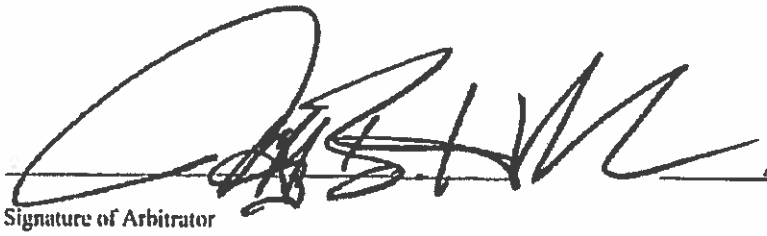
ORDER

Claim for Compensation denied. Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on April 7, 2010 and failed to prove a causal connection between his employment and his current condition of ill-being regarding his cervical spine.

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.



August 1, 2016

Signature of Arbitrator

Date

ICArbDec19(b)

AUG 2 - 2016

INTRODUCTION

This matter was tried with a consolidated matter, Case No. 12 WC 017526. Petitioner's claims allege repetitive trauma to the cervical spine. An accident date of April 7, 2010 is alleged in this case. An accident date of May 26, 2009 is alleged in Case No. 12 WC 017526. Respondent was represented by different counsel in each case. Compensability is disputed in both cases. Arbitrator Black presided in the hearings of February 27, 2014, March 25, 2014 and April 25, 2014. Arbitrator Huebsch presided in the hearings of July 14, 2014 and September 3, 2014. The Parties agreed that a total of $132,902.40 in compensation benefits have been paid regarding both cases.

Decisions will be entered in Case No. 10 WC 014721 and 12 WC 017526, concurrently.

STATEMENT OF FACTS

Petitioner worked as a sprinkler fitter for 39 years. He worked for Respondent for 13 years. He was a sprinkler fitter foreman when he retired, effective April1, 2009. Petitioner's date of birth is April 8, 1947. In the last 6 months of his work for Respondent, Petitioner worked in the service department. Petitioner testified that he was laid off by Respondent in March of 2009 and he chose to retire. The trade was slowing down, Petitioner had neck pain and he did not want to start with a new employer. Therefore, he chose to retire. Petitioner is a member of Local 281, Sprinkler and Pipe Fitters Union.

The trade of sprinkler fitter is a very physical job. Petitioner would install pipe and various devices for automatic fire protection systems. He installed pipes, valves, fire pumps, dry pipe systems, control valves and worked with various sized pipe, from one inch to ten inch. He would work with various lengths of pipe, from one foot to twenty feet long. The pipes could weigh 250 pounds. Most of Petitioner's work installing pipes would be overhead. He would use various wrenches and drills. He would bend his head back to look at the work that he was performing. Sometimes, Petitioner would have to hold a pipe up with his head. Other times, Petitioner would lift a pipe to his shoulder and then lift the pipe up to fit it in a hanger. (Px. 7, 8, 9) Petitioner is right handed.

Petitioner testified that he experienced 9/10 neck pain beginning in February to March 2009. The pain remained even after he retired.

Petitioner first received treatment for cervical spine complaints by Dr. William Farrell of Parkview Orthopedics on May 26, 2009. Dr. Farrell charted that Petitioner had been a patient previously and that for six months he had been having cervical spine pain to the point where he had to make an appointment. Petitioner described no history of injury and he retired not long ago as an "ironworker". Dr. Farrell did not chart that Petitioner retired due to neck pain complaints. Dr. Farrell said that Petitioner's job clearly has contributed at least in part to his back condition and now to his neck condition. Petitioner denied any arm pain and had no numbness or tingling. Petitioner had restrictions with respect to neck rotation to both sides and his symptoms were primarily in the midline. Petitioner denied any recent injurious event and stated that his symptoms are worse with certain weather as well. Dr. Farrell noted that Petitioner's motion was restricted particularly with rotation of the cervical spine. X-rays showed some evidence of disk narrowing consistent with mild degenerative joint disease with no acute changes noted. Dr. Farrell diagnosed Petitioner with mild DJD of the cervical spine without acute changes. Dr. Farrell recommended that Petitioner start with outpatient physical therapy to control his

symptoms. Dr. Farrell recommended a one month follow up and an MRI might be an option if Petitioner was not responding to treatment. Petitioner returned on December 22, 2009 for follow up evaluation with respect to his cervical spine. Dr. Farrell's chart actually states that the patient "has no degenerative arthritis of the cervical spine." This is assumed to be a typing error, as the exam is consistent with cervical spine arthritis. Petitioner was noted to have chronic pain in the area with intermittent episodes of worsening pain of the cervical spine. Dr. Farrell noted that Petitioner's pain proceeded through the shoulders likely through the trapezius. Dr. Farrell diagnosed Petitioner with cervical spine pain and recommended that Petitioner should continue on medication only as needed. Dr. Farrell suggested a return to his care as needed and charted that the patient knows to make appropriate appointments in the event his situation worsens. Dr. Farrell noted that MRI imaging would be an option as well as physical therapy if Petitioner's symptoms persist. (Px. 4, R2x. 4)

In March of 2010, Petitioner sought treatment with Dr. Anthony Rinella. Petitioner filled out a Spine Patient Questionnaire and several other documents on March 26, 2010. The questionnaire indicates that the patient had neck pain for 1 year. The pain started on March 10, 2009. Previous spinal injury was denied, although Petitioner said that he had back surgery in 1995. Petitioner's daughter had referred Petitioner to Dr. Rinella. Petitioner testified that he did not follow up with Dr. Farrell because he wanted to treat with a spine surgeon. He had previously seen Dr. Farrell for low back pain in 2008 and had undergone a lumbar fusion with a doctor from Parkview in 1996. (R2x. 4) Petitioner filled out another form advising that his primary insurance was Blue Cross/Blue Shield and that he had an attorney (Kevin Veugeler) "involved in his case." (Px. 1, R2x. 1) Petitioner was sent for an MRI of the c-spine, which was done on March 26, 2010.

Petitioner was first seen by Dr. Rinella on April 7, 2016. Dr. Rinella noted that Petitioner was a 62-year-old sprinkler fitter who was injured at work on March 10, 2009. The patient did not recall a specific injury. Over a four to six month period he developed progressive pain in his neck that caused occipital headaches and bilateral trapezial pain. The patient stated that his job regularly involved lifting heavy pipes up to high levels and that at times when he was unable to lift with his shoulders due to the height of the pipe he would lift with the pipe on his head. Petitioner worked for the same company for many years and feels as though this was a repetitive injury as opposed to a specific event. He saw Dr. Farrell in March of 2009, right after the injury and cervical radiographs were taken. He has since retired due to the pain. Petitioner rates his pain at a five out of ten on a one point visual analog scale. X-rays showed mild degenerative disk disease and the cervical spine MRI showed C4-5 bilateral foraminal stenosis and C5-6 central foraminal stenosis. Dr. Rinella diagnosed Petitioner with work related cervical spondylotic radiculopathy. Dr. Rinella believed the symptoms were classic for cervical radiculopathy and that when Petitioner was evaluated by Dr. Farrell on May 26, 2009 he had similar symptoms. Dr. Rinella noted that Petitioner's retirement has not allowed his symptoms to resolve. Dr. Rinella recommended physical therapy, traction program and a series of epidural injections. (Px. 1)

On April 19, 2010, Dr. Farris Abusharif provided the first of the injections. Petitioner described a one year duration of pain in his neck that he described as shooting and worse at night during usual sleep hours. Dr. Abusharif recorded that Petitioner was employed as a pipefitter for many years which involved hours daily of having his head in an extended position. Dr. Abusharif noted that this would likely contribute to facet arthropathy and cervical stenosis. Dr. Abusharif noted that Petitioner's pain started with no reason and that his injury occurred from repetitive activity. Dr. Abusharif provided injections to Petitioner at the C5-6 level on April 19, May 3 and May 17, 2010. On June 4, 2010, Petitioner returned to Dr. Abusharif for follow up after the series of cervical epidural steroid injections. Petitioner reported no change in his symptoms following the injections and that his pain level remained the same. Dr. Abusharif indicated that Petitioner's pain was likely of a facet origin. Dr. Abusharif recommended physical therapy for cervical spine stabilization and range of motion but if the therapy did not provide relief, a cervical facet joint injection or possible medial branch block would be necessary with the possibility of a radio frequency ablation. (Px. 2)

Petitioner began physical therapy on July 1, 2010 at Flexion Rehabilitation. Petitioner complained of developing cervical pain two months after retiring indicating that he had pain in his neck, severe headaches and muscle spasms. Physical therapy for passive intervertebral joint mobility was initiated. (Px. 3)

On August 4, 2010, Dr. Abusharif performed a cervical medial branch block at C5 and C6 on the left and right. On August 26, 2010, Petitioner returned to Dr. Abusharif with continued neck pain with radiation to his head. Petitioner described the pain as shooting with symptoms at a five out of ten along the entire neck. Dr. Abusharif recommended a cervical radial frequency ablation at C4, C5 and C6 bilaterally. Dr. Abusharif performed the ablation on September 27, 2010 at Pain Treatment Centers of Illinois. Following the ablation, on October 14, 2010, Petitioner returned to Dr. Abusharif with noticeable improvement. Petitioner described some neck discomfort but described improvement from before the ablation. Dr. Abusharif noted that Petitioner was two weeks post ablation of the cervical medial branch nerves at C5 and C6 bilaterally with 50% reduction in pain levels and full range of motion. Dr. Abusharif indicated that it would be possible for the medial branch nerves to regenerate and that future treatments may be necessary after ten to twelve months. (Px. 2)

On December 3, 2010, Petitioner returned to Dr. Rinella. Petitioner advised Dr. Rinella of significant improvement following Dr. Abusharif's medial branch blocks. However, Petitioner continued to have pain here and there and felt that it was becoming more progressive in the posterior cervical spine. Dr. Rinella appreciated full range of motion in his neck and opined that Petitioner was neurologically intact. Dr. Rinella discussed another medial branch block versus consideration of a cervical decompression. Dr. Rinella recommended a new MRI scan of the cervical spine before considering any further interventions. Dr. Rinella found no reason to place petitioner on any restrictions as of December 3, 2010. (Px. 1)

Petitioner underwent the MRI of the cervical spine on February 17, 2011, which was indicative of multilevel degenerative changes in the cervical spine. At C6-7, there was a central focal disk protrusion measuring four millimeters in diameter abutting and displacing the cord and narrowing the central canal. (Px. 1)

On February 22, 2011, Dr. Rinella charted that Petitioner had progressive trapezial pain after a work related injury on March 10, 2009. The patient was initially evaluated by Dr. Farrell, who noted his posterior cervical headaches and bilateral trapezial tenderness. Petitioner felt as though he has maximized conservative management with physical therapy. Dr. Rinella noted that Petitioner's cervical spine MRI demonstrated C5-6 and C6-7 disk protrusions and spondylosis. Dr. Rinella believed Petitioner's pain was related to many years of working as a pipefitter. Dr. Rinella noted that Petitioner was a very stoic man, who for many reasons has avoided significant evaluation of his posterior cervical headaches and trapezial symptoms. Dr. Rinella noted that the epidural steroid injections confirm that his pain represents a cervical spondylitic radiculopathy. Dr. Rinella recommended a C5-6 and C6-7 anterior cervical diskectomy and fusion. (Px. 1)

On March 17, 2011, Petitioner returned to Dr. Abusharif with complaints of neck pain and headaches. Dr. Abusharif noted that Petitioner was likely to undergo surgical intervention at some point but not in the very near future and, therefore, Petitioner wished to have some interventions performed which would reduce his pain. Dr. Abusharif recommended a radial frequency ablation of the medial branch nerve at C4, C5 and C6. Dr. Abusharif performed the procedure on April 21, 2011. Petitioner returned to Dr. Abusharif's care on May 5, 2011 with continued complaints of arm pain and neck pain. Petitioner reported two days of relief and no significant change in symptoms located in the cervical spine. (Px. 2)

Petitioner returned to Dr. Rinella on March 9, 2012 with complaints of posterior headaches. Dr. Rinella charted a new date of accident on this date. Petitioner continued to have complaints of pain "after a work

related injury (4/7/10)." Dr. Rinella recommended a new cervical MRI and surgery or an FCE would be considered thereafter. Dr. Rinella's records do not reveal a reason for the change in accident date from March 10, 2009 to April 7, 2010. (Px. 1)

On April 12, 2012, Petitioner returned to Dr. Rinella and the date of accident was again charted as April 7, 2010. Dr. Rinella noted that Petitioner's pain has been more variable and that he complains of lumbar back pain after no particular injury. Dr. Rinella diagnosed Petitioner with a cervical spondylitic radiculopathy and a lumbar spine strain after lumbar fusion. Dr. Rinella indicated that that he was doing his best to avoid a cervical fusion and that Petitioner would continue his current work restrictions and follow up in the near future. On May 3, 2012, Dr. Rinella opined that he did not believe that Petitioner required any specific surgical intervention at the time and recommended continued care by Dr. Abushariff. (Px. 1)

Petitioner did not return to Dr, Rinella until September 25, 2013, when he complained of pain at a 9/10 scale with continued treatment with Dr. Abushariff. Dr. Rinella noted that Petitioner's cervical radiculopathy was increasing over time. Dr. Rinella opined that he would likely require a cervical discectomy and fusion. Dr. Rinella recommended a new cervical MRI. The MRI was performed on May 1, 2014. The MRI showed development of disc bulge at the midline posterior protrusion with thecal sac and cord effacement as well as disc bulges with canal narrowing at C4/C5 and C5/C6. (Px. 1)

Dr. Rinella recommended an ACDF and performed the surgery on June 18, 2014 at Silver Cross Hospital. (Px. 5) The reason for the surgery was: "67 yo gentleman with a cervical radiculopathy after an injury." The procedure was ACDF with instrumentation and cage and spinal allograft at C5-C6 and C6-C7. (Px. 1)

Petitioner returned to Dr. Rinella on July 3, 2014 with reports of doing well post-operatively. Dr. Rinella authorized Petitioner off of work and set a follow-up appointment for 4 weeks. According to the records, Petitioner returned on July 18, 2014 with reports that he was doing well until a flare up for the past 4 days. Petitioner reported that he was in court observing when a very large gentlemen left the courtroom and slammed a heavy door closed. Reverberation caused his head to bounce off the wall. Petitioner reported a significant flare-up in symptoms. Dr. Rinella diagnosed a cervical strain after courtroom injury and continued Petitioner's care for 6 weeks, including therapy and shoulder exercises to avoid a frozen right shoulder. (Px 1)

Petitioner has not worked since March of 2009. If he worked in his trade, beyond certain limits, he would lose his pension. (R2x. 5)

At the September 3, 2014 hearing, Petitioner claimed that he first became aware that his neck problems were worked related when he saw Dr. Rinella on April 7, 2010. At the February 27, 2014 hearing, Petitioner agreed that he thought his neck pain was related to his work as a sprinkler fitter when he saw Dr. Farrell in May of 2009. Dr. Farrell said that Petitioner's neck problems were work related at the first visit in May of 2009. Petitioner filled out the spine questionnaire document for Dr. Rinella on March 26, 2010, claiming an injury date of March 9, 2009. (R1x. 1)

Petitioner claimed that he gave notice of his injury to Scott Massoglia, superintendent, in March of 2009. (Arbx. 1 and 2) Petitioner said that he advised Massoglia of his neck complaints in a general fashion. Massoglia testified that he did not know of any neck complaints made by Petitioner. Petitioner did not give Massoglia notice of any injury. If Petitioner had told him about an injury, he would have reported it to his supervisor or advised the injured worker to report the injury to the supervisor. Massoglia was not a superintendent in February or March of 2009. He was not Petitioner's supervisor at that time.

Kathy Sawyer testified that she was Petitioner's supervisor in February and March of 2009. She worked at Respondent as service and inspection manager. She left Respondent's employ in 2013. She knew Petitioner. Petitioner did not report any injury to her. She had no knowledge of Petitioner suffering an injury during this time. If an injury was reported, appropriate accident reports would have been prepared and an investigation would have taken place. Sawyer was involved in Petitioner's separation of employment with Respondent in March of 2009. Petitioner was let go by Respondent because of service issues. Basically, it was three strikes, and he was out.

Petitioner testified that he was doing better after the neck surgery. He has had some setbacks, including an increase in pain after a large man (Massoglia) slammed the door in Room 208 on July 14, 2014. The Arbitrator does not recall the event as being in anger or with an intent to injure Petitioner or anyone else. Petitioner testified that he has less pain after the surgery. Petitioner had 7 prior workers' compensation cases that were processed through the Commission. (R2x. 4)

Petitioner claimed medical bills from Dr. Rinella in the amount of $110,820.00, to Silver Cross Hospital for $60,911.90, to Pain Treatment Centers for $4,140.10, to Pain Treatment Surgical Suites for $60,195.00, Flexeon Rehabilitation for $46.00. (Px. 10 – 15) Petitioner claimed TTD from 3/16/2009 through 9/3/14 (285-2/7 weeks).

Three evidence depositions of three board certified orthopedic surgeons were submitted into evidence by the Parties.

Dr. Anthony Rinella Deposition

Dr. Rinella was deposed on March 17, 2011. Dr. Rinella is a spine surgeon. Dr. Rinella stated that the history given by Petitioner was that he was injured at work on March 10, 2009. The pain didn't occur on any one day, it just gradually increased over a four-to six month period. Dr. Rinella diagnosed "work-related cervical spondylotic radiculopathy, or a pinched nerve." Petitioner would not be able to work full-duty as a sprinkler fitter as of the April 7, 2010 visit. Dr. Rinella opined that Petitioner's need for surgery is due to repetitive injury in 2009. Dr. Rinella opined that based upon the history Petitioner gave, he believed it is consistent. Dr. Rinella stated that he believed Dr. Farrell's records set the timeline very rigorously. Per the redirect of Petitioner's counsel, Dr. Rinella opined that the symptoms were exactly the same at the Farrel visit as when he saw the patient, so he was indirectly indicating that Petitioner was diagnosed with spondylitic radiculopathy by Dr. Farrell. Dr. Rinella noted that Dr. Farrel called it joint disease because he is a joint surgeon. In follow up, Petitioner's counsel questioned Dr. Rinella that while the symptoms may have been the same when Petitioner first saw Dr. Farrell, that wouldn't be necessarily something that Petitioner would have been aware of until he came to see Dr. Rinella and had been diagnosed with spondylitic radiculopathy. Dr. Rinella agreed.

Dr. Joseph Manaco Deposition

The deposition of Dr. Joseph Monaco was taken on August 21, 2012. Dr. Monaco was deposed in relation to his reports issued in March 2011 and August 2011. Dr. Monaco does not perform cervical spine surgery. Most of his surgeries are to the knee or shoulder. Dr. Monaco had issued a report that Petitioner's work activities were not the cause of his cervical spine pathology and that Petitioner's cervical pathology was a long standing degenerative process unrelated to his work activities. Petitioner's work activities for Respondent were not a proximate cause of Petitioner's neck and radicular pain.

Dr. Monaco explained during his testimony that based upon his understanding of Petitioner's records and reports of complaints regarding the spine, Petitioner's complaints were normal for a person of his age. Dr. Monaco explained that Petitioner had worked for forty years as a sprinkler fitter and in that time did not voice any complaints. Dr. Monaco explained that this would suggest that his work activities were not the cause, but rather Petitioner just had a degenerative process. Dr. Monaco further testified that because Petitioner's complaints drove him to seek treatment some two months after his retirement, this suggested that Petitioner did not have complaints of pain during his employment with Respondent. Petitioner had age related degenerative findings about the cervical spine which were not related to Petitioner's work for Respondent.

Dr. Monaco agreeed that Petitioner told Dr. Farrell in May of 2009 that he had neck pain for six months prior. Dr. Monaco conceded that Petitioner had complaints prior to his retirement based on Petitioner's report to Dr. Farrell. Dr. Monaco conceded that the type of job duties that Petitioner performed would be sufficient to cause pain. Dr. Monaco attempted to clarify his opinion that while the work activities were a possible cause of neck pain, he did not believe that they were the cause of pain in Petitioner's case.

Petitioner's attorney, in questioning Dr. Monaco, pointed out that Petitioner had complaints of pain for six months prior to his report to Dr. Farrell. Dr. Monaco agreed that if Petitioner had complaints at work, his work could have contributed to the neck pain.

Dr. Alexander Ghanayem Deposition

Dr. Alexander Ghanayem was deposed on July 10, 2013. Dr. Ghanayem is a spine surgeon. He served as a §12 physician for F.E. Moran under their May 26, 2009 claim as insured by CNA Insurance. Dr. Ghanayem did not believe that Petitioner was in need of surgery on his cervical spine. Petitioner has age appropriate degenerative arthritis of the cervical spine.

Dr. Ghanayem explained that there was a difference between a condition and symptoms. Dr. Ghanayem also conceded that Petitioner's overhead work as a sprinkler fitter could cause Petitioner to complain of symptoms, but Dr. Ghanayem explained that Petitioner had no "condition" in his cervical spine. Dr. Ghanayem also opined that Petitioner's work did not cause, or even accelerate the condition of ill-being seen on MRI. He identified the changes seen as age-appropriate arthritis. Dr. Ghanayem opined that if Petitioner was a sprinkler fitter his entire career, it would not change his causation opinion.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Statement of Facts in support of the Conclusions of Law set forth below.

WITH REGARD TO ISSUES: (B) EMPLOYMENT; (C) ACCIDENT; (D) DATE OF ACCIDENT; (E) NOTICE; AND (F) CAUSAL CONNECTION, THE ARBITRATOR FINDS THE FOLLOWING:

Petitioner's testimony is found to be not credible. The Arbitrator observed Petitioner's testimony on direct and cross examination on September 3, 2014. Several inconsistencies in Petitioner's testimony are noted

above. He retired because the trade was getting slow and he had lost his job with Respondent. He did not retire because of neck pain, as he told Dr. Rinella, but not Dr. Farrell. He did not complain of neck pain to Massoglia. The Arbitrator does believe that Massoglia would have at least urged Petitioner to report an injury to Sawyer if he had mentioned anything. Certainly, Petitioner would have mentioned his neck problems to Sawyer at the time that he separated from Respondent, if he was experiencing them (9/10 pain in February and March of 2009, never went away). Petitioner was an experienced claimant; it is reasonable to assume that he was savvy enough to understand that he needed to timely report any injury and give a good history to all his physicians. He failed to do so.

The Arbitrator finds that Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on April 7, 2010. This is a repetitive trauma case and it is conceded that no specific injury occurred on April 7, 2010.

It is axiomatic that a claimant alleging a repetitive trauma injury "must meet the same standard of proof as a petitioner alleging a single, definable accident." Three D Discount Store v. Industrial Comm'n, 198 Ill. App. 3d 43, 47 (1989) Thus, Petitioner "must prove a precise, identifiable date when the accidental injury manifested itself." Id. An injury manifests itself when the causal relationship between the injury and the employment would have become apparent to a reasonable person. Id.

First, there was no employee/employer relationship between Petitioner and Respondent on April 7, 2010. Petitioner's last day of employment with Respondent was March 16, 2009. Thereafter, he retired, effective April 1, 2009. Arguably, repetitive trauma case law allows a claimant to prove a manifestation date at a reasonable time after his employment with an employer has terminated. In this case, more than a year after the employment relationship ended is not a reasonable time. Here, Petitioner conceded that he related his neck complaints to his employment at the time that he saw Dr. Farrell and that Dr. Farrell informed Petitioner that he thought that the condition was related to his work, both events occurring in May of 2009. The Arbitrator declines to decline an employee/employer relationship in April of 2010 based upon these circumstances.

Next, while April 7, 2010 was the day that Petitioner first was seen for treatment by Dr. Rinella, the Record does not support a finding that April 7, 2010 was the manifestation date. Petitioner had presented to Dr. Rinella's office on March 26, 2010, advising of an injury on March 10, 2009. Dr. Rinella's causation opinion is not persuasive, for the reasons set forth below. Because there is no causal connection between Petitioner's work activities and his cervical spine condition, there is no manifestation date. Thus, there is no accident date.

On the issue of causation, the Arbitrator finds the opinion of Dr. Ghanayem that there is no causal relationship between Petitioner's cervical spine arthritis (age appropriate) and his work duties to be credible and persuasive. Petitioner may have experienced neck pain while working. Of course, this is a symptom and it does not require a finding of causation. Petitioner has age appropriate cervical spine arthritis. This condition was not caused or aggravated by his work for Respondent. Dr. Rinella's opinion on causation is not persuasive. His April 7, 2010 charting of an injury on March 10, 2009 and the diagnosis of work-related cervical spondylotic radiculopathy does not convince the Arbitrator that his opinions are objective. Further, if Petitioner's cervical spine arthritis was truly aggravated by Petitioner's work activities to the extent that causality could be established, one would expect that Petitioner would have sought treatment form an orthopod more than 2 times in the year period from his retirement on April 1, 2009 to the time that he saw Dr. Rinella, April 7, 2010. Petitioner's case just does not add up.

As to the issue of Notice in this case, Petitioner did not give notice to Respondent via telling Massoglia of neck pain in March of 2009. Notice can't be given one year before the accident date. Further, the Arbitrator

does not find that Petitioner told Massoglia of any neck pain complaints in approximately March of 2009. Petitioner did file his Application in this case on April 10, 2010 and the proof of service does reveal that the Application was mailed to Respondent. Notice, within the meaning of §6, as to the disputed accident of April 7, 2010, has been proven.

WITH REGARD TO ISSUES: (J) REASONABLENESS AND NECESSITY OF MEDICAL TREATMENT; (K) PROSPECTIVE MEDICAL; (L) TTD; AND (M) PENALTIES, THE ARBITRATOR FINDS THE FOLLOWING:

As the Arbitrator has found above that Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on April 7, 2010, failed to prove an employee/employer relationship existed with Respondent on said date and failed to prove a causal connection between his work activities and his condition of ill-being regarding his cervical spine, the Arbitrator needs not decide these issues.

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

MORSOVILLO, GERALD T
Employee/Petitioner

Case# **12WC017526**
10WC014721

F E MORAN FIRE PROTECTION
Employer/Respondent

18IWCC0082

On 8/2/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0391 HEALY SCANLON LAW FIRM
KEVIN T VEUGELER
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

0011 LAW OFFICES OF EDWARD J. KOZEL
ANITA S OAK
333 S WABASH AVE 25TH FL
CHICAGO, IL 60604

G. T. Morsovillo v. F. E. Moran, etc., 12 WC 017526

18IWCC0082

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)

Gerald T. Morsovillo
Employee/Petitioner

v.

F.E. Moran Fire Protection
Employer/Respondent

Case # **12 WC 017526**

Consolidated cases: **10 WC 014721**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Milton Black, and Jeffrey Huebsch, Arbitrators** of the Commission, in the city of **Chicago, on 02/27/2014, 03/25/2014 and 04/25/2014, 07/14/2014 and 09/03/2014, respectively.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☒ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What 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

18IWCC0082

FINDINGS

On the date of accident, **5/26/2009**, 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 **$88,529.22**; the average weekly wage was **$1,702.49**.

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 **$132,902.40** for TTD, **$0** for TPD, $0 for maintenance, and **$0** for other benefits, for a total credit of **$132,902.40**.

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

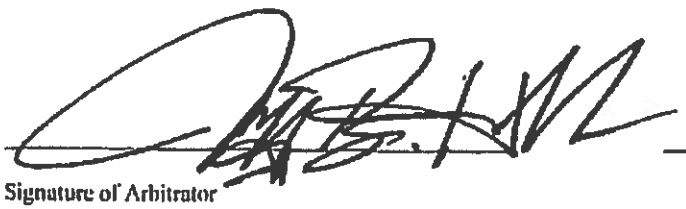
ORDER

Claim for Compensation denied. Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on May 26, 2009 and failed to prove a causal connection between his employment and his current condition of ill-being regarding his cervical spine. Further, Petitioner did not provide timely Notice of the accident alleged herein.

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

August 1, 2016

Date

ICArbDec19(b)

AUG 2 – 2016

INTRODUCTION

This matter was tried with a consolidated matter, Case No. 10 WC 014721. Petitioner's claims allege repetitive trauma to the cervical spine. An accident date of May 26, 2009 is alleged in this case. An accident date of April 7, 2010 is alleged in Case No. 10 WC 014721. Respondent was represented by different counsel in each case. Compensability is disputed in both cases. Arbitrator Black presided in the hearings of February 27, 2014, March 25, 2014 and April 25, 2014. Arbitrator Huebsch presided in the hearings of July 14, 2014 and September 3, 2014. The Parties agreed that a total of $132,902.40 in compensation benefits have been paid regarding both cases.

Decisions will be entered in Case No. 10 WC 014721 and 12 WC 017526, concurrently.

STATEMENT OF FACTS

Petitioner worked as a sprinkler fitter for 39 years. He worked for Respondent for 13 years. He was a sprinkler fitter foreman when he retired, effective April1, 2009. Petitioner's date of birth is April 8, 1947. In the last 6 months of his work for Respondent, Petitioner worked in the service department. Petitioner testified that he was laid off by Respondent in March of 2009 and he chose to retire. The trade was slowing down, Petitioner had neck pain and he did not want to start with a new employer. Therefore, Petitioner chose to retire. Petitioner is a member of Local 281, Sprinkler and Pipe Fitters Union.

The trade of sprinkler fitter is a very physical job. Petitioner would install pipe and various devices for automatic fire protection systems. He installed pipes, valves, fire pumps, dry pipe systems, control valves and worked with various sized pipe, from one inch to ten inch. He would work with various lengths of pipe, from one foot to twenty feet long. The pipes could weigh 250 pounds. Most of Petitioner's work installing pipes would be overhead. He would use various wrenches and drills. He would bend his head back to look at the work that he was performing. Sometimes, Petitioner would have to hold a pipe up with his head. Other times, Petitioner would lift a pipe to his shoulder and then lift the pipe up to fit it in a hanger. (Px. 7, 8, 9) Petitioner is right handed.

Petitioner testified that he experienced 9/10 neck pain beginning in February to March 2009. The pain remained even after he retired.

Petitioner first received treatment for cervical spine complaints by Dr. William Farrell of Parkview Orthopedics on May 26, 2009. Dr. Farrell charted that Petitioner had been a patient previously and that for six months he had been having cervical spine pain to the point where he had to make an appointment. Petitioner described no history of injury and he retired not long ago as an "ironworker". Dr. Farrell did not chart that Petitioner retired due to neck pain complaints. Dr. Farrell said that Petitioner's job clearly has contributed at least in part to his back condition and now to his neck condition. Petitioner denied any arm pain and had no numbness or tingling. Petitioner had restrictions with respect to neck rotation to both sides and his symptoms were primarily in the midline. Petitioner denied any recent injurious event and stated that his symptoms are worse with certain weather as well. Dr. Farrell noted that Petitioner's motion was restricted particularly with rotation of the cervical spine. X-rays showed some evidence of disk narrowing consistent with mild degenerative joint disease with no acute changes noted. Dr. Farrell diagnosed Petitioner with mild DJD of the cervical spine without acute changes. Dr. Farrell recommended that Petitioner start with outpatient physical therapy to control his

symptoms. Dr. Farrell recommended a one month follow up and an MRI might be an option if Petitioner was not responding to treatment. Petitioner returned on December 22, 2009 for follow up evaluation with respect to his cervical spine. Dr. Farrell's chart actually states that the patient "has no degenerative arthritis of the cervical spine." This is assumed to be a typing error, as the exam is consistent with cervical spine arthritis. Petitioner was noted to have chronic pain in the area with intermittent episodes of worsening pain of the cervical spine. Dr. Farrell noted that Petitioner's pain proceeded through the shoulders likely through the trapezius. Dr. Farrell diagnosed Petitioner with cervical spine pain and recommended that Petitioner should continue on medication only as needed. Dr. Farrell suggested a return to his care as needed and charted that the patient knows to make appropriate appointments in the event his situation worsens. Dr. Farrell noted that MRI imaging would be an option as well as physical therapy if Petitioner's symptoms persist. (Px. 4, R2x. 4)

In March of 2010, Petitioner sought treatment with Dr. Anthony Rinella. Petitioner filled out a Spine Patient Questionnaire and several other documents on March 26, 2010. The questionnaire indicates that the patient had neck pain for 1 year. The pain started on March 10, 2009. Previous spinal injury was denied, although Petitioner said that he had back surgery in 1995. Petitioner's daughter had referred Petitioner to Dr. Rinella. Petitioner testified that he did not follow up with Dr. Farrell because he wanted to treat with a spine surgeon. He had previously seen Dr. Farrell for low back pain in 2008 and had undergone a lumbar fusion with a doctor from Parkview in 1996. (R2x. 4) Petitioner filled out another form advising that his primary insurance was Blue Cross/Blue Shield and that he had an attorney (Kevin Veugeler) "involved in his case." (Px. 1, R2x. 1) Petitioner was sent for an MRI of the c-spine, which was done on March 26, 2010.

Petitioner was first seen by Dr. Rinella on April 7, 2016. Dr. Rinella noted that Petitioner was a 62-year-old sprinkler fitter who was injured at work on March 10, 2009. The patient did not recall a specific injury. Over a four to six month period he developed progressive pain in his neck that caused occipital headaches and bilateral trapezial pain. The patient stated that his job regularly involved lifting heavy pipes up to high levels and that at times when he was unable to lift with his shoulders due to the height of the pipe he would lift with the pipe on his head. Petitioner worked for the same company for many years and feels as though this was a repetitive injury as opposed to a specific event. He saw Dr. Farrell in March of 2009, right after the injury and cervical radiographs were taken. He has since retired due to the pain. Petitioner rates his pain at a five out of ten on a one point visual analog scale. X-rays showed mild degenerative disk disease and the cervical spine MRI showed C4-5 bilateral foraminal stenosis and C5-6 central foraminal stenosis. Dr. Rinella diagnosed Petitioner with work related cervical spondylotic radiculopathy. Dr. Rinella believed the symptoms were classic for cervical radiculopathy and that when Petitioner was evaluated by Dr. Farrell on May 26, 2009 he had similar symptoms. Dr. Rinella noted that Petitioner's retirement has not allowed his symptoms to resolve. Dr. Rinella recommended physical therapy, traction program and a series of epidural injections. (Px. 1)

On April 19, 2010, Dr. Farris Abusharif provided the first of the injections. Petitioner described a one year duration of pain in his neck that he described as shooting and worse at night during usual sleep hours. Dr. Abusharif recorded that Petitioner was employed as a pipefitter for many years which involved hours daily of having his head in an extended position. Dr. Abusharif noted that this would likely contribute to facet arthropathy and cervical stenosis. Dr. Abusharif noted that Petitioner's pain started with no reason and that his injury occurred from repetitive activity. Dr. Abusharif provided injections to Petitioner at the C5-6 level on April 19, May 3 and May 17, 2010. On June 4, 2010, Petitioner returned to Dr. Abusharif for follow up after the series of cervical epidural steroid injections. Petitioner reported no change in his symptoms following the injections and that his pain level remained the same. Dr. Abusharif indicated that Petitioner's pain was likely of a facet origin. Dr. Abusharif recommended physical therapy for cervical spine stabilization and range of motion but if the therapy did not provide relief, a cervical facet joint injection or possible medial branch block would be necessary with the possibility of a radio frequency ablation. (Px. 2)

Petitioner began physical therapy on July 1, 2010 at Flexion Rehabilitation. Petitioner complained of developing cervical pain two months after retiring indicating that he had pain in his neck, severe headaches and muscle spasms. Physical therapy for passive intervertebral joint mobility was initiated. (Px. 3)

On August 4, 2010, Dr. Abusharif performed a cervical medial branch block at C5 and C6 on the left and right. On August 26, 2010, Petitioner returned to Dr. Abusharif with continued neck pain with radiation to his head. Petitioner described the pain as shooting with symptoms at a five out of ten along the entire neck. Dr. Abusharif recommended a cervical radial frequency ablation at C4, C5 and C6 bilaterally. Dr. Abusharif performed the ablation on September 27, 2010 at Pain Treatment Centers of Illinois. Following the ablation, on October 14, 2010, Petitioner returned to Dr. Abusharif with noticeable improvement. Petitioner described some neck discomfort but described improvement from before the ablation. Dr. Abusharif noted that Petitioner was two weeks post ablation of the cervical medial branch nerves at C5 and C6 bilaterally with 50% reduction in pain levels and full range of motion. Dr. Abusharif indicated that it would be possible for the medial branch nerves to regenerate and that future treatments may be necessary after ten to twelve months. (Px. 2)

On December 3, 2010, Petitioner returned to Dr. Rinella. Petitioner advised Dr. Rinella of significant improvement following Dr. Abusharif's medial branch blocks. However, Petitioner continued to have pain here and there and felt that it was becoming more progressive in the posterior cervical spine. Dr. Rinella appreciated full range of motion in his neck and opined that Petitioner was neurologically intact. Dr. Rinella discussed another medial branch block versus consideration of a cervical decompression. Dr. Rinella recommended a new MRI scan of the cervical spine before considering any further interventions. Dr. Rinella found no reason to place petitioner on any restrictions as of December 3, 2010. (Px. 1)

Petitioner underwent the MRI of the cervical spine on February 17, 2011, which was indicative of multilevel degenerative changes in the cervical spine. At C6-7, there was a central focal disk protrusion measuring four millimeters in diameter abutting and displacing the cord and narrowing the central canal. (Px. 1)

On February 22, 2011, Dr. Rinella charted that Petitioner had progressive trapezial pain after a work related injury on March 10, 2009. The patient was initially evaluated by Dr. Farrell, who noted his posterior cervical headaches and bilateral trapezial tenderness. Petitioner felt as though he has maximized conservative management with physical therapy. Dr. Rinella noted that Petitioner's cervical spine MRI demonstrated C5-6 and C6-7 disk protrusions and spondylosis. Dr. Rinella believed Petitioner's pain was related to many years of working as a pipefitter. Dr. Rinella noted that Petitioner was a very stoic man, who for many reasons has avoided significant evaluation of his posterior cervical headaches and trapezial symptoms. Dr. Rinella noted that the epidural steroid injections confirm that his pain represents a cervical spondylitic radiculopathy. Dr. Rinella recommended a C5-6 and C6-7 anterior cervical diskectomy and fusion. (Px. 1)

On March 17, 2011, Petitioner returned to Dr. Abusharif with complaints of neck pain and headaches. Dr. Abusharif noted that Petitioner was likely to undergo surgical intervention at some point but not in the very near future and, therefore, Petitioner wished to have some interventions performed which would reduce his pain. Dr. Abusharif recommended a radial frequency ablation of the medial branch nerve at C4, C5 and C6. Dr. Abusharif performed the procedure on April 21, 2011. Petitioner returned to Dr. Abusharif's care on May 5, 2011 with continued complaints of arm pain and neck pain. Petitioner reported two days of relief and no significant change in symptoms located in the cervical spine. (Px. 2)

Petitioner returned to Dr. Rinella on March 9, 2012 with complaints of posterior headaches. Dr. Rinella charted a new date of accident on this date. Petitioner continued to have complaints of pain "after a work

related injury (4/7/10)." Dr. Rinella recommended a new cervical MRI and surgery or an FCE would be considered thereafter. Dr. Rinella's records do not reveal a reason for the change in accident date from March 10, 2009 to April 7, 2010. (Px. 1)

On April 12, 2012, Petitioner returned to Dr. Rinella and the date of accident was again charted as April 7, 2010. Dr. Rinella noted that Petitioner's pain has been more variable and that he complains of lumbar back pain after no particular injury. Dr. Rinella diagnosed Petitioner with a cervical spondylitic radiculopathy and a lumbar spine strain after lumbar fusion. Dr. Rinella indicated that that he was doing his best to avoid a cervical fusion and that Petitioner would continue his current work restrictions and follow up in the near future. On May 3, 2012, Dr. Rinella opined that he did not believe that Petitioner required any specific surgical intervention at the time and recommended continued care by Dr. Abushariff. (Px. 1)

Petitioner did not return to Dr. Rinella until September 25, 2013, when he complained of pain at a 9/10 scale with continued treatment with Dr. Abushariff. Dr. Rinella noted that Petitioner's cervical radiculopathy was increasing over time. Dr. Rinella opined that he would likely require a cervical discectomy and fusion. Dr. Rinella recommended a new cervical MRI. The MRI was performed on May 1, 2014. The MRI showed development of disc bulge at the midline posterior protrusion with thecal sac and cord effacement as well as disc bulges with canal narrowing at C4/C5 and C5/C6. (Px. 1)

Dr. Rinella recommended an ACDF and performed the surgery on June 18, 2014 at Silver Cross Hospital. (Px. 5) The reason for the surgery was: "67 yo gentleman with a cervical radiculopathy after an injury." The procedure was ACDF with instrumentation and cage and spinal allograft at C5-C6 and C6-C7. (Px. 1)

Petitioner returned to Dr. Rinella on July 3, 2014 with reports of doing well post-operatively. Dr. Rinella authorized Petitioner off of work and set a follow-up appointment for 4 weeks. According to the records, Petitioner returned on July 18, 2014 with reports that he was doing well until a flare up for the past 4 days. Petitioner reported that he was in court observing when a very large gentlemen left the courtroom and slammed a heavy door closed. Reverberation caused his head to bounce off the wall. Petitioner reported a significant flare-up in symptoms. Dr. Rinella diagnosed a cervical strain after courtroom injury and continued Petitioner's care for 6 weeks, including therapy and shoulder exercises to avoid a frozen right shoulder. (Px 1)

Petitioner has not worked since March of 2009. If he worked in his trade, beyond certain limits, he would lose his pension. (R2x. 5)

At the September 3, 2014 hearing, Petitioner claimed that he first became aware that his neck problems were worked related when he saw Dr. Rinella on April 7, 2010. At the February 27, 2014 hearing, Petitioner agreed that he thought his neck pain was related to his work as a sprinkler fitter when he saw Dr. Farrell in May of 2009. Dr. Farrell said that Petitioner's neck problems were work related at the first visit in May of 2009. Petitioner filled out the spine questionnaire document for Dr. Rinella on March 26, 2010, claiming an injury date of March 9, 2009. (R1x. 1)

Petitioner claimed that he gave notice of his injury to Scott Massoglia, superintendent, in March of 2009. (Arbx. 1 and 2) Petitioner said that he advised Massoglia of his neck complaints in a general fashion. Massoglia testified that he did not know of any neck complaints made by Petitioner. Petitioner did not give Massoglia notice of any injury. If Petitioner had told him about an injury, he would have reported it to his supervisor or advised the injured worker to report the injury to the supervisor. Massoglia was not a superintendent in February or March of 2009. He was not Petitioner's supervisor at that time.

Kathy Sawyer testified that she was Petitioner's supervisor in February and March of 2009. She worked at Respondent as service and inspection manager. She left Respondent's employ in 2013. She knew Petitioner. Petitioner did not report any injury to her. She had no knowledge of Petitioner suffering an injury during this time. If an injury was reported, appropriate accident reports would have been prepared and an investigation would have taken place. Sawyer was involved in Petitioner's separation of employment with Respondent in March of 2009. Petitioner was let go by Respondent because of service issues. Basically, it was three strikes, and he was out.

Petitioner testified that he was doing better after the neck surgery. He has had some setbacks, including an increase in pain after a large man (Massoglia) slammed the door in Room 208 on July 14, 2014. The Arbitrator does not recall the event as being in anger or with an intent to injure Petitioner or anyone else. Petitioner testified that he has less pain after the surgery. Petitioner had 7 prior workers' compensation cases that were processed through the Commission. (R2x. 4)

Petitioner claimed medical bills from Dr. Rinella in the amount of $110,820.00, to Silver Cross Hospital for $60,911.90, to Pain Treatment Centers for $4,140.10, to Pain Treatment Surgical Suites for $60,195.00, Flexeon Rehabilitation for $46.00. (Px. 10 – 15) Petitioner claimed TTD from 3/16/2009 through 9/3/14 (285-2/7 weeks).

Three evidence depositions of three board certified orthopedic surgeons were submitted into evidence by the Parties.

Dr. Anthony Rinella Deposition

Dr. Rinella was deposed on March 17, 2011. Dr. Rinella is a spine surgeon. Dr. Rinella stated that the history given by Petitioner was that he was injured at work on March 10, 2009. The pain didn't occur on any one day, it just gradually increased over a four-to six month period. Dr. Rinella diagnosed "work-related cervical spondylotic radiculopathy, or a pinched nerve." Petitioner would not be able to work full-duty as a sprinkler fitter as of the April 7, 2010 visit. Dr. Rinella opined that Petitioner's need for surgery is due to repetitive injury in 2009. Dr. Rinella opined that based upon the history Petitioner gave, he believed it is consistent. Dr. Rinella stated that he believed Dr. Farrell's records set the timeline very rigorously. Per the redirect of Petitioner's counsel, Dr. Rinella opined that the symptoms were exactly the same at the Farrel visit as when he saw the patient, so he was indirectly indicating that Petitioner was diagnosed with spondylitic radiculopathy by Dr. Farrell. Dr. Rinella noted that Dr. Farrel called it joint disease because he is a joint surgeon. In follow up, Petitioner's counsel questioned Dr. Rinella that while the symptoms may have been the same when Petitioner first saw Dr. Farrell, that wouldn't be necessarily something that Petitioner would have been aware of until he came to see Dr. Rinella and had been diagnosed with spondylitic radiculopathy. Dr. Rinella agreed.

Dr. Joseph Manaco Deposition

The deposition of Dr. Joseph Monaco was taken on August 21, 2012. Dr. Monaco was deposed in relation to his reports issued in March 2011 and August 2011. Dr. Monaco does not perform cervical spine surgery. Most of his surgeries are to the knee or shoulder. Dr. Monaco had issued a report that Petitioner's work activities were not the cause of his cervical spine pathology and that Petitioner's cervical pathology was a long standing degenerative process unrelated to his work activities. Petitioner's work activities for Respondent were not a proximate cause of Petitioner's neck and radicular pain.

Dr. Monaco explained during his testimony that based upon his understanding of Petitioner's records and reports of complaints regarding the spine, Petitioner's complaints were normal for a person of his age. Dr. Monaco explained that Petitioner had worked for forty years as a sprinkler fitter and in that time did not voice any complaints. Dr. Monaco explained that this would suggest that his work activities were not the cause, but rather Petitioner just had a degenerative process. Dr. Monaco further testified that because Petitioner's complaints drove him to seek treatment some two months after his retirement, this suggested that Petitioner did not have complaints of pain during his employment with Respondent. Petitioner had age related degenerative findings about the cervical spine which were not related to Petitioner's work for Respondent.

Dr. Monaco agreed that Petitioner told Dr. Farrell in May of 2009 that he had neck pain for six months prior. Dr. Monaco conceded that Petitioner had complaints prior to his retirement based on Petitioner's report to Dr. Farrell. Dr. Monaco conceded that the type of job duties that Petitioner performed would be sufficient to cause pain. Dr. Monaco attempted to clarify his opinion that while the work activities were a possible cause of neck pain, he did not believe that they were the cause of pain in Petitioner's case.

Petitioner's attorney, in questioning Dr. Monaco, pointed out that Petitioner had complaints of pain for six months prior to his report to Dr. Farrell. Dr. Monaco agreed that if Petitioner had complaints at work, his work could have contributed to the neck pain.

Dr. Alexander Ghanayem Deposition

Dr. Alexander Ghanayem was deposed on July 10, 2013. Dr. Ghanayem is a spine surgeon. He served as a §12 physician for F.E. Moran under their May 26, 2009 claim as insured by CNA Insurance. Dr. Ghanayem did not believe that Petitioner was in need of surgery on his cervical spine. Petitioner has age appropriate degenerative arthritis of the cervical spine.

Dr. Ghanayem explained that there was a difference between a condition and symptoms. Dr. Ghanayem also conceded that Petitioner's overhead work as a sprinkler fitter could cause Petitioner to complain of symptoms, but Dr. Ghanayem explained that Petitioner had no "condition" in his cervical spine. Dr. Ghanayem also opined that Petitioner's work did not cause, or even accelerate the condition of ill-being seen on MRI. He identified the changes seen as age-appropriate arthritis. Dr. Ghanayem opined that if Petitioner was a sprinkler fitter his entire career, it would not change his causation opinion.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Statement of Facts in support of the Conclusions of Law set forth below.

WITH REGARD TO ISSUES: (B) EMPLOYMENT; (C) ACCIDENT; (D) DATE OF ACCIDENT; (E) NOTICE; AND (F) CAUSAL CONNECTION, THE ARBITRATOR FINDS THE FOLLOWING:

Petitioner's testimony is found to be not credible. The Arbitrator observed Petitioner's testimony on direct and cross examination on September 3, 2014. Several inconsistencies in Petitioner's testimony are noted

above. He retired because the trade was getting slow and he had lost his job with Respondent. He did not retire because of neck pain, as he told Dr. Rinella, but not Dr. Farrell. He did not complain of neck pain to Massoglia. The Arbitrator does believe that Massoglia would have at least urged Petitioner to report an injury to Sawyer if he had mentioned anything. Certainly, Petitioner would have mentioned his neck problems to Sawyer at the time that he separated from Respondent, if he was experiencing them (9/10 pain in February and March of 2009, never went away). Petitioner was an experienced claimant; it is reasonable to assume that he was savvy enough to understand that he needed to timely report any injury and give a good history to all his physicians. He failed to do so.

The Arbitrator finds that Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on May 26, 2009. This is a repetitive trauma case and it is conceded that no specific injury occurred on May 26, 2009. May 26, 2009 is the day that Petitioner sought treatment with Dr. Farrell for cervical spine complaints.

It is axiomatic that a claimant alleging a repetitive trauma injury "must meet the same standard of proof as a petitioner alleging a single, definable accident." Three D Discount Store v. Industrial Comm'n, 198 Ill. App. 3d 43, 47 (1989) Thus, Petitioner "must prove a precise, identifiable date when the accidental injury manifested itself." Id. An injury manifests itself when the causal relationship between the injury and the employment would have become apparent to a reasonable person. Id.

As to the issue of employee/employer relationship between Petitioner and Respondent on May 26, 2009, it is noted that Petitioner's last day of employment with Respondent was March 16, 2009. Thereafter, he retired, effective April 1, 2009. Arguably, repetitive trauma case law allows a claimant to prove a manifestation date at a reasonable time after his employment with an employer has terminated. In this case, Petitioner conceded that he related his neck complaints to his employment at the time that he saw Dr. Farrell and that Dr. Farrell informed Petitioner that he thought that the condition was related to his work, both events occurring in May of 2009. If the Arbitrator did find in favor of Petitioner on the issues of accident and causation in this case, a finding of an employee/employer relationship would be appropriate.

Next, while May 26, 2009 was the day that Petitioner first was seen for treatment by Dr. Farrell and the day the Petitioner related his cervical spine pain to his work and the day that Dr. Farrell informed Petitioner that his cervical spine condition was related at least in part to his employment, because there is no causal connection between Petitioner's work activities and his cervical spine condition, there is no manifestation date. Thus, there is no accident date.

On the issue of causation, the Arbitrator finds the opinion of Dr. Ghanayem that there is no causal relationship between Petitioner's cervical spine arthritis (age appropriate) and his work duties to be credible and persuasive. Petitioner may have experienced neck pain while working. Of course, this is a symptom and experiencing a symptom at work does not require a finding of causation. Petitioner has age appropriate cervical spine arthritis. This condition was not caused or aggravated by his work for Respondent. Dr. Rinella's opinion on causation is not persuasive. His April 7, 2010 charting of an injury on March 10, 2009 and the diagnosis of work-related cervical spondylotic radiculopathy does not convince the Arbitrator that his opinions are objective. Further, if Petitioner's cervical spine arthritis was truly aggravated by Petitioner's work activities to the extent that causality could be established, one would expect that Petitioner would have sought treatment from an orthopod more than 2 times in the year period from his retirement on April 1, 2009 to the time that he saw Dr. Rinella, April 7, 2010. Petitioner's case just does not add up.

As to the issue of Notice in this case, Petitioner did not give notice to Respondent via telling Massoglia of neck pain in March of 2009. Notice can't be given at a time before the accident date. Further, the Arbitrator does not find that Petitioner told Massoglia of any neck pain complaints in approximately March of 2009. Finally, Massoglia was not management in March of 2009 and Petitioner's complaints of pain to a fellow employee at that time does not prove that timely Notice was given.

WITH REGARD TO ISSUES: (J) REASONABLENESS AND NECESSITY OF MEDICAL TREATMENT; (K) PROSPECTIVE MEDICAL; (L) TTD; AND (M) PENALTIES, THE ARBITRATOR FINDS THE FOLLOWING:

As the Arbitrator has found above that Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on May 26, 2009 and failed to prove a causal connection between his work activities and his condition of ill-being regarding his cervical spine, the Arbitrator needs not decide these issues.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Little John Testerman,

Petitioner,

vs. NO: 16 WC 21942

Alltech Decorating,

18IWCC0083

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 all of the issues, and being advised of the facts and law, reverses the Decision of the Arbitrator and substitutes its own findings below.

Facts

Petitioner testified that he was hired as an apprentice painter for Respondent two days before his accident. (Arb. Trans. P9-10). On July 8, 2016, he said, he was working to clean sand off of a flat roof—a task that involved sandblasting the surface and then dumping sand from a wheelbarrow over the roof's edge—when he fell off due to the wet surface. (Arb. Trans. P11-13). As Petitioner described it, he "[w]ent to the edge of the roof, *** stopped about a foot away from the edge of the roof," then "put [his] left foot to the straight, and *** [his] right foot to the side to assume a stable position of balance." Then, he said, he "grabbed the wheelbarrow" and "started to flip the wheelbarrow over" when "it started to shift and to try to pull [him] over." He said that the wheelbarrow slipped on the wet surface and he "let go of [it] for it not to pull [him] over," causing him to lose his balance and fall off the roof. (Arb. Trans. P13-14).

He agreed that this was his first job with Respondent and his first time performing this task. (Arb. Trans. P13). Petitioner landed on his right leg and felt immediate pain in his leg and knee. (Arb. Trans. P15). He was later treated for meniscal tears in both knees (see PX2), and surgery was recommended for the right knee.

Petitioner agreed that, during his ensuing hospital visit, he was administered a drug screen, which was positive for opiates and cannaboids; he said that he had been administered opioid painkillers in the emergency room. (Arb. Trans. P16-17; PX1). Petitioner testified that he had

not ingested marijuana—in fact that he had not since he was a teenager—but that he had ridden in a vehicle with a supervisor, Matthew Murray, who smoked marijuana during their ride to the job site two days prior. (Arb. Trans. P16-19). On cross-examination, Petitioner agreed that he had had a drug problem in the past and that, immediately following his drug screen, he told an insurance adjuster that he knew the screen would come back with a positive result. (Arb. Trans. P21-22).

Dr. Leon Gussow, a medical toxicologist called by Petitioner, testified about drug testing generally, but specifically did not testify about this case. (Arb. Trans. P25-26). He explained that a number of factors can cause a falsely positive test and that positive tests do not necessarily establish impairment. (Abr. Trans. P27-28).

Called as a witness for Respondent, Matthew Murray, Petitioner's supervisor for Respondent, testified that Respondent imposes extensive worker safety measures, including the use of body harnesses to prevent roof falls. (Arb. Trans. P39). Murray said that those measures were in place, and had been explained to Petitioner, on the day of his accident. (Arb. Trans. P40). Murray said that he noticed "some twitching and stuff going on in the face" of Petitioner on the morning of the accident, but he noted no behavioral or other abnormalities. (Arb. Trans. P40). He also said that, when he picked Petitioner up at the airport prior to the job, "one of the first things out of his mouth was how he took a drug test," an event that he mentioned "multiple times." (Arb. Trans. P45).

In the afternoon, Murray said, they took a work break due to weather, and he was distracted by a work-related errand during the break. (Arb. Trans. P41). When he returned ten minutes later, Murray said, he noticed that Petitioner was no longer on break, and that the wheelbarrow on the roof was "missing." He then saw Petitioner laying on the ground. (Arb. Trans. P42-43). He said that he and Petitioner were moving sand on the roof and that none of that sand appeared to have been moved during the break. (Arb. Trans. P43-44).

Murray testified that he had used an e cigarette on his and Petitioner's shared ride to the job site, but he said that he does not use the device to smoke marijuana. (Arb. Trans. P45). (He did admit to having smoked marijuana in the past, but not for the prior two years.) On cross-examination, Murray agreed that he had been convicted of a misdemeanor for obtaining unemployment benefits by false means.

Recalled as a rebuttal witness, Petitioner denied that Murray had given him any safety training, and he denied that Murray followed safety protocols that included using a harness. (Arb. Trans. P59). According to Petitioner, Murray told him to return to work while Murray performed the side errand. (Arb. Trans. P60).

A drug test administered on July 11, 2016, returned a negative result for both opiates and marijuana metabolites. (PX2).

Findings

In his brief, Petitioner argues that the arbitrator erred in finding that his knee condition did not arise out of and in the course of his employment. An employee's injury is compensable

under the Act only if it arises out of and in the course of his employment. 820 ILCS 305/2. However, "[n]o compensation shall be payable" if "the employee's intoxication is the proximate cause of the employee's accidental injury." 820 ILCS 305/11. Further, "[i]f, at the time of the accidental injuries, *** there is any evidence of impairment due to the unlawful or unauthorized use of," among other things, cannabis, "there shall be a rebuttable presumption that the employee was intoxicated and that the intoxication was the proximate cause of the employee's injury." 820 ILCS 305/11. "The employee may overcome the rebuttable presumption by the preponderance of the admissible evidence that the intoxication was not the sole proximate cause or proximate cause of the accidental injuries." 820 ILCS 305/11.

In this case, Petitioner was unquestionably injured as a result of his fall from a roof while at work. Respondent asserts, however, that the evidence here triggers the Act's rebuttable presumption that his intoxication was the proximate cause of his accident. Petitioner disputes that he voluntarily ingested marijuana. The arbitrator rejected this argument on the ground that the Act draws no distinction between voluntary and involuntary ingestion. However, the Act does in fact draw such a distinction, by applying the intoxication presumption only in cases of "unlawful or unauthorized" use of cannabis. That said, the arbitrator did not err in applying the presumption, because the evidence of his intoxication was admitted without objection. Here, even though Petitioner testified that he did not voluntarily ingest cannabis, there was evidence—in the form of a positive drug test immediately following the injury and Murray's denial that he had caused Petitioner to ingest marijuana—of Petitioner's unlawful use. For that reason, the statutory presumption applies, and Petitioner may succeed on his claim only if he can show that the preponderance of the evidence establishes that his intoxication was not the proximate cause of his accident.

To that end, Petitioner argues at some length that his testimony was more credible than Murray's. Petitioner correctly points out that Murray has a prior conviction for a crime of dishonesty. Because both he and Murray had been working on the roof prior to Murray's leaving for an errand, it is also not implausible that Petitioner resumed work on his own in Murray's absence. Indeed, Murray testified that the wheelbarrow had been moved while Petitioner was alone on the roof. Further, although it is true that Murray's contemporaneous accident report accorded with his testimony, that prior consistent statement does not lend independent credence to his version of events. On the other hand, as the arbitrator noted, it is unlikely that Petitioner would have been instructed to continue work alone, on the first day of his apprenticeship, with no safety equipment. In total, it cannot be said that one witness was obviously more credible than the other.

That said, the credibility question is largely academic. The two witnesses disagreed essentially on three points: whether Murray caused Petitioner to ingest second-hand marijuana, whether they used proper safety equipment, and whether Petitioner was performing work or on break at the time of his accident. None of these three points affects the outcome of the case. The first point, regarding the voluntariness of Petitioner's marijuana ingestion, is resolved above. The proper use of safety equipment may have prevented Petitioner's accident, but it is not argued that the lack of safety equipment precludes his recovery for the accident. As for the dispute regarding whether Petitioner was working, it is more likely, given the agreed fact that the wheelbarrow was moved, that he was working. If Petitioner was on break, however, he would

still have been injured during a work break while confined to an area dictated by his employment, and there is no indication he was engaging in any unusually physically dangerous activity during that break. If he was on break, then, the personal comfort doctrine would dictate that his actions be considered work-related. See *Karastamatis v. Industrial Comm'n (Annunciation Greek Orthodox Church)*, 306 Ill. App. 3d 206, 211 (1999) (explaining personal comfort doctrine).

The record presents other reasons to find the proximate cause of this accident to be something other than Petitioner's intoxication. As Petitioner points out, although he registered a positive drug test, that test does not establish the extent, or even the existence, of his intoxication, if any. In fact, Murray testified that Petitioner exhibited no unusual behavior (other than facial twitching) on the day of the accident. Murray's and Petitioner's testimonies also corroborated one another on an important point: it had rained just prior to Petitioner's accident, so that the roof was wet. Whether Petitioner slipped on the wet surface while dumping material from the roof or whether on break on the roof, the unavoidable inference from this record is that hazardously slippery conditions on the roof led to his accident. The Commission finds that those conditions, and not Petitioner's alleged intoxication, were the most direct cause of his accident.

For those reasons, the preponderance of evidence refutes the statutory presumption that Petitioner's intoxication was the proximate cause of his accident. Instead, the evidence shows that his accident was the result of a job-related hazard—his placement on a slippery roof. For that reason, he is entitled to benefits under the Act for his injury.

Respondent offers no argument as to why medical or other benefits should be denied if Petitioner's injury is, in fact, job-related. In fact, as Petitioner points out in his brief, Respondent rested its defense entirely on its intoxication defense. Thus, Petitioner should receive medical expenses related to his treatment, prospective medical treatment, and temporary total disability for his time off of work through the date of the arbitration hearing.

Conclusion

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated November 1, 2016, is reversed as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner be awarded past and prospective medical expenses, subject to the fee schedule, for treatment related to his workplace injury.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner be awarded TTD for 16 and 4/7 weeks, for the period from July 9, 2016, through November 1, 2016.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980).

Bond for the removal of this cause to the Circuit Court is hereby fixed at the sum of $2,000.00. 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.

FEB 8 - 2018

DATED:
o:12/18/17
TJT/knc
51

Thomas J. Tyrrell

Michael J. Brennan

DISSENT

I respectfully dissent from the Majority's opinion reversing the Arbitrator's decision. I find Arbitrator Falcioni's decision to be thorough and well reasoned. I would affirm and adopt this decision.

Kevin W. Lamborn

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

TESTERMAN, LITTLE JOHN
Employee/Petitioner

Case# **16WC021942**

ALLTECH DECORATING
Employer/Respondent

18IWCC0083

On 11/1/2016, 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 0.50% 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:

4128 RUBENS AND KRESS
FRANK D KRESS
134 N LASALLE ST SUITE 444
CHICAGO, IL 60602

0210 GANAN & SHAPIRO PC
JULIE SCHUM
210 W ILLINOIS ST
CHICAGO, IL 60654

18IWCC0083

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Little John Testerman
Employee/Petitioner

v.

AllTech Decorating
Employer/Respondent

Case # **16** WC **21942**

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 **Robert Falcioni**, Arbitrator of the Commission, in the city of **New Lenox**, on **October 5, 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, **July 8, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**Petitioner was injured on his second day of work and did not receive a full week's wages**; the average weekly wage was **$1,047.00**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **0** dependent children.

ORDER

Based upon the evidence presented, the Arbitrator finds that evidence of intoxication on July 8, 2016 created a rebuttable presumption that said intoxication was the proximate cause of the accident and not his employment. Given this, the Arbitrator finds that Petitioner's condition is not causally related to his employment.

No benefits are awarded.

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.

Robert E Abrams

Signature of Arbitrator

October 21, 2016

Date

ICArbDec19(b)

NOV 1 - 2016

Little John Testerman v. AllTech Decorating 18IWCC0083

16 WC 21942

Statement of Facts

Little John Testerman, hereinafter "Petitioner", testified that he was employed by AllTech Decorating, hereinafter "Respondent", on July 8, 2016. He was hired on July 2, 2016, as an apprentice painter. On July 6, 2016, he reported for work and rode in a truck with Matthew Murray and another supervisor to northern Michigan for his first job. Mr. Murray, the crew leader for that particular job, testified that Petitioner appeared nervous and mentioned his drug test for the employer several times. He also testified that Petitioner had mentioned a prior drug habit but that they did not discuss it in depth. Mr. Murray testified that he smoked an electric cigarette during the ride. Petitioner contended that the cigarette was marijuana and that the cab filled with smoke from said cigarette.

On July 8, 2016, Petitioner worked with Mr. Murray on a roof to clean off the sand left behind by sandblasting. This was done by collecting the sand into piles, shoveling the sand into a wheelbarrow, and dumping it off the side onto tarps for disposal. Mr. Murray testified that he instructed Petitioner on the use of the 5 point safety harness and explained that they were required to tie off to an anchor system whenever they worked on the roof. The anchor system had to be anchored to a point on the roof capable of sustaining at least 5000lb. Petitioner contended that no safety system was provided or used.

Subsequent to lunch, there was a brief period of rain. Mr. Murray testified that they took a break to see if the "drizzle" would subside or if they would need to stop work for the day due to weather. Petitioner initially testified that they had taken a break for weather but then later changed his testimony on rebuttal to state that they had taken only a five minute break regardless of weather. During the break, the job contact approached Mr. Murray and requested the use of his ladder as he wished to check on one of the antennas. Mr. Murray cited concerns about liability if there was an incident and indicated he would be happy to take photographs of the antenna. Mr. Murray testified that he told Petitioner to remain on break while he did so. He testified that he then went up on the roof and took the pictures. At that point, he testified the roof was not wet enough to cause any traction problems.

As he returned from taking the pictures, Mr. Murray testified that he noticed the wheelbarrow was gone from the roof even though the piles they had been working on prior to their break were untouched. At that point, he found Petitioner on the ground. Petitioner contended that Mr. Murray had ordered him back to work and that he slipped while dumping a load of sand off the roof. On July 11, 2016, Mr. Murray wrote out a detailed three page statement going through the events of the day which comported with his testimony.(RX1)

Subsequent to the incident, Petitioner was taken to the emergency room at Portage Health Hospital. He was diagnosed with a meniscal tear to the right knee and a possible meniscal tear to the left knee. The drug test performed in the emergency room was shown to be positive for opioids and cannabinoids. It is noted that at the emergency room Petitioner was administered morphine, and the records do not indicate if it was administered before or after the drug screen sample was gathered. The drug screen report merely reported the sample as positive for the presence of cannabinoids, without reporting the level of cannabinoids present in the sample.

Since that time, Petitioner has been treating with Physicians Immediate Care where he has been diagnosed with meniscal tears to both knees and surgery for the right knee has been recommended.

At trial, Petitioner presented the testimony of Dr. Leon Gussow, over the objections of Respondent. Dr. Gussow testified that *in general* drug screens can have a false positive due to a number of factors. He also testified that in general a drug screen can be positive for days or even weeks after exposure and that it is not possible to tell the level of impairment based upon a positive drug screen. He testified only in generalities and gave no opinions regarding the circumstances or testing in this specific case.

Both parties stipulated at trial that Petitioner has an underlying AWW of $697.00 and received an expense card for $350.00 per week. Mr. Murray testified at trial that, to the best of his knowledge, employees receive a per diem. He was unsure of whether or not it the per diem appeared on a W-2 but he testified that it was not taxed. Petitioner presented no testimony with regards to his manner of compensation.

Conclusions of Law

The preceding Statement of Facts is hereby incorporated into every section of the following Conclusions of Law.

With regards to "C", did an accident occur which arose out of and in the course of employment and "F" is Petitioner's current condition causally related to the injury, the Arbitrator finds as follows:

The Arbitrator notes that accident and causal connection were disputed only in that an intoxication defense was raised based upon the drug test performed by the hospital. The Arbitrator finds that there is proof of intoxication sufficient to establish the rebuttable presumption that the intoxication was the proximate cause of the incident and that Petitioner has not provided sufficient evidence to overcome that presumption.

Under the Illinois Workers' Compensation Act,

> "If at the time of the accidental injuries, there was 0.08% or more by weight of alcohol in the employee's blood, breath, or urine or if there is any evidence of impairment due to the unlawful or unauthorized use of (1) cannabis as defined in the Cannabis Control Act... then there shall be a rebuttable presumption that the employee was intoxicated and that the intoxication was the proximate cause of the employee's injury. The employee may overcome the rebuttable presumption by the preponderance of the admissible evidence that the intoxication was not the sole proximate cause or proximate cause of the accidental injuries."

The hospital records in this matter show a clear positive test for cannabis on the date of accident. The records do not provide any evidence of the concentration of cannabinoids in the sample. While Petitioner presented general evidence that false positives are possible, no direct evidence was presented showing that the result in the current matter from the date of accident was a false positive. Additionally, no testimony or evidence was presented against the validity of the specific test itself. The Arbitrator additionally notes the language in the Act which states that "..***ANY*** evidence of impairment shall create a rebuttable presumption that the employee was intoxicated and that the intoxication was the proximate cause of the employe's injury."

(emphasis added) Given this, the existence of the positive test on the date of accident is sufficient to establish the rebuttable presumption that the intoxication is the proximate cause of Petitioner's injuries.

Petitioner does have the right to present evidence to contest that presumption. Petitioner presented testimony towards several positions at hearing. The first was the testimony of Dr. Gussow regarding the general existence of false positives. As noted above, there was no testimony that this particular test was a false positive, no testimony that Petitioner ingested either of the drugs the doctor testified could give a false positive and no other evidence provided to support that there was anything faulty about the test itself.

The second position Petitioner presented at hearing was his testimony that Mr. Murray had been smoking marijuana on the truck ride the day before the date of accident. Even if this were taken as true, there is nothing in the Act which would create an exception to the presumption if Petitioner unknowingly or passively ingested the intoxicating substance. Based upon the plain language of the Act, the manner of intoxication is irrelevant.

The third position Petitioner presented was that, regardless of his positive test, he was not impaired and thereby that the intoxication itself was not the proximate cause of his injury. The Arbitrator rejects this premise as well. In his testimony, Petitioner would assert that on his first day on the job as an *apprentice* with a company large enough to have multistate contracts, he was given no safety training and was sent to work on a roof with no safety equipment while the only other coworker was occupied when there is no testimony or evidence that he had any experience in the field at all. In fact, his position as an apprentice would speak to the opposite. Common sense alone renders this position unsupportable.

The only testimony that Petitioner presented to rebut the established presumption was his own testimony that he was not intoxicated or under the influence of marijuana at the time of the accident. The Arbitrator finds this insufficient to overcome the presumption.

Based upon all the above, the Arbitrator concludes that Petitioner has not presented sufficient evidence to overcome the rebuttable presumption established by the positive cannabis test from the date of accident, and therefore finds that the Petitioner did not sustain an accident arising out of and in the course of his employment with Respondent as alleged herein. All other issues except (G) below are therefore moot.

With regards to "G", what were Petitioner's earnings, the Arbitrator concludes as follows:

The parties stipulated at trial that Petitioner's underlying AWW was $697.00 per week and that he received an expense card of $350.00 per week. Petitioner himself presented no testimony as to his compensation and admitted that he only began his employment a week prior to the date of accident. Though Mr. Murray testified that employees in general get a per diem expense, he stated that it was not taxable, but that it appeared on his paycheck. Rather the stipulation, which is controlling and binding per the prior decisions of the Appellate Court, was that Petitioner received an expense card for $350.00 per week.

The Arbitrator notes that no evidence was provided that said card was in way provided for Petitioner's use outside of work or that those funds were part of Petitioner's taxable compensation. Rather, the stipulation was that it was an expense card – presumably to be used for expenses incurred on the job as there was absolutely no testimony to that effect. However no testimony was presented that Petitiner actually used the card for any expenses or did anything other than keep the money for his own purposes, whatever those may have been.

The testimony of long-time employee Matthew Murray is clear that regardless of whether the $350.00 is spent by an employee of the Respondent, he or she is free to keep that money as an economic gain. Per diem benefits are included in the average weekly wage only to the extent they constitute "real economic gain." Swearingen et al. v. Industrial Comm'n, 298 Ill. App. 3d 666, 699 N.E.2d 237, 232 Ill.Dec.790 (5th Dist. 1998); Bartlett v. Alarm One, 01 UC 0132. In Swearingen, the employer paid its employees by a method in which half of payments made to its employees were reimbursement for travel "per diem" payments. The record revealed that the employer did not pay employment taxes on those amounts and that one of the Petitioners involved in the case also did not pay taxes on the per diem either. However, a second Petitioner involved in the case did pay taxes on the "per diem." The Appellate Court held that the payments designated as reimbursement for travel expenses should be included when calculating an employee's average weekly wage only to the extent that such payments present real economic gain rather than reimbursement for actual travel expenses.

It is clear to the Arbitrator that in the event that the Respondent's employees do not use the $350.00 per week, they can keep that money as an economic gain. Again it is noted that no evidence was presented that any of the $350.00 was used for actual travel expenses. For that reason and based upon the holding in Swearingen, the Arbitrator finds that the Petitioner's average weekly wage shall include the $350.00 "per diem" and that the total average weekly wage is $1,047.00.

With regards to "J" "K" and "L", the medical benefits due and owing, TTD due and owing and prospective medical, the Arbitrator finds:

Based upon the Arbitrator's findings with regards to causal connection and accident, the issues of medical, TTD and prospective medical are moot. As the intoxication is found to be the cause of the accident, no benefits are awarded.

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

Carl Crittenden,

Petitioner,

vs. NO: 08 WC 19505

18IWCC0084

City of Chicago,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission following the remand order of the Appellate Court of Illinois, First District, reversing the circuit court's confirmation of the Commission's decision (14 IWCC 0884) and remanding the case for further proceedings. The Commission, after considering the issue of nature and extent, affirms the Decision of the Arbitrator with changes, for the reasons stated below.

I. PROCEDURAL HISTORY:

A) Arbitration Decision

In a decision dated February 15, 2013, the Arbitrator awarded "... wage differential benefits of $581.06/week from 4/9/12 through 1/4/13, a period of 38 5/7 weeks, and continuing thereafter 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." (Arb.Dec.[Form], p.2). In support of this determination, the Arbitrator noted that there was no dispute "... as to Petitioner's inability to resume his former laborer job. Nor is there any dispute as to how much Petitioner would be earning, i.e. $32.79 per hour, if he could still perform that job. PX10. While (rehabilitation consultants) Blumenthal and Bose did not rely on identical histories, their opinions overlapped to the extent that they both targeted cashier and customer service jobs when they evaluated Petitioner in 2010 and 2011, noting Petitioner's past retail experience. Blumenthal noted that Petitioner was earning $11.00 per hour when he left his part-time job at Target. Blumenthal projected earnings of $8.25 to $13.78 per hour. Bose did not criticize this projection or make a projection of her own. The Arbitrator selects

$11.00 per hour as a reasonable wage. The Arbitrator arrives at a wage differential rate of $581.06 by multiplying $32.79 by 40 hours to arrive at $1,311.60, subtracting $440.00 ($11.00/hour x 40) to arrive at $871.60 and dividing $871.60 by 2/3." (Arb.Dec.[Addendum], p.13).

B) Commission Decision

In an order dated October 9, 2014 (14 IWCC 0884), the Commission found that Petitioner had proved entitlement to a wage differential award under §8(d)1. (Com.Dec., p.1). However, the Commission disagreed with the Arbitrator as to the rate, finding that "... Petitioner did not provide the effort that he should have in performing his job search, and exaggerated the difficulties he encountered in dealing with the Respondent's initial method of vocational assistance." (Id., p.2). The Commission noted that "[w]hen a claimant is receiving weekly benefits while performing a search for alternative employment, the search is his 'job' during this time. Taking the evidence as a whole, the Commission agrees that the Petitioner has clearly shown entitlement to a wage differential, however his lack of effort in obtaining alternative suitable employment leads us to determine that he is capable of earning the highest amount that Mr. Blumenthal opined he was capable of earning, $13.78 per hour. We note that while the Respondent could have initially provided more assistance to the Petitioner in his job search than it did, but this does not absolve the Petitioner's responsibility to do his best and give his best effort in finding alternative employment. In this case, we do not believe he provided much effort, and as a result have determined the proper weekly wage differential should be $506.93 per week." (Id.).

C) Circuit Court Decision

In an order entered December 17, 2015, Cook County Circuit Court Judge Edmund Ponce de Leon confirmed the Commission decision.

D) Appellate Court Decision

In an opinion filed February 24, 2017, the Illinois Appellate Court determined that the Commission erred in basing its wage differential award on the hourly wage associated with an occupation for which it determined he was not qualified – namely that of a bus driver, given that the claimant did not possess a valid driver's license. As a result, the court vacated the Commission's wage differential award and remanded the matter "…. to the Commission for further proceedings, including the identification by the Commission of an occupation the claimant is able and qualified to perform, and a calculation of the wage differential using the average wage of that occupation." *Crittenden v. Ill. Workers' Comp. Comm'n*, 73 N.E.3d 654, 411 Ill. Dec. 570 (1st Dist. 2017).

II. FINDINGS OF FACT:

The Commission incorporates, by reference herein, the findings of fact contained in the previous decisions issued during the pendency of this claim. With respect to the current remand, the Commission specifically notes the following:

In an FCE report dated October 17, 2009, it was noted that "[o]verall test findings, in combination with clinical observations, suggest the presence of good, though not entirely full, effort on Mr. Crittenden's behalf. In describing his effort, this evaluator is by no means implying intent. Rather, it is simply meant to reflect that Mr. Crittendon [sic] was limited by reported low back pain before objective measures of physical effort (heart rate, body mechanics, and accessary muscle recruitment) indicated that full maximal physical effort was being exerted. In light of his identified pathology, reliable subjective reports, clinical consistency, and other measures of physical effort measured during testing, this report may be considered a reliable indicator of his safe physical capacity. However, the possibility that Mr. Crittenden may be able to do slightly more physically at times than was demonstrated during this testing day cannot be completely ruled out." (PX3). It was also noted that "[o]verall test findings, in combination with clinical observations, identify Mr. Crittenden's subjective reports of pain and associated disability to be both reasonable and reliable." (PX3).

In addition, this report revealed that Petitioner demonstrated the ability to safely meet Light level physical demand requirements, and did not meet the identified physical demand requirements of his target job of Laborer-Refuse Collector. (PX3). In addition, it was noted that Petitioner had achieved maximal functional improvement related to his low back injury, and that "[t]o match safe physical capacity demonstrated during this evaluation, appropriate restrictions would be as follows: no lifting or carrying greater than 20 pounds on an occasional basis, and up to approximately 13 pounds on a more frequent basis; no pushing/pulling with greater than approximately 40 pounds of force on an occasional basis; no frequent or repetitive bending or twisting; allow positional changes as needed to avoid constant standing/walking or constant static sitting over a full workday. To match estimated tolerances and physical capacity demonstrated during this evaluation, he should be allowed to change positions approximately every 30 minutes to 1 hour as needed to minimize symptoms. He should also avoid prolonged walking intervals greater than approximately 10 minutes as tolerated." (PX3).

In an IME report dated March 18, 2010, Dr. Kern Singh provided a diagnosis of status post L3-L4 laminectomy and posterior spinal fusion with instrumentation and released Petitioner to full duty with permanent restrictions based upon the October 17, 2009 FCE. (PX5). Dr. Singh noted that "[a]t this point, the patient is at maximum medical improvement. I do agree with his treating physician that he should be allowed to return to work with restrictions based upon his functional capacity evaluation from October 1, 2009. I do not believe any additional treatment is required. It appears that based upon his FCE he is not capable of performing the current demands. I do not believe he is capable of returning back to work full duty. I would place permanent restrictions as per above..." (PX5).

In an IME report dated March 29, 2010 (following an examination on March 27, 2010), Dr. Samuel J. Chmell noted a diagnosis of 1) traumatic aggravation of degenerative disc disease of the lumbar spine; 2) L3-4 disc herniation with sciatic status post L3-4 laminectomy, discectomy and posterior lumbar interbody fusion with internal fixation and iliac bone graft." (PX6). Following his examination and review of the records, Dr. Chmell was of the opinion "... based upon a reasonable degree of medical and orthopedic certainty, that Mr. Crittenden sustained an injury to his lumbar spine at work in the 4/11/2009 occurrence. The injuries are defined by the diagnoses above. The medical, surgical and therapy treatment that Mr. Crittenden underwent for

his low back subsequent to the 4/11/2009 occurrence were reasonable and attributable to this occurrence. I think that Mr. Crittenden has achieved maximal medical improvement following his 4/11/2008 work injury and appropriate treatment that ensued. As a result of the 4/11/2009 work occurrence, Mr. Crittenden cannot ever return to back to his regular job as a laborer in the Department of Streets and Sanitation. He requires permanent restrictions and limitations with regard to his physical activities. I am in agreement with the results of the FCE. These opinions are based upon a reasonable degree of medical and orthopedic surgical certainty." (PX6).

In a report dated August 2, 2010, certified rehabilitation counselor and vocational evaluation specialist Steven Blumenthal recorded that Petitioner had worked for the City of Chicago Department of Streets and Sanitation as a laborer since 1985, and that from 1999 to 2003 he drove other laborers around and supervised them in the cleaning of streets and alleys. (PX7). He also noted that "[f]rom November of 2007 to his date of injury in 2008, Mr. Crittenden reports work experience as a maintenance worker with Shriners Hospital in Chicago, IL. He states that he cleaned around the kitchen and performed mopping, wiping down of tables, and vacuuming of carpets. Mr. Crittenden reports that he earned $12.00 an hour." (PX7). In addition, Mr. Blumenthal noted that from 1997 to 2003 Petitioner "... was employed part time with Target Stores as a supervisor in customer service. He states that he answered any questions regarding store policies, returns policies, issued credit, and handled problems with customers. Mr. Crittenden states that he counted out cash each night from each register and in the morning would put the cash into each register. He states that he worked 5:00 pm to 9:00 pm or would open the store and work from 7:00 am to 2:00 pm. Mr. Crittenden reports that when he left in 2003 he earned $11.00 an hour." (PX7). Mr. Blumenthal also noted that Petitioner had previously worked at Jewel as a cashier, having started as a bagger, from 1982 to 1983, as well as a casual worker for the U.S. Post Office during the holiday seasons, filling in for mail carriers from 1981 to 1982. (PX7).

Following his interview and review of the records, Mr. Blumenthal noted that "Mr. Crittenden is interested in viewing his occupational placement options but it is also very clear that he will require specialized job placement assistance to identify job settings where his physical abilities can be accommodated by the employer. Certain job descriptions as an unarmed security guard in a gated community or industrial guard shack where Mr. Crittenden could sit/stand as needed, or as a school bus driver where he could get in and out of the bus to change positions would be consistent with his documented physical abilities (Mr. Crittenden stated he enjoyed driving workers around in the past). Customer Service and cashiering, or even hotel clerk positions would require specific accommodations being made by the employer." (PX7).

Mr. Blumenthal believed that Petitioner was a good candidate for vocational rehabilitation job placement services and would benefit from job readiness training. (PX7). Furthermore, Mr. Blumenthal noted that "[i]t is projected that Mr. Crittenden will earn $8.25 to $13.78 an hour based on State of Illinois Department of Economic Security Wage Data. This would be dependent on the job title he performs and the hiring employer's pay scale." (PX7).

In an Initial Vocational Rehabilitation Evaluation Report dated October 22, 2011, certified rehabilitation consultant Julie Bose recorded that Petitioner attended high school through the 11th grade and that he does not have a GED. (RX2). She also noted Petitioner did not have a current driver's license, given two recent DUIs, and that he "... does not anticipate getting his license back

anytime soon, as he owes a considerable sum of money to pay court fees and fines." (RX2). She indicated that Petitioner began working for the City of Chicago Department of Streets and Sanitation in 1985 and continued to work for the City until one month after his 4/11/08 injury. (RX2). In addition, she noted that Petitioner "... worked for a considerable amount of time at Target as a customer service representative and cashier. He also indicated that he worked at Shriners Hospital as a janitor. He stated that he also had numerous side jobs as a furniture mover for the city. Mr. Crittenden also indicated that prior to work for the City of Chicago he worked as a cashier for Jewel Food Stores and a mailman for the United States Post Office." (RX2).

Ms. Bose indicated that Petitioner "... sustained a work-related back injury necessitating permanent light duty work restrictions. Overall, this consultant is of the opinion that Mr. Crittenden is a good candidate for vocational rehabilitation services. However, his history of DUIs and lack of license, as well as his lack of a high school diploma will adversely affect his job search." (RX2). Ms. Bose recommended a vocational rehabilitation plan that includes job seeking skills instruction, attendance at GED and basic computer classes, and a direct job search. (RX2).

Ms. Bose testified that the job leads provided to Petitioner "... were primarily positions in the sedentary or light physical demand level, utilizing previous retail and customer service experience such as that of a customer service representative, a sedentary cashier, for example, a cashier at an automotive dealership, and positions – there were some light cleaning positions as well, I believe." (T.105). Ms. Bose was of the opinion that Petitioner did not fully comply with the vocational rehab program, specifically with the job logs starting 3/2/12 through 4/6/12, noting that "... most of the weeks during that period of time [Mr. Crittenden] didn't have the number of contacts that we require, both in total and in person. He did not always send online confirmations that he completed the online application... There was also repetition in contacts ... [a]nd during this time frame, there were several weeks – I believe most every week – that he did not provide the documentation that he followed up on our job leads." (T.117-118).

Ms. Bose agreed that Petitioner is unable to return to work doing the kind of work he had been doing for Respondent – namely, as a sanitation laborer. (T.131-132). She also agreed that Petitioner is unable to resume a job that pays him $1,138.26 a week, and that as a result it is necessary for him to look for work in some other area. (T.132). Likewise, she agreed that based on her evaluation those job leads should focus on the retail area, including customer service and cashier, which she said were "examples" and not an "exhaustive list." (T.137-138). She agreed that since he did not have a high school diploma a security guard position would be beyond his qualifications. (T.138). She also conceded that not one of her reports identified how much the suggested jobs would pay, although she added that she "... can provide that." (T.139).

On re-direct, Ms. Bose testified that "[t]ypically employers don't provide pay scale until after an interview and sometimes only with a job offer. I can provide a pay range based on experience if the Court desires." (T.140). She also reiterated that the job positions she identified for Petitioner were not exhaustive of what he could do. (T.142).

III. CONCLUSIONS OF LAW:

"In making the calculation of a wage differential under section 8(d)1 of the Act (820 ILCS 305/8(d)(1) (West 2012), the Commission must determine 'the average amount which [the

claimant] is able to earn in some suitable employment or business after the accident.' In calculating this average amount, ... if the claimant is not working at the time of the calculation, the Commission must rely on functional and vocational expert evidence." *Crittenden v. Ill. Workers' Comp. Comm'n*, 73 N.E.3d 654, 660, 411 Ill. Dec. 570, 576-77 (1st Dist. 2017). "In addition, where the claimant is not working at the time of the hearing, it is important to note that section 8(d)(1) requires that an average weekly wage be derived from suitable employment for the claimant. Suitable employment is employment in which the claimant is both able and qualified to perform." *Crittenden*, 73 N.E.3d at 660-61. Furthermore, "... in order to calculate a wage differential award, the Commission must identify, based on the evidence in the record, an occupation that the claimant is able and qualified to perform, and apply the average wage for that occupation to the wage differential calculation." *Id.*, at 661.

The Commission notes that in its decision, the appellate court specifically found that "[w]hether the claimant is entitled to a wage differential is not an issue on appeal." *Crittenden*, 73 N.E.3d at 659. It is these words of the appellate court's opinion that compel us to render a decision finding that Petitioner is entitled to a wage differential award. But for these comments of the appellate court, we would not be so inclined. As a result, the Commission's present inquiry is limited to the amount of the wage differential to be awarded.

Along these lines, the Commission notes that neither vocational expert in this case – Mr. Blumenthal or Ms. Bose – identified specific occupations that Petitioner was able and qualified to perform and the wages associated with those jobs. Instead, Mr. Blumenthal simply opined that "[i]t is projected that Mr. Crittenden will earn $8.25 to $13.78 an hour based on State of Illinois Department of Economic Security Wage Data. This would be dependent on the job title he performs and the hiring employer's pay scale." (PX7). Earlier, Mr. Blumenthal had noted that possible jobs included "... an unarmed security guard in a gated community or industrial guard shack where Mr. Crittenden could sit/stand as needed, or as a school bus driver where he could get in and out of the bus to change positions [and which] would be consistent with his documented physical abilities (Mr. Crittenden stated he enjoyed driving workers around in the past). Customer Service and cashiering, or even hotel clerk positions would require specific accommodations being made by the employer." (PX7). For her part, Ms. Bose noted that the job leads that were provided to Petitioner "... were primarily positions in the sedentary or light physical demand level, utilizing previous retail and customer service experience such as that of a customer service representative, a sedentary cashier, for example, a cashier at an automotive dealership, and positions – there were some light cleaning positions as well, I believe." (T.105). She conceded that not one of her reports identified how much these suggested jobs would pay, although she added that she could "... provide a pay range based on experience if the Court desires." (T.139-140).

Thus, since neither vocational expert identified a specific job title and the average wage associated with such a position, the Commission is unable to rely exclusively on their opinions as to the amount Petitioner is capable of earning performing suitable work.

As an alternative, the Commission notes that Mr. Blumenthal referenced several prior jobs by way of work history, including a part-time position at Target from 1997 to 2003 as a customer service supervisor paying $11.00/hour, as well as a maintenance worker position paying $12.00/hour from November of 2007 to the date of injury in 2008. (PX7). Mr. Blumenthal

recorded that this latter position involved "... clean[ing] around the kitchen and perform[ing] mopping, wiping down tables, and vacuuming of carpets." (PX7).

Out of the above two occupations, the Commission is less inclined to base a wage differential award on the aforementioned maintenance worker position given that it is highly unlikely that the duties associated therewith would necessarily fall within Petitioner's current Light physical demand level work restrictions. Indeed, the Commission notes that maintenance worker was not one of the occupations listed by either Mr. Blumenthal or Ms. Bose as a suitable job option, although Ms. Bose did testify that potential job leads provided to Petitioner included "some light cleaning positions."

As a result, the Commission is left with little more than the part-time, customer service supervisor position, paying $11.00/hour, that Petitioner held at Target from 1997 to 2003 as a basis for a wage differential award, or the same basis used by the Arbitrator. In support of this finding, the Commission notes that both Mr. Blumenthal and Ms. Bose targeted customer service positions as one of several employment options for Petitioner. Furthermore, as previously mentioned, Mr. Blumenthal was of the opinion that Petitioner was capable of earning wages in the range of $8.25 to $13.78 per hour -- a figure that Ms. Bose did not necessarily dispute, having recommended no pay range of her own. Thus, under the circumstances, the Commission finds that $11.00/hour is a reasonable amount on which to base such an award.

Therefore, based on the above, and pursuant to the remand order of the appellate court, the Commission affirms the decision of the Arbitrator and finds that Petitioner is entitled to wage differential benefits in the amount of $581.06 per week, commencing April 9, 2012 and extending through the duration of the disability, based on 2/3rds of the difference between the amount Petitioner would have been earning in the performance of his previous position ($1,311.60, or $32.79/hour x 40 hours) and the amount he is currently able to earn in suitable employment ($440.00, or $11.00 x 40 hours).

The Commission also clarifies the decision of the Arbitrator to find that Petitioner was entitled to temporary total disability benefits in the amount of $758.84 per week from April 12, 2008 through April 27, 2008 and from April 30, 2008 through March 15, 2010 under §8(b), for a period of 100 weeks, and maintenance benefits under §8(a) of the Act in the amount of $758.84 per week from March 16, 2010 through April 8, 2012, for a period of 107-6/7 weeks. Thereafter, Petitioner is entitled to wage differential benefits commencing April 9, 2012, as previously mentioned above.

All other aspects of the Arbitrator's decision are otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $758.84 per week for a period of 100 weeks, from April 12, 2008 through April 27, 2008 and from April 30, 2008 through March 15, 2010, that being the period of temporary total incapacity for work under §8(b) of the Act.

18IWCC0084

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $758.84 per week in maintenance benefits for a period of 107-6/7 weeks, from March 16, 2010 through April 8, 2012, under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that commencing on April 9, 2012, Respondent pay to Petitioner the sum of $581.06 per week for the duration of Petitioner's disability, as provided in §8(d)1 of the Act, for the reason that the injuries sustained permanently incapacitated Petitioner from pursuing the duties of his usual and customary line of employment.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury, including but not limited to the $150,891.76 in temporary total and maintenance benefits paid, as indicated in the Arbitrator's decision.

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 - 2018
o:12/5/17
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

DISSENT

I respectfully dissent.

While I understand my colleagues need to abide by the appellate court order, and agree that the clear language of that decision dictated that Petitioner's entitlement to a wage differential was not an issue on appeal, I believe that Petitioner failed to present sufficient proof of "... the average amount which he is earning or is able to earn in some suitable employment or business after the accident", and as such failed to prove his entitlement to a wage differential award.

In its decision, the appellate court pointed out that "... the claimant is required to introduce evidence sufficient for the Commission to identify an occupation that the claimant is able and

qualified to perform, and the average wage for that occupation." *Crittenden*, 73 N.E.3d at 661.

As the majority points out, neither vocational expert in this case – Mr. Blumenthal for Petitioner or Ms. Bose for Respondent – identified a concomitant rate of pay for a specific job that Mr. Crittenden is both able and qualified to perform. Instead, Mr. Blumenthal offered only a range of pay from $8.25 to $13.78 an hour, while Ms. Bose offered to provide such figures if the court so desired.

I would suggest that based upon the appellate court decision, such information isn't just desired, it's a prerequisite to an award.

As a result, I would find that Petitioner failed to prove by a preponderance of the credible evidence that he is entitled to a wage differential award pursuant to §8(d)1 and would instead find that Mr. Crittenden sustained permanent partial disability to the extent of 40% person-as-a-whole pursuant to §8(d)2 of the Act.

Kevin W. Lamborn

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

Iris Alicea,

Petitioner,

vs.

18IWCC0085

NO: 14 WC 30835

Chicago Transit Authority,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the circuit court of Cook County. The Order of the circuit court reverses the Decision of the Commission denying Petitioner's request for benefits pursuant to §19(b). Petitioner appealed the Commission's Decision to the circuit court, and on June 23, 2016 Judge Carl Anthony Walker set aside the Commission's Decision and remanded the matter for further proceedings consistent with its Opinion and Order (15-L-50828). Respondent subsequently appealed to the Appellate Court of Illinois, which dismissed Petitioner's appeal for lack of jurisdiction on September 7, 2017. We hereby issue this Decision and Opinion in accordance with the remand from the circuit court of Cook County. 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 facts of this case are undisputed and set forth in our prior Decision as well as the Opinion and Order of the circuit court of Cook County. Petitioner, a 47-year-old train operator, sustained injuries to her right knee, right great toe, and back on September 13, 2014 when she fell on the platform after stepping out of a moving train at O'Hare Airport. On the morning of September 13, 2014, Petitioner drove a train into the O'Hare Airport terminal and then exited the train to walk across the terminal to her next scheduled departure. Petitioner immediately realized that she left her operator keys in the motor cab, and she reentered the train to retrieve her keys. Petitioner testified that she used her handheld radio to ask the operator to hold the train, but the train doors closed and the train began to depart from the terminal while Petitioner was still on-board. Petitioner testified that she pulled the overhead emergency ball to open the door and exited the moving train to board her next scheduled departure and not cause system delays. However, Petitioner fell onto the platform as she stepped out of the moving train, injuring her right knee,

right great toe, and back.

In a Decision dated November 24, 2015, a majority of the Commission found that Petitioner exposed herself to an unnecessary personal danger and that her conduct took her outside of the sphere of her employment or constituted a deviation from her employment. The circuit court found the opposite, and reversed and remanded this case with instructions to the Commission to determine the amount of benefits owed to Petitioner, finding that her injury arose out of and in the course of her employment. The circuit court explained that although Petitioner acted recklessly, she was nevertheless within the sphere of her employment and entitled to compensation for the injuries she sustained in the performance of her job duties.

The circuit court concluded, "It is apparent from the facts of the case that while negligent in her actions, Alicea was alighting from the train to further the interests of the CTA. Illinois case law holds "one of the [Illinois Workers' Compensation] Act's objectives was to do away with defenses of contributory negligence or assumed risk." *Gerald D. Hines v. Indus. Comm'n*, 191 Ill. App. 3d 913, 932 (1st Dist. 1989). Therefore, the CTA may not invoke Alicea's negligence in alighting from a moving train. It is clear such actions arose out of her employment in that it was connected to her employment. Alicea was still "clocked in," was retrieving operator keys necessary for her to do her job, and was not on a personal mission (e.g. to return home)." Therefore, the circuit court found the Commission's Decision clearly erroneous.

After the accident, Petitioner was taken via ambulance to the emergency department at Presence Resurrection Medical Center on September 13, 2014. At the hospital, Petitioner was examined and x-rays were taken, which were negative for any acute injury. She was diagnosed with contusions to her right knee and right great toe, as well as a lumbosacral strain. Petitioner was advised to remain off work for two days and allowed return to full duty work on September 16, 2014. Petitioner testified that she subsequently treated with her primary care physician, Dr. Locatelli, who kept her off work and referred her to Hinsdale Orthopaedic Associates. However, there are no records from Dr. Locatelli in evidence. The only documentation of medical treatment following Petitioner's emergency room discharge is her evaluation by PA-C Monika Strand at Hinsdale Orthopaedic Associates on October 2, 2014. On that date, Petitioner was evaluated for complaints of lower back pain radiating toward her left leg, and bilateral foot numbness. Petitioner gave a history of the accident, and reported that her knee pain had improved since the accident. She gave a history of prior episodes of back pain and left leg pain. Petitioner told PA-C Strand that she had been off work since the accident and was also seeing a podiatrist on referral from her primary care doctor. PA-C Strand took a new x-ray of the lumbar spine which was unremarkable, and diagnosed back pain and radiculopathy. She recommended Petitioner start a course of physical therapy and return after undergoing a lumbar MRI, and advised Petitioner to remain off work in the interim. At the 19(b) hearing on October 31, 2014, Petitioner had not had the MRI and was seeking an award of medical treatment, medical bills, and TTD benefits for lost time.

Petitioner submitted medical bills for emergency room treatment at Presence Resurrection Medical Center on September 13, 2014 with itemized charges for emergency room, laboratory, pharmacy, and radiology, for a total of $2,999.50. (PX4) Petitioner submitted a corresponding bill from Midwest Imaging Professionals totaling $166.00. (PX5) Petitioner also submitted a bill in the amount of $528.00 for her treatment at Hinsdale Orthopaedic Associates on October 2, 2014. (PX6) Pursuant to this Decision and Opinion on Remand, Respondent shall pay the foregoing medical bills related to the treatment of her work-related injuries, and shall authorize the recommended lumbar MRI and follow-up visit with Hinsdale Orthopaedic Associates.

Petitioner claims that because of her injuries she was off work from September 13, 2014 through October 31, 2014, amounting to 6 and 6/7 weeks. However, Petitioner failed to offer any evidence to support her claim for TTD benefits from September 16, 2014 until October 2, 2014. The emergency room physician medically authorized Petitioner to be off work only through September 15, 2014, and there are no other medical records in evidence until Petitioner's evaluation at Hinsdale Orthopaedic Associates on October 2, 2014.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $845.33 per week for a period of 4 and 3/7 weeks, from September 13, 2014 through September 15, 2014, and from October 2, 2014 through October 31, 2014, 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 Petitioner is awarded payment of all medical expenses in Petitioner's Exhibits #4, #5, and #6 in accordance with the Fee Schedule and §8(a) and §8.2 of the Act, and Respondent is given credit for bills paid by the health insurer.

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 have credit for all amounts paid to or on behalf of Petitioner on account of said accidental injury.

IT IS FURTHER ORDERED BY THE COMMISSION that 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 $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: FEB 8 - 2018
DLS/plv
o-1/25/18
46

Deborah L. Simpson

Deborah L. Simpson

David L. Gore

David L. Gore

Stephen J. Mathis

Stephen J. Mathis

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

Michelle Watts,

Petitioner,

vs.

18IWCC0086

NO: 14 WC 07161

Global Brass & Copper,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the circuit court of Madison County, Judge David W. Dugan, on July 5, 2017. The circuit court reversed the Commission's Decision in part and remanded this case to the Commission to assess penalties and fees against Respondent with respect to the period of unpaid temporary total disability benefits from April 1, 2014 through December 4, 2014. We hereby issue this Decision and Opinion in accordance with the Order of the circuit court, and remand 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 facts of this case are set forth in our prior Decision as well as the Order of the circuit court of Madison County. Petitioner, a 51-year-old machine operator, sustained injuries to her back on February 4, 2014. At the §19(b) hearing on October 22, 2015, the issues in dispute were Petitioner's ability to work light duty, periods of TTD benefits, and penalties and fees for unpaid TTD. In a §19(b) Decision dated December 10, 2015, the Arbitrator found that Petitioner failed to prove she was entitled to TTD benefits from February 27, 2014 through December 4, 2014 and from September 7, 2015 through October 22, 2015, and denied Petitioner's request for penalties and attorneys' fees. Petitioner sought Commission review, and on November 7, 2016 the Commission modified and otherwise affirmed the Arbitrator's Decision. We found that Petitioner was entitled to TTD benefits from April 1, 2014 through December 4, 2014 and awarded TTD benefits for this period, however we found that Petitioner was not entitled to penalties or attorneys' fees. Petitioner appealed to the circuit court of Madison County.

18IWCC0086

The circuit court concluded that our finding that Respondent's denial of TTD benefits was not unreasonable or vexatious was against the manifest weight of the evidence. The employer bears the burden of justifying its withholding of benefits, and the employer is held to a standard of objective reasonableness. The circuit court found that Respondent offered no justification for its failure to pay benefits during the period of April 1, 2014 through December 4, 2014, a total of 35 and 3/7 weeks. Therefore, the circuit court found that Respondent is liable for penalties and fees under §19(k), §19(l), and §16.

Section 19(k) provides for penalties equal to 50% of the amount payable at the time of the award. At the time of the award, Petitioner was entitled to TTD benefits of $736.80 per week for a period of 35 and 3/7 weeks with respect to the period from April 1, 2014 through December 4, 2014, totaling $26,103.77. Therefore, Petitioner is entitled to $13,051.89 in §19(k) penalties.

Section 19(l) provides for penalties in the amount of $30 per day for each day that the benefits were withheld or refused, with a limit of $10,000. Due to the length of time TTD benefits remained unpaid, the maximum limit applies in this case and Petitioner is entitled to $10,000 in §19(l) penalties.

Section 16 provides for the assessment of attorneys' fees, in conjunction with §19(k) penalties. We hereby award Petitioner additional compensation of 20% of the §19(k) penalties award, amounting to $2,610.38.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $736.81 per week for a period of 77 and 5/7 weeks, from February 7, 2014 through February 26, 2014, April 1, 2014 through December 4, 2014, and December 5, 2014 through September 6, 2015, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner §19(k) penalties in the amount of $13,051.89, §19(l) penalties in the amount of $10,000, and §16 attorneys' fees in the amount of $2,610.38 because Respondent's refusal to pay TTD for the period of April 2, 2014 through December 4, 2014 was unreasonable and vexatious.

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 have credit for all amounts paid to or on behalf of Petitioner on account of said accidental injury.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner

18IWCC0086

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 $57,000. 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 8 - 2018
DLS/plv
o-1/25/18
46

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ETHAN BARNETT,

Petitioner,

18IWCC0087

vs.

NO: 10 WC 45765

DIVERSATECH METAL FAB,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Arbitrator found that Petitioner proved his current condition of ill-being of his lumbar spine was causally related to a stipulated work accident on November 11, 2010. He found Petitioner's average weekly wage was $491.15, awarded Petitioner 274&5/7 weeks of temporary total disability benefits, $290,437.56 in medical expenses, and found Petitioner permanently and totally disabled. The Commission concurs with the determination of the Arbitrator about causal connection, temporary total disability benefits, medical expenses, and average weekly wage rate and affirms the Decision of the Arbitrator on those issues. However, the Commission vacates the portion of the Decision of the Arbitrator awarding Petitioner permanent total disability benefits. Rather, the Commission awards Petitioner 250 weeks of permanent partial disability benefits representing the loss of 50% of the person-as-a-whole. The analysis below is limited to elements that directly relate to the nature and extent of Petitioner's permanent disability.

Findings of Fact & Conclusions of Law

1. On November 17, 2010, Petitioner was working for Respondent sandblasting metal products. The parties stipulated that on that date Petitioner suffered an injury to his lumbar spine while lifting items at work. He was 21 years old at the time of the accident.

2. Petitioner underwent extensive conservative treatment including chiropractic manipulation, physical therapy, work hardening, prescription medication, epidural steroid injections, and the use of a TENS unit.

3. There developed a disagreement between Petitioner's treating doctors, Petitioner's Section 12 medical examiner, and Respondent's Section 12 medical examiner about what treatment would be most appropriate.

4. Apparently, at the suggestion of an arbitrator at a pretrial conference, the parties agreed to have a 3rd party doctor, Dr. Geisler, evaluate Petitioner. He later became Petitioner's treating surgeon. On February 11, 2013, Dr. Geisler performed a fusion with cage at L5-S1 and a "ProDisc Dynamic Stabilizer" at L4-5. Petitioner had postop physical therapy and continued to complain of back pain. He had a CT on February 4, 2014 which showed pseudoarthrosis (non-union) at L5-S1. Dr. Rinella, Respondent's Section 12 medical examiner, then recommended posterior instrumentation and fusion at L5-S1 and extension of the fusion to L4-5. Petitioner did not have the surgery.

5. At arbitration, Petitioner testified that after surgery, his legs started feeling better because he was taking Lyrica. However, his back continued to worsen. He had physical therapy, but it made his condition worse. Symptoms in his leg began to return. He developed a sexual condition, "retrograde ejaculation" which means he can no longer ejaculate or have children; but he wasn't impotent. This condition has affected him "dramatically" psychologically; he has become antisocial and depressed. His sex-drive is almost non-existent. He has not sought psychological treatment because he had difficulty getting authorization for normal medical treatment.

6. Petitioner also testified he currently has constant back pain and pain in his legs. His legs have a burning sensation "almost like liquid fire." Any physical activity increases his pain. He no longer uses the "push mower" because almost three years previously, he had so much pain after using it that he was laid up for almost a week.

7. Petitioner also testified that he takes frequent hot Epsom-salt soaks. He only sleeps three to five hours because of his back pain. Typically, he has low energy level and is always exhausted because of his lack of sleep. His condition affects his ability to perform many household activities such as washing dishes. He was still being prescribed Morphine. Petitioner has not tried to find employment within his restrictions. Based on his difficulty performing everyday functions, he did not know if he could concentrate sitting for prolonged periods or drive. He has to stop driving and rest every 20 minutes.

8. Petitioner lives between 15 and 25 miles from Illinois Valley CC. He feels "pretty rough and sore" after being in a car for 15 to 25 miles. He doubted whether he could sit in a classroom after such a drive. He would also have to get up every 10 minutes "to walk this off." The same would be true for a job interview. He would have had trouble traveling the 15 to 20 miles to the local college "repetitively nonstop." He considered an online educational option, but it "it is just not for" him; "that's not how [he] likes to learn." A change of scenery would be nice.

9. Petitioner also testified his daily activities depend on how he feels. Sometimes he will sit on the couch all day watching TV and using a computer. He knows how to type and how to use Microsoft Word. Petitioner never had to type papers at school; he only "made it to the 10th grade in high school." Petitioner agreed that he stopped the functional capacity evaluation ("FCE") after four hours; he wanted to stop earlier. The test was stopped due to his complaints of pain. Petitioner felt the activity was making his condition worse.

10. Petitioner's prior work experience consisted of manual labor. He had not considered any service-type work because he lacks "people skills;" he has no patience and gets aggravated easily. He doesn't "like people. It is called an introvert." Being constantly tired makes his patience worse. There had been discussion about additional surgery. He decided not to have any because of his bad experience with this one. He thought "it made everything worse."

11. Dr. Eilers testified by deposition on October 6, 2015. On November 20, 2014, at the request of Petitioner's lawyer he performed a Section 12 medical examination on Petitioner, reviewed his medical records, and issued a report.

12. Petitioner reported he continued to have pain after the surgery. He had an MRI "and basically it was eventually noted that he had pseudoarthrosis or lack of a fusion at L5-S1." Thereafter, Dr. Rinella recommended a repeat L5-S1 fusion with extension to L4-5. That surgery had not been done and Petitioner was still in pain. He developed impotence (incorrect according to Petitioner's testimony) and retrograde ejaculation after the surgery and was concerned about additional surgery. He still wore a brace and was taking Norco and Lyrica. He was referred for pain management, but it had not been authorized.

13. Petitioner was "more agitated because he [was] having the pain." He had problems walking long distances or on uneven surfaces, standing over 20 minutes, or driving more than an hour. He had problems with coordination/balance and had sleep disturbance. His biggest problem appeared to involve bending which affected bathing and clothing. Petitioner could not take baths but only showers. He had trouble with activities of daily living, and was not working. His job had involved heavy manual labor.

14. After his examination and review of the medical records, Dr. Eilers diagnosed disc herniation at L4-5 with a stabilizer placed at that level, pseudoarthrosis at L5-S1, impotence/retrograde ejaculation, significant myofascial pain, and chronic low back pain from the fusion/pseudoarthrosis, which meant muscle involvement.

15. If Petitioner chooses not to have surgery prospectively, he should have pain management for the chronic use of narcotic pain medication. He also may be a candidate for a spinal cord stimulator. Dr. Eilers did not really see Petitioner as being employable, certainly not back at heavy labor. "At the very best he may be able to intermittently do sedentary type tasks." He did not believe he could work eight hours a day because of his need to always change positions. Petitioner's deficits were permanent. Petitioner's lack of progress in physical therapy was consistent with his findings. In addition, Dr. Eilers' findings of limitations were consistent with the diagnosis of pseudoarthrosis.

16. On cross, Dr. Eilers agreed that in work hardening, Petitioner was "able to do a number of activities." However, that did not mean he could be competitively employed. He was profoundly limited in his abilities and did not have "a lot of educational skills." He will also be dependent on narcotic analgesics, which would interfere with possible employment. Even though Norco is not a narcotic, Dr. Eilers would not want a client driving after taking Norco. Similarly, Lyrica can change one's performance when using machinery.

17. Dr. Eilers agreed that work hardening records indicated Petitioner's capabilities increased from the conditioning. However, the work conditioning may have "basically disrupted the fusion so he developed a pseudoarthrosis." Petitioner should consider re-fusion, even though there is no guarantee that it would eliminate his pain. In addition, he would not order an FCE because his spine was unstable. Finally, Dr. Eilers testified that pseudoarthrosis is going to limit a patient's capabilities because it causes pain with movement.

18. Petitioner had an FCE on January 21, 2016. The report indicated he "failed 6/14 Performance Criteria" and exhibited six non-organic signs. However, "the preponderance of evidence indicates the client participated fully in testing" and exhibited "acceptable effort." He functioned mostly at the medium work level, but only at the sedentary level in endurance. Petitioner was "classified mostly in the medium work demand level, but also demonstrated abilities in the sedentary, light, and heavy levels depending on the activity. He would not be able to perform the required activity for required time frame in the medium demand level (he terminated the test at nearly 4 hours. This is a half day of work)."

19. Dr. Rinella was retained by Respondent to perform Section 12 medical examinations on Petitioner both before and after his surgery. He also testified twice by deposition. Initially, he recommended against surgery because the source of Petitioner's pain was not clearly identified.

20. Dr. Rinella testified a second time by deposition on February 17, 2016. He viewed a CT taken February 4, 2014. He noted some lucency in the cage at L5-S1 suggesting pseudoarthrosis or a failed fusion. Dr. Rinella then recommended re-fusion at L5-S1 and consideration of extending the fusion to L4-5. If Petitioner did not have additional surgery, he would be at maximum medical improvement.

21. Dr. Rinella noted that the CT confirmed the pseudoarthrosis. The level would be less stable than a fused vertebra, but "it's much more stable than a normal spine." While, the restrictions in the FCE were more thorough than his, "they basically agreed with" his assessment. He agreed that he recommended Petitioner avoid manual labor.

22. Dr. Rinella also testified that pseudoarthrosis does not necessarily cause instability, and Petitioner had absolutely no instability. The CT showed no evidence of any motion in the screws. In his practice, Dr. Rinella often has to interpret FCEs and issue restrictions based on them. However, sometimes he imposes restrictions other than those recommended in an FCE

23. When Dr. Rinella issued one of his reports on August 13, 2015, Petitioner had not had additional surgery or an FCE. Nevertheless, Dr. Rinella established restrictions, based on his daily work conditioning reports. Basically, he restricted Petitioner to 40-lb lifting/80-lbs pushing/pulling for no more than 33% of his work day. Dr. Rinella did not believe Petitioner was disabled from work and noted that "there are many lines of employment that fit within those restrictions."

24. Dr. Rinella also testified that the FCE results did not change his opinion about Petitioner's capabilities. Dr. Rinella noted that the ½ day of the FCE was longer than the 33% of the workday, he specified in his restrictions. While Petitioner was "not permanently disabled at all," he "would encourage him not to use his back for a living." Petitioner should consider the surgery he recommended because if he does have pseudoarthrosis, "he has a treatable pain generator." But he still would not be permanently and totally disabled even if he did not have the surgery.

25. Petitioner retained certified vocational counselor, Mr. Gustafson, who testified by deposition on March 4, 2016. He saw Petitioner on February 17, 2016 and basically reviewed his FCE, the vocational report of Mr. Hammond (Respondent's vocational counselor who testified on a later date), the report of Dr. Eilers, and the operative report.

26. Petitioner reported he was driven to the appointment and had to get out to walk around three times. He moved to Illinois from Arkansas at 19, had two years of high school, received a GED, and had vocational classes in auto-body repair. In Arkansas, he assembled commercial flooring which snapped together and as a roofer's assistant. His job with Respondent was his only job in Illinois. His last job as sandblaster was unskilled manual labor. That job was considered heavy labor because of the material he had to handle. He had no transferable job skills from that job. Petitioner would be qualified only for an entry-level position.

27. Mr. Gustafson noted that Dr. Eilers' report indicated that Petitioner had significant deficits which were permanent and he would probably be permanently and totally disabled from employment whether or not he had additional surgery. Petitioner could not tolerate the FCE activities for more than four hours and had to change positions frequently, which would indicate he would not be sufficiently productive to keep a job.

28. Petitioner would not be suitable for an office-job because he had no background other than in manual labor. A prospective employer would look for a candidate with relevant experience or a person right out of high school. To obtain requisite skills to become employable, Petitioner would have to be retrained and he recommended he go to the local community college.

29. Mr. Gustafson's impression that Petitioner was "very talkative." "He's the type that just wants to dominate a conversation, perhaps wants to manipulate others in that regard, so forth. He's not the kind that is likely to be able to communicate effectively with people because he's not going to have the intent probably to listen. He's not a good listener."

30. Mr. Gustafson also indicated that Petitioner's use of narcotics may affect that behavior and no employer he knew of would allow the use of narcotics in their workplace.

31. On cross examination, Mr. Gustafson agreed that according to Dr. Rinella, Petitioner could work at most jobs in the medium physical demand level. Dr. Rinella's assessment was "not even close" to the assessment by the therapist in the FCE who indicated while Petitioner could perform activities at the medium demand level, he only had the endurance to work at a sedentary level. The totality of the FCE supported Mr. Gustafson's assessment. Petitioner's lack of experience makes unrealistic the proposition that an employer would hire him to train in an entry-level clerical job, especially because he would not be able to work an eight-hour day even in a sedentary job.

32. Mr. Gustafson agreed that Petitioner used a keyboard for his computer. However, to be a data entry clerk, a person would probably have to type 80 WPM. He did not test Petitioner's typing skills. He believed Petitioner expressed interest in further education because he realized he could not return to work in manual work. Mr. Gustafson was not aware of any job search Petitioner performed. Mr. Gustafson understood that Petitioner had refused a pervious FCE and a voc assessment by Mr. Hammond.

33. Normally, Mr. Gustafson recommends part-time job for clients who cannot work full time to gain confidence and hopefully be able to increase hours. However, Petitioner was "not likely to ever get a chance to do that because of his background – and that he's not – he's an irritating guy, to be honest." Mr. Gustafson was "getting some negative vibes about that." He "didn't see him as being personable in the sense you're going to put him into a people job or into an environment where he has to relate to people quite a bit in terms of communication." Generally, requirements to get part-time jobs are the same as getting full-time jobs.

34. Respondent retained certified vocational counselor, Mr. Hammond, who testified by deposition on April 1, 2016. He did two "file reviews" regarding Petitioner. He had tried to meet Petitioner for an "in-person interview, and that didn't happen." He reviewed some medical records, including reports from Dr. Eilers and Dr. Rinella, physical therapy records, and an SSI application denial. Mr. Hammond performed a labor market review seeking to find jobs within the restrictions imposed by Dr. Rinella, so he "was looking at mostly lower medium level categories" as well and light and sedentary jobs.

35. The jobs that Mr. Hammond identified paid between $8.50 to up to $13.00 an hour. "A lot of them in the $9 an hour range." "On average, you're going to do to about $11." He identified telephone/switchboard jobs, assembly-line jobs through temp agencies, spray painting, sterilizing medical equipment, and janitorial jobs that were well within the 40-lb restriction. He also identified some hand-pallet jobs. Mr. Hammond would not include forklift driving because of Petitioner's use of narcotic pain medication. All the jobs he listed were rated at between sedentary to light medium. Temporary agencies hire both on part-time and full-time basis. However, Mr. Hammond only included full-time jobs in his report. Mr. Hammond concluded that there was a stable job market for Petitioner.

36. After his initial evaluation, Mr. Hammond reviewed additional documentation, including the FCE. Although the FCE indicated Petitioner was able to perform at the medium physical demand level, the FCE was terminated after 4 hours. Mr. Hammond interpreted the FCE results to place Petitioner closer to a 20-lb occasional/10-lb frequent restriction, with frequent position changes. He thought it was significant that the FCE was terminated at Petitioner's request, and not by the therapist based on his/her objective physiological findings of the participant. Mr. Hammond noted that Dr. Rinella testified that the restrictions recommended in the FCE were basically in agreement with those he imposed previously.

37. Mr. Hammond reviewed the report of Mr. Gustafson. He noted that Mr. Gustafson believed that Petitioner could not work and/or retain employment because the ½ day FCE showed his endurance problems. Mr. Hammond disagreed with that assessment. Petitioner had the functional capacity to return to gainful employment and there were jobs available within his restrictions in Petitioner's geographic area. He also found Mr. Gustafson's recommendation for further education/training inconsistent with his conclusion that Petitioner was unemployable.

38. After his review of the additional information, Mr. Hammond concluded that Petitioner was currently employable "at the sedentary to light minimally." He agreed with Mr. Gustafson's recommendation for education. However, "if you can attend school full time, you can work full time." The jobs Mr. Hammond identified would have allowed change of positions and occasional sitting/standing. In addition, Mr. Hammond did not believe Petitioner's lack of experience precludes him from an entry-level clerical position. Employers will train such employees and many of these jobs require no more than a high-school education. Data entry positions are a good example of these types of jobs.

39. Mr. Hammond testified he did not know what to make of the suggestion that Petitioner's alleged inability to get along with others as a hindrance to employment. He noted that there was no psychological testing performed. If Mr. Hammond had such concerns about a client, he would have conducted testing. In his second report, Mr. Hammond identified jobs he believed Petitioner was qualified to work. He still believed there was a stable labor market for Petitioner in his geographic area.

40. On cross examination, Mr. Hammond testified he was not aware that Dr. Rinella indicated that Petitioner should avoid manual labor. He reviewed Dr. Rinella's deposition, but he did not remember him specifically referring to avoiding manual labor. In order to assess the importance of the statement, he would have to know what Dr. Rinella meant by "manual labor."

41. Mr. Hammond agreed that the FCE indicated that Petitioner gave valid effort, that he should be limited to occasional sitting/standing/walking/waist-high reaching, and he should avoid squatting/climbing/crawling/kneeling. Mr. Hammond also agreed that in his 2nd report, he indicated that Petitioner did not have transferable skills.

42. On redirect examination, Mr. Hammond guessed that when Dr. Rinella stated Petitioner should avoid manual labor, he meant labor in excess of his restrictions. The term is inexact, which is why they do not use the term. Mr. Hammond had to rely on specific limitations/restrictions. After all the information he had, and in light of the deposition, Mr. Hammond still opined that there was a stable labor market for Petitioner.

In looking at the entire record before us, the Commission finds that Petitioner has not sustained his burden of proving that he is permanently and totally disabled from gainful employment. First, the Commission notes that none of Petitioner's treating doctors have actually opined that he is permanently disabled from working and there is no definitive medical opinion that he was so disabled.

Petitioner's Section 12 medical examiner, Dr. Eilers testified that he did not believe him employable, at least in heavy labor, but that he may be able to intermittently do sedentary type tasks. The Commission agrees with the proposition that Petitioner is not able to return to his previous employment, which was classified as requiring a heavy physical demand level, but that does not mean that he is completely unemployable. Both the FCE and Dr. Rinella basically assessed Petitioner to able to work at a light to medium physical demand level.

Second, the Commission finds the testimony of Dr. Rinella and Mr. Hammond more persuasive than Dr. Eilers and Mr. Gustafson. Dr. Eilers seemed to rely largely on Petitioner's subjective complaints while Dr. Rinella relied largely on physical therapy and work conditioning records. Dr. Eilers indicated that Petitioner's spine was unstable because of the pseudoarthrosis, while Dr. Rinella explained that there was absolutely no evidence that Petitioner's spine was unstable and that the non-fused vertebra was still more stable than a normal non-surgically repaired vertebra. Finally, the Commission takes exception to Dr. Eilers' statement that Norco is not a narcotic.

Regarding the vocational counselors, the Commission notes that in his vocational assessment report, Mr. Gustafson recommended that to be employable Petitioner would need to be retrained and recommended education and vocational counseling at a local Community College. However, he later testified that Petitioner was unsuited to office-work because of his unpleasant demeanor. Absent an identifiable psychological condition, the Commission does not believe a vocational counselor's impression that a claimant is an "irritating guy," or Petitioner's assessment that he was not a "people person" are legitimate criteria to determine employability.

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Third, because there is no medical determination that Petitioner is permanently and totally disabled from employment, he must establish that he is entitled to permanent total disability status under an odd-lot theory of disability. To qualify as permanently and totally disabled under odd-lot designation a claimant must first show a diligent but unsuccessful job search.

Here, Petitioner testified that he never looked for any employment after his accident and that he has not attended school or participated in any other vocational training. Therefore, Petitioner does not qualify to be declared permanently and totally disabled from gainful employment under an odd-lot theory.

In looking at the entire record before us, the Commission finds that an award of loss of 50% of the person-as-a-whole is appropriate in this claim. Accordingly, the Commission modifies the Decision of the Arbitrator and vacates his direction for the Rate Adjustment Fund to pay cost-of-living adjustments.

Finally, the Commission notes that in his Decision, the Arbitrator found Petitioner's average weekly wage was $431.91. The Commission affirms that determination. The Arbitrator awarded temporary total disability benefits of $287.94 a week. However, the Arbitrator also awarded permanent total disability benefits of $431.91 a week, the amount of Petitioner's average weekly wage. That award is incorrect. The permanent partial disability award should be 60% of the average weekly wage for a total benefit rate of $259.15 per week. The Commission corrects that clerical error as well.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $287.94 per week for a period of 274&6/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $259.15 per week for a period of 250 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of the use of 50% of the person-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $290,437.58 for medical expenses under §8(a) of the Act, pursuant to the applicable medical fee schedule.

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

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

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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 proceeding for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: FEB 8 - 2018

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/dw
O-1/11/18
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0087

BARNETT, ETHAN
Employee/Petitioner

Case# 10WC045765

DIVERSATECH METAL FAB INC
Employer/Respondent

On 3/20/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.91% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1097 SCHWEICKERT & GANASSIN LLP
MARK M WILSON
2101 MARQUETTE RD
PERU, IL 61354

0000 RUSIN & MACIOROWSKI LTD
JENNIFER MEJIA
2506 GALEN DR SUITE 104
CHAMPAIGN, IL 61821

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STATE OF ILLINOIS)
)SS.
COUNTY OF Rock Island)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Ethan BArnett
Employee/Petitioner

v.

Diversatech Metal Fab, Inc.
Employer/Respondent

Case # **10** WC **45765**

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 **Rock Island**, on **4/5/16**. 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 **11/17/10**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$22,459.32**; the average weekly wage was **$431.91**.

On the date of accident, Petitioner was **21** 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 **$46,923.21** for TTD, **$0** for TPD, **$21,455.58** for maintenance, and **$0** for other benefits, for a total credit of **$68,378.79**.

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 $290,437.56, as set forth in PX 1, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall pay Petitioner temporary total disability benefits of $287.94/week for 274 6/7 weeks, commencing 11/18/10 through 2/23/16, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent and total disability benefits of **$431.91**/week for life, commencing **2/24/16**, as provided in Section 8(f) of the Act.

Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

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

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

Signature of Arbitrator

2/28/17
Date

ICArbDec p. 2

MAR 20 2017

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FINDINGS OF FACT

On November 17, 2010, Petitioner was employed by Respondent as a sandblaster. His job duties consisted of transporting materials by hand or fork truck to and from work stations such as the paint booth or the welding stations on the beam line to his sandblasting booth. He would then sandblast the material and move it onto its next station.

On November 17, 2010 Petitioner was loading angle iron onto a pallet. While lifting and twisting with a stack of angle iron weighing about 20 pounds he felt a pop in his back. He told his foreman what happened and sought treatment that day at Urgent Care. The accident is not disputed.

On November 17, 2010, Petitioner was taken off work. (Px.2) Petitioner received chiropractic treatment and physical therapy before being referred to Dr. George DePhillips, a neurosurgeon, who Petitioner saw on January 3, 2011. (Px.2, Px.3) Dr. DePhillips noted Petitioner was experiencing lower back pain that radiated into the buttock and into the posterolateral thighs to the knees. He graded his lower back pain a 10 on a scale of 1-10. He was kept off work and prescribed Flexeril and Norco 10/325. A lumbar MRI was ordered. (Px.5) Dr. DePhillips interpreted the lumbar MRI as showing degenerative disc disease at the L4-L5 level, which is moderate in severity with disc space narrowing and collapse. There is also a right posterolateral annular tear. A series of two lumbar epidural steroid injections and trigger point injections were performed, which did not give relief. A discogram performed on April 21, 2011 indicated concordant pain at L4-L5. Dr. DePhillips recommended a minimally invasive transforaminal lumber interbody fusion at the L4-L5 level. (Id.)

Petitioner was seen by Dr. Anthony Rinella, Respondent's Section 12 examiner, on January 28, 2011 and June 3, 2011. Dr. Rinella expressed concern that at Petitioner's young age an L4-L5 or L4-S1 transforaminal lumbar interbody fusion would predispose him to severe arthritis in the future. (Rx.2, Ex.6)

On July 5, 2011, Petitioner saw Dr. Michel Malek for a second opinion regarding surgery. Dr. Malek agreed with the recommendation for the L4-L5 lumbar fusion and indicated that Petitioner's condition of ill-being is related to the November 17, 2010 work injury. (Px. 5)

Based upon the pretrial recommendation of the sitting Arbitrator at the time, Petitioner began treating with Dr. Geisler as a neutral physician. Petitioner first saw Dr. Geisler on March 19, 2012. Dr. Geisler indicated Petitioner had extreme discomfort and a lot of tension is his lower back. He noted pain radiating to his legs, mainly to the right. The pain was described as severe and was aggravated by standing, walking, sitting, sneezing, climbing stairs, riding in car, straining at bowels, and general activity. Symptoms are improved by lying down and medication. His lumbar range of motion was moderately decreased with extension and bilateral lateral bending. Dr. Geisler diagnosed Petitioner with L4-5 disc desiccation and discogram position at L4-5; onset related to work related injury. He ordered a repeat lumbar MRI which was performed on August 16, 2012. The findings indicated L4-5 degenerative disc disease with loss of height and dehydration; and L5-S1 midline herniated nucleus pulposus with annular tear and retrolisthesis of L5-S1. He recommended a lumbar fusion. (Px.8)

On July 19, 2012, Petitioner attended another Section 12 examination with Dr. Rinella. Dr. Rinella opined that there was literature to support either a lumbar disc replacement procedure or a transforaminal

lumbar interbody fusion at the L4-5 level. He also opined that Petitioner should avoid manual labor. (Rx.2, Ex.5)

On February 11, 2013, Dr. Geisler performed an L4-L5 and L5-S1 anterior discectomy and fusion. At the March 15, 2013 follow up appointment, Petitioner continued to complain of low back pain with bilateral lower extremity pain. Physical therapy, aquatic therapy, and pain medication were prescribed. (Px.8)

Petitioner began undergoing physical therapy on March 25, 2013. (Px.7) Petitioner underwent work conditioning from June 26, 2013 to August 2, 2013. He participated in 1 evaluation session and 24 work conditioning/hardening sessions. It was noted that he had multiple shortened sessions due to his reported inability to continue because of intense pain. As of August 2, 2013, Petitioner's documented capabilities were "frequent repetitive kneeling, frequent sustained kneeling, 40 lb. squat lift, 40 lb. power lift, 40 lb. bilateral carry, 80 lb. pushing/pulling, and frequent walking." On August 6, 2013, Petitioner refused to continue or complete the assigned activities due to intense pain. He was discharged from the work conditioning program due to limited progress. (Px.7)

On August 14, 2013, Petitioner followed up with Dr. Geisler. His chief complaint was lower back pain that was the same or worsened compared to how it was prior to surgery. He indicated that the pain was aggravated in physical therapy. He had decreased lumbar range of motion with flexion, extension, and bilateral lateral bending. He indicated that he is able to get an erection and climax, but nothing comes out. This is compatible with retrograde ejaculation. Dr. Geisler diagnosed status post L4-5 total disc replacement and L5-S1 ALIF, residual lower back pain aggravated in physical therapy/work hardening, and residual/unresolved retrograde ejaculation. A repeat lumbar MRI was ordered. It was recommended that he restart physical therapy gently and work up. (Px.8)

On September 5, 2013, Petitioner attended another re-evaluation with Dr. Rinella, Respondent's Section 12 physician. It was noted that Petitioner continued to have lumbosacral pain that he rated at a level 7 on a 10 point scale despite taking Norco 10/325 regularly. He reported that his leg symptoms improved to some extent after the surgical procedure but that his lumbar back pain is worse than before the surgery. Dr. Rinella recommended that a CT of the lumbar spine be performed to confirm solid fusion at L4-S1. (Rx.2, Ex.4)

Petitioner again attended physical therapy from September 23, 2013 through October 10, 2013 at which point therapy was discontinued due to lack of progress. (Px.7)

On October 11, 2013, Petitioner followed up with Dr. Laich, who took over for Dr. Geisler upon his retirement. Petitioner reported that he was experiencing more pain with "new" exercises in physical therapy. He reported sexual problems secondary to pain. Dr. Laich reviewed the lumbar MRI that was performed on August 29, 2013 which revealed a large amount of artifact at L4-5 and otherwise indicated mild multi-level degenerative disc disease and degenerative arthropathy of lumbar spine without evidence for acquired canal stenosis or nerve impingement. A disability index conducted indicated patient can care for himself (wash, dress, etc.) but it is very painful; he can lift only very light weight items; pain prevents him from walking more than about 4 blocks; pain prevents him from sitting more than 1 hour; pain prevents him from standing for more than 30 minutes; pain limits him to less than 6 hours of sleep; pain severely interferes with sexual activity; pain interferes with his social life; and he can travel over 2 hours but the pain is bad. Dr. Laich's assessments were

lumbar degenerative disc disease and lumbar stenosis without neurogenic claudication. He recommended a CT of the lumbar spine and prescribed Lyrica, Zanaflex, and Norco 10/325. He referred him to pain management for lumbar facet injections. (Px.8)

Petitioner underwent a CT of the lumbar spine on February 4, 2014. The radiologist report indicates an apparent left paracentral and lateral protrusion versus soft tissue attenuation at L5-S1 without significant spinal canal stenosis or neuroforaminal narrowing. On February 19, 2014, Dr. Laich refilled the Lyrica and again referred Petitioner for pain management and lumbar facet injections. (Px.8)

Petitioner testified that he was not able to undergo the injections or to see a physician for pain management because it was not authorized by Respondent.

In a report dated July 24, 2014, Dr. Rinella, Respondent's Section 12 examiner, reviewed the CT of the lumbar spine and indicated that it showed a psuedoarthrosis at L5-S1. He also indicated that the total disc replacement has skewed to the left and slightly anterior. He recommended Petitioner undergo a posterior instrumented fusion at L5-S1 with consideration of extending the fusion to L4-5. He indicated that if surgery is not elected, he recommended Petitioner undergo a functional capacity evaluation to set long term restrictions. (Rx.2, Ex.3)

On November 20, 2014, Petitioner attended an evaluation at the request of his attorney with Dr. Robert Eilers. Dr. Eilers is a board certified physical medicine and rehabilitation physician. (Px.14, Ex1) Dr. Eilers reviewed the lumbar CT scan done on February 4, 2014 and indicated that it demonstrated a psuedoarthrosis at L5-S1. He noted that Petitioner has numbness in the anterior abdominal wall in the lumbar distribution. He does not have pinprick sensation. He is still wearing a lumbar orthosis which helps to reduce his pain due to the fact that it limits his movement. He has problems bending over to bathe and to put on shoes and socks. He needs to sit down to put on his pants. Getting in and out of bed is a problem. Shopping, carrying, standing, cooking, lifting overhead, cleaning, laundry, and yardwork are all difficult. He can sit about an hour, stand 20 minutes, walk 20 minutes, and maybe drive an hour at the most. He is concerned about his impotence and retrograde ejaculation and his ability to have children. He notes that he is more agitated due to the pain. He has numbness in the hamstrings and calves. His coordination and balance is diminished. He has a great deal of sleep disruption as his pain awakens him at night. Physical examination reveals decreased sensation below the umbilicus at the L2-3 levels. He has some banding sensory deficit. He can only forward flex to 24 inches from the ground. His rotation and lateral bending is limited. He has significance myofascial trigger points over the lumbosacral paraspinals as well as over his piriformis area. His gait pattern is fairly slow. He has a reduced stride. He is somewhat slow and deliberate in his movement, but does not embellish any pain. He has increasing pain with forward flexion and extension at the lumbar spine consistent with the findings of the psuedoarthrosis at L5-S1. Dr. Eilers' diagnostic impressions are L4-5 disc herniation; L5-S1 disc herniation; status post fusion at L5-S1 and ProDisc Dynamic Stabilizer placement at L4-L5; L5-S1 psuedoarthrosis accounting for his increased pain; impotence and retrograde ejaculation secondary to surgery; myofascial pain; and chronic low back pain secondary to multi-level fusion and psuedoarthrosis. Dr. Eilers opined that the patient's care has been reasonable and appropriate. He opined that Petitioner is likely permanently and totally disabled from competitive employment and added that he did not believe that he was even capable of sedentary work since he cannot sit or stand for prolonged periods of time and has few if any transferrable skills. (Px.9)

On July 10, 2015, Petitioner saw Dr. Udit Patel for pain management. He examined Petitioner and prescribed Mobic. Petitioner followed up with Dr. Patel on August 5, 2015 and indicated that the Mobic was causing hot flashes and night sweats. He was prescribed Tramadol. On August 31, 2015, Petitioner reported that the Tramadol did not provide relief. Dr. Patel referred him to Dr. Gutta. (Px.6)

In a report dated August 13, 2015, Dr. Rinella, Respondent's Section 12 examiner, recommended permanent restrictions due to Petitioner having not undergone a functional capacity evaluation. Based upon the work conditioning reports from July and August of 2013, Dr. Rinella recommended permanent restrictions of lifting no more than 40 lbs. on an occasional basis; may push and pull 80 lbs.; no restrictions with regard to standing and sitting. (Rx.2, Ex.2)

Based upon the permanent restrictions recommended by Dr. Rinella, Respondent retained vocational consultant Bob Hammond who authored a report on September 22, 2015. Based upon Dr. Rinella's restrictions, Mr. Hammond opined that the Petitioner had limitations at the medium level and identified 20 potential positions Petitioner was capable of performing. As such, he opined that there is a reasonable stable labor market in which Petitioner could find work. (Rx.3, Ex.1)

On September 28, 2015, Petitioner saw Dr. Gutta for pain management. Petitioner testified that he believes he was referred to Dr. Gutta because Dr. Gutta was able to prescribe a more potent combination of medications. Dr. Gutta assessed Petitioner with lumbago, lumbar radiculopathy, and neuropathy. He prescribed him Hysingla ER. He followed up with Dr. Gutta on December 3, 2015 at which time he prescribed Morphine Sulfate. (Px.10)

Petitioner followed up with Dr. Patel on January 11, 2016. Dr. Patel indicated Petitioner is stable on medications prescribed by Dr. Gutta. He ordered a functional capacity evaluation. (Px.6)

On January 21, 2016, Petitioner underwent a functional capacity evaluation. The evaluation report indicated that Petitioner gave a consistent and acceptable effort that likely represented his true status. He is classified mostly in the medium work demand level for activity and at the sedentary demand level for endurance. He would not be able to perform the required activity for the required time frame in the medium demand level as the test was terminated at nearly 4 hours – a half day of work. The results of the functional capacity evaluation indicated Petitioner could function on a very limited basis as follows:

1. Material Handling: Occasional: floor to waist 43#, waist to shoulder 28#, overhead 18#, 2 hand carrying 28#, push force #88, pull force 79#. Frequent: waist high 23#, shoulder high 23#, 2 hand carrying 14#.

2. Non-Material Handling: Occasional: sitting, standing, walking and waist-high reaching. Frequent: grip, and fine motor. Constant: nothing. Avoid: bending, squatting, climbing, kneeling, crawling, all constant activity performance, overhead, increased repetition, longer duration, and higher intensity activity. (Px.11, p.3)

It was further noted that Petitioner was only able to tolerate activity for 4 hours and that he needed to change positions and take frequent breaks. It was opined that he would not be able to return to work given his condition and his inability to tolerate longer bouts of activity without breaks or changing positions. The therapist spoke to

Petitioner the following day and reported that he had increased pain in the low back and had been taking his medication and lying down. His pain rating was up to a level 9 out of 10. (Id.)

Petitioner followed up with Dr. Patel on February 24, 2016 to go over the functional capacity evaluation results. Dr. Patel indicated Petitioner was at maximum medical improvement and put him on permanent restrictions per the FCE consisting of "material handling with occasional floor to waist 43 lbs, waist to shoulder 28lbs, overhead 18 lbs, 2 hand carry 28 lbs, push force 88 lbs, pull force 79 lbs, and frequent waist high 23 lbs, shoulder high 23 lbs, 2 hand carry 14 lbs. Non material handling occasional sitting, standing, walking, and waist-high reaching and frequent grip, fine motor. Constant: nothing. Avoid bending, squatting, climbing, kneeling, crawling, all constant activity performance, overhead, increased repetition, long duration, and higher activity. Patient is limited to a 4 hour work day." (Px.6)

Petitioner met with vocational consultant Dennis Gustafson at the request of his attorney on February 17, 2016 for a vocational assessment. In his report, Mr. Gustafson stated that Petitioner attended high school in Arkansas for 2 years before dropping out. He completed a GED, but has no additional education or formal job training. He has worked cutting grass, installing commercial PVC flooring for 4 months, and as a roofer helper for a few weeks. In March 2008 he moved from Arkansas to Streator, Illinois. He began working at Diversatech in approximately January 2009 continuing until his November 17, 2010 work accident. Overall, he has gained no skills as a result of the jobs performed by him during his brief work history. Thus, he faces the job market as an entry level worker subject to the physical limitation as set forth in the functional capacity evaluation. He currently takes Morphine Sulfate and a time release version of Morphine on a daily basis. His girlfriend visits him on a daily basis and provides him assistance with cooking, laundry, and doing the dishes. He spends the majority of the day sitting or lying on his couch either watching TV or using a computer that is hooked up to his television. He also sleeps on the couch at night since he is able to contort his body to a more comfortable position. He reports getting approximately 4 hours of sleep per night. Based upon his observed need to take frequent rest breaks as set forth in the functional capacity evaluation over a less than 4 hour period, Mr. Gustafson opined that he would be unable to sustain work activity at an acceptable performance level to maintain employment. Mr. Gustafson further opined that the ability to regularly change body position without losing significant levels of productivity is normally found in jobs most often classified as sedentary and performed in an office type environment. Given his lack of education and experience suggesting competence in clerical related tasks, it would be unlikely for him to be considered for entry level employment of this kind. Moreover, it would appear to be just as likely that he would be unable to physically tolerate regularly scheduled employment and meet the productivity requirements for such jobs on a sustained basis. As such, Mr. Gustafson opined that based upon the totality of vocationally relevant information that Petitioner is not capable of securing and/or sustaining competitive employment at the present time. He advised Petitioner to seek assistance from the vocational guidance department at Illinois Valley Community College. (Px.12)

Mr. Gustafson testified by way of deposition. (Px.15) Mr. Gustafson testified in a manner consistent with his vocational assessment report. Additionally, he testified that employers would not hire an individual who they knew was taking narcotic medication, such as Morphine. (Px.15, p.24-25) He also testified Petitioner would not be suitable for a clerical type job as he does not come across as somebody with the communication skills, demeanor, or appearance appropriate for such a job. (Px.15, p.52, 70, & 75-76)

Respondent's section 12 examiner testified by deposition as well. (Rx.2) Dr. Rinella testified consistent with his various reports and reiterated his opinion that he believed the appropriate permanent restrictions to be placed on Petitioner were no lifting more than 40 lbs. on an occasional basis; he may push or pull 80 lbs.; and he has no restrictions with regard to standing and sitting. (Rx.2, p.21-22) On cross-examination, Dr. Rinella conceded that Petitioner's retrograde ejaculation condition is likely a complication of the surgery that was performed. (Rx.2, p.38) He also agreed that psuedoarthrosis can cause increased levels of pain. (Rx.2, p.39, 44) He further admitted that the permanent restrictions he recommended were based on work conditioning reports from July and August 2013 and that he did not consider any records after September 5, 2013 when giving such restrictions. (Rx.2, p.45) Dr. Rinella further acknowledged that on July 19, 2012 he encouraged the Petitioner to avoid manual labor in the future and reiterated that he continues to recommend that he avoid manual labor. (Rx.2, p56) He testified that he considers working on an assembly line, working as a picker/packer, and working as a janitor to be manual labor. (Rx.2, p.55) He conceded that he has not seen the Petitioner since September 5, 2013 and that he has no idea what Petitioner's current level of symptomatology related to his back condition other than the functional capacity evaluation of January 21, 2016. (Rx.2, p.45, 57) He admitted that he never documented any symptom magnification and that he believed his pain complaints were legitimate and genuine. (Rx.2, p.65-66)

Bob Hammond also testified by way of deposition. (Rx.3) Mr. Hammond testified on direct examination consistent with his September 22, 2015 vocational report as well as a second vocational report that he authored on March 12, 2016, which reiterated his previous opinion that there is a reasonable stable labor market in which the Petitioner was employable. (Rx.3, Ex.1 & 3) On cross-examination, he testified that he was not aware of Dr. Rinella's opinion that Petitioner should avoid manual labor. (Rx.3, p.46-47) He conceded that his opinions were based upon Petitioner being capable of working a 40 hour week. (Rx.3, p.50) He admitted that he never met the Petitioner and does not have a feel for his communication skills or personality. (Id.) He testified that he agreed with Mr. Gustafson that Petitioner did not have transferrable skills. (Rx.3, p.51-52) Likewise, he was not provided with the lumbar CT scan indicating Petitioner had a psuedoarthrosis nor was he provided with any pain management records. (Rx.3, p.52-53, 55-56) Mr. Hammond emphasized the importance of a physician correlating an individual's functional capabilities and assigning limitations. (Rx.3, p.56-57) He indicated that he used the restrictions set forth by Dr. Rinella in his vocational assessment because he was the only physician who assigned limitations. (Rx.3, p.59) He conceded that he did not have the record from Dr. Patel of the Pain & Spine Institute dated February 24, 2016 within which Dr. Patel set forth restrictions based upon the FCE of January 21, 2016. (Rx.3, p.55-56)

Petitioner testified that following the functional capacity evaluation he was laid up for 2-3 days because of the pain. He testified that at the time of the hearing he was experiencing pain at a level 7 or 8. He has constant low back pain that radiates into the legs. He described the leg pain as a burning feeling. The constant back and leg pain that he feels is increased with physical activity, movement, and sitting in the same position for a period of time. After sitting for more than 5-15 minutes, he experiences increased pain causing him to fidget. He can be on his feet 10-20 minutes and then will experience increased pain. He testified that he weighed 180 pounds at the time of the November 2010 work accident and now weighs approximately 220 pounds. He takes a hot bath with Epsom Salt every day for up to an hour which seems to reduce some of the pain. He sleeps 3-5 hours in a typical night. He testified that he is always exhausted. He performs household chores like the laundry, and doing dishes by taking breaks about every 5 minutes. He continues to experience retrograde

ejaculation in which he testified that he is able to have an erection but is not able to ejaculate. This has made his sex drive almost non-existent and made him depressed. He has not attempted to find work within the restrictions put on him by Dr. Patel because he has such a hard time just doing normal activity around the house and it is a struggle even driving in a car as he needs to take a break every 20 minutes. He has not sought further education for the same reasons.

He explained that he never considered going into service type work because he lacks people skills, has no patience and gets aggravated easily. He considers himself to be an introvert. He testified that his chronic pain and fatigue makes him less able to tolerate others.

He testified that he has considered undergoing an additional surgery, but does not wish to do it because of the problems he had after the first surgery. He believes that the surgery made everything worse and that he does not trust another surgery. He testified that his next appointment with Dr. Gutta is scheduled for April 11th and that this appointment is authorized by workers' compensation.

CONCLUSIONS

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

It is not disputed that Petitioner sustained an injury to his back as a result of a lifting accident at work on November 17, 2010. Petitioner had no history of back problems or treatment before the accident. Petitioner credibly testified that he began to feel pain immediately after the lifting injury. The medical records demonstrate that from the initial visit with Urgent Care on November 17, 2010 through the date of hearing, Petitioner has consistently complained of low back pain with associated leg pain.

Both the treating physicians and Respondent's section 12 examiner relate Petitioner's symptoms to the work accident.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner's current condition of ill-being is causally related to the November 17, 2010 work accident.

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

Prior to the commencement of the hearing the parties stipulated that if Mike Surma, the president of Diversatch Metal Fab were called were called to testify that he would testifiy that overtime was voluntary rather than mandatory.

Petitioner testified that the hours he worked varied each week depending on the materials that came into the factory and the deadlines that had to be met related to those materials. Petitioner testified that he was the only individual that worked in the sandblasting department. He testified that his normal shift without overtime would be from 8:00 a.m. to 3:00 p.m. and that he would not know whether he would be required to work overtime on a typical day until he would be told by Josh, his foreman, whether he needed to work late that day. He believes that if he would have ever told Josh that he could not work overtime that he would be replaced. He is not aware of any other individual who ever worked at Diversatech who refused to work overtime. Petitioner considered the overtime to be mandatory. The Arbitrator finds Petitioner's testimony persuasive and credible.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds the overtime Petitioner worked was mandatory and was regular enough that it should be included in calculation the average weekly wage. Accordingly, the Arbitrator finds Petitioner's average weekly wage was $431.91.

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

During the course of care Petitioner incurred medical expenses totaling $290,437.56. (Px.1)

While Dr. Rinella would not have performed the surgery which Petitioner underwent, he did acknowledge that there was literature to support either a lumbar disc replacement procedure or a transforaminal lumbar interbody fusion at the L4-5 level.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that the medical services provided to Petitioner were reasonable and necessary.

Respondent shall pay reasonable and necessary medical services of $290,437.56, as set forth in PX 1, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

Petitioner has been off work since the November 17, 2010 work accident. Petitioner claims entitlement to temporary total disability benefits from November 18, 2010 through February 23, 2016, the day prior to his being placed at MMI by Dr. Patel.. Respondent contends that Petitioner was entitled to temporary total disability benefits from November 18, 2010 through July 24, 2014 and maintenance benefits from July 25, 2014 to January 11, 2016; and from January 21, 2016 to February 23, 2016.

The Arbitrator finds it significant that as of February 24, 2016 Petitioner was deemed to be at maximum medical improvement by Dr. Patel, his treating physician and given permanent restrictions per the January 21, 2016 functional capacity evaluation. (Px.6) The Arbitrator finds Petitioner was not at maximum medical improvement as of July 24, 2014. On that date Dr. Rinella drafted a report in which he reviewed the CT of the lumbar spine and indicated that it showed a psuedoarthrosis at L5-S1. (Rx.2, Ex.3) He recommended Petitioner undergo a posterior instrumented fusion at L5-S1 with consideration of extending the fusion to L4-5. (Id.)

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner was temporarily and totally disabled from November 18, 2010 through February 23, 2016, a period of 274 6/7 weeks.

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

Since the November 17, 2010 work accident, the medical records have documented persistent chronic low back pain with radiating leg pain. Petitioner's pain complaints have been noted to be consistent with the objective evidence. Dr. Rinella found no indication of symptom magnification and believed Petitioner's pain complaints were legitimate and genuine. (Rx.2, p.65-66) Dr. Rinella further testified that he is not surprised

Petitioner gave a valid effort on the January 21, 2016 functional capacity evaluation as he "always gave a valid effort with me." (Rx.2, p.66)

The Arbitrator finds it significant that Dr. Rinella's recommended permanent restrictions were based upon work conditioning records from July and August 2013 and do not take into consideration the psuedoarthrosis at L5-S1 that was identified in the CT of the lumbar spine performed on February 4, 2014. Likewise, Dr. Rinella's work restrictions do not take into consideration the fact that Petitioner's symptoms clearly worsened after the work conditioning program. In fact, the August 14, 2013 record of Dr. Geisler states Petitioner's lower back pain was aggravated in physical therapy/work hardening. (Px.8) Moreover, the post-August 2013 records document Petitioner's limited tolerance for sitting, standing, and walking. Notwithstanding, Dr. Rinella's recommended permanent restrictions did not take into consideration such difficulties. Nor did his restrictions take into account the January 21, 2016 FCE results. Dr. Rinella's recommended permanent restrictions did not take into account all of the relevant evidence in this case and are therefore not persuasive.

Bob Hammond's opinions of employability were premised on the Dr. Rinella's recommended permanent restrictions. Moreover, Mr. Hammond included potential manual labor jobs in his vocational assessment despite the fact that even Dr. Rinella indicated that Petitioner should avoid such work. The Arbitrator finds the opinions regarding employability from consultant Dennis Gustafson more persuasive as his opinions were based upon a valid, thorough, and recent functional capacity evaluation and the opinions of Petitioner's treating surgeon. Additionally, Mr. Gustafson's opinions took into consideration the Petitioner's use of narcotic medication as well as his lack of communication skills and demeanor.

Dr. Eilers' evaluation of November 20, 2014 documented Petitioner's difficulties with activities of daily living. Petitioner discussed these difficulties in his trial testimony and further discussed sexual dysfunction and related depression he has experienced since the February 11, 2013 surgery.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds the evidence supports an award of permanent and total disability benefits in this case.

Respondent shall pay Petitioner permanent and total disability benefits of $431.91/week for life, commencing February 24, 2016, the date that Dr. Patel found Petitioner to be at maximum medical improvement and set permanent restrictions based upon the functional capacity evaluation, as provided in Section 8(f) of the Act.

Issue (M) Should penalties or fees be imposed upon Respondent?

Petitioner claimed entitlement to penalties because benefits were paid at a rate which did not take into account overtime earnings. Although the evidence in this case supports the inclusion of Petitioner's overtime hours in the average weekly wage calculation, Respondent's payment of benefits calculated using only the straight time hours cannot be said to be unreasonable of vexatious. Penalties are therefore denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Monica P. Perez,
Petitioner,
vs.

NO: 13WC 9886

The Cheesecake Factory Restaurant, Inc.,
Respondent.

18IWCC0088

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, permanent disability, temporary total disability, any and all other issues raised at hearing and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 29, 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 - 9 2018
O013018
LEC/jrc
043

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PEREZ, MONICA P
Employee/Petitioner

Case# **13WC009886**

12WC003735

THE CHEESECAKE FACTORY RESTAURANT INC
Employer/Respondent

18IWCC0088

On 8/29/2016, 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:

1922 SALK, STEVEN B & ASSOC LTD
FRANK GAUGHAN
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

2542 BRYCE DOWNEY & LENKOV LLC
BRIAN J HINDMAN
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

M. Perez v. The Cheesecake Factory, 13 WC 09886

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

Monica P. Perez
Employee/Petitioner

v.

The Cheesecake Factory Restaurant, Inc.
Employer/Respondent

Case # **13** WC **09886**

Consolidated cases: **12 WC 03735**

18IWCC0088

An *Application for Adjustment 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 **3/8/2016 and 4/11/2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0088

FINDINGS

On **5/12/2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$29,529.04**; the average weekly wage was **$567.48**.

On the date of accident, Petitioner was **36** years of age, ***married*** with **3** dependent children.

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

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

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

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

ORDER

Claim for compensation denied. Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent on May 12, 2011.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 29, 2016
Date

ICArbDec p 2

AUG 29 2016

FINDINGS OF FACT

This matter was tried with a consolidated case, Case No. 12 WC 03735. This case involves the claimed accident date of May 12, 2011. Case No. 12 WC 03735 involves the claimed accident date of January 28, 2012. It is noted that Petitioner previously filed and prosecuted Case No. 11 WC 023812 against Respondent. Case No. 11 WC 023812 involved the claimed accident date of November 22, 2010. The Commission denied Petitioner's claim in Case No. 11 WC 023812, finding that Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent on November 22, 2010 and failed to prove a causal connection, reversing the Arbitrator's award of benefits. The Commission Case No. was 12 IWCC 1253. (Rx. 7)

Prior to the hearing on March 8, 2016, the Arbitrator heard arguments on Respondent's Motion to dismiss Case Nos. 12 WC 03735 and 13 WC 09886, based upon the doctrine of Res Judicata. A record was made and the Motion was denied. Respondent's Motion was admitted as Arbitrator's Exhibit 1. Petitioner's Reply was admitted as Arbitrator's Exhibit 2.

In the present case, on March 8, 2016, Petitioner testified via a Spanish/English interpreter and her testimony was submitted. Respondent's witness, Ryan Cook also testified on March 8. On April 11, 2016, exhibits were submitted.

The issues in dispute in Case No. 12 WC 03735 were: Did Petitioner sustain accidental injuries which arose out of and in the course of her employment by Respondent on January 28, 2012? ; Causal connection; Medical expenses; TTD; Nature and extent; and Res Judicata.

The issues in dispute in Case No. 13 WC 09886 were: Did Petitioner sustain accidental injuries which arose out of and in the course of her employment by Respondent on May 12, 2011? ; Notice; Causal connection; Medical expenses; TTD, TPD; Nature and extent and Res Judicata.

The operative facts in these consolidated matters were set forth in the Decision in Case No. 12 WC 03735. The Findings of Fact in Case No. 12 WC 03735 are hereby incorporated by reference.

The Arbitrator notes that May 12, 2011 was the first day that Petitioner reported the alleged accident of November 22, 2010 (right wrist hyperextension, lifting a plate of food) to the Respondent's General Manager, Ryan Cook. She was sent to Concentra by Respondent on May 12, 2011. (Px. 1, Rx. 6, 7)

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

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

The Arbitrator finds that Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent on May 12, 2011.

When she sought treatment at Concentra (at the direction of Respondent) on May 12, 2011, she related her complaints to the wrist hyperextension injury of 11/22/2010. Five days after 11/22/2010, she developed pain in her right shoulder. Thereafter, she developed right elbow pain and right forearm pain. Per the Concentra records, Petitioner saw a chiropractor who advised that he could not help her due to the chronic nature of the problem. (Px. 1)

Given the above, the persuasive opinion of Dr. Phillips that Petitioner's diagnosis is myofascial pain of the upper extremity with non-structural complaints of pain, symptom magnification, and positive Waddell's signs, likely due to somatization disorder and the Commission's prior denial of Petitioner's claim in Case No. 12 IWCC 1253, the Arbitrator cannot find that a repetitive trauma injury manifested on May 12, 2011.

Petitioner's claim for compensation is, therefore, denied.

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

The testimony of Petitioner and of Ryan Cook, along with Respondent's Exhibit 6 establish that timely notice of the accident, as required by §6 of the Act, was given.

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

As the Arbitrator has found that Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of Petitioner's employment by Respondent on May 12, 2011, the Arbitrator needs not decide this issue.

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

As the Arbitrator has found that Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent on May 12, 2011, the Arbitrator needs not decide this issue.

The Arbitrator does find it disappointing that Respondent did not pay the Concentra bills, even though it sent Petitioner to Concentra for treatment and obviously authorized the treatment given to Petitioner. (Px. 1, 10) Respondent should consider itself fortunate to have prevailed in Case No. 12 IWCC 1253 and should pay the Concentra bill.

K. What temporary total disability benefits are in dispute? L. What is the nature and extent of the injury?

As the Arbitrator has found that Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent on May 12, 2011, the Arbitrator needs not decide these issues.

O. Other – Res Judicata

The Arbitrator finds that this claim is not barred by the doctrine of res judicata, as there is no unity of the cause of action between this case and Case No. 11 WC 23812. Case No. 11 WC 23812 involved a claim for a specific injury that allegedly occurred on November 22, 2010 and this case involves a repetitive trauma claim that has a claimed accident date of May 12, 2011.

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

Monica P. Perez,
Petitioner,
vs.

NO: 12WC 3735

The Cheesecake Factory Restaurant, Inc.,
Respondent.

18IWCC0089

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, permanent disability, temporary total disability, any and all other issues raised at hearing and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 29, 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 $4,200.00. 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 - 9 2018
O013018
LEC/jrc
043

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PEREZ, MONICA P
Employee/Petitioner

Case# **12WC003735**

13WC009886

THE CHEESECAKE FACTORY RESTAURANT INC
Employer/Respondent

18IWCC0089

On 8/29/2016, 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:

1922 SALK, STEVEN B & ASSOC LTD
FRANK GAUGHAN
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

2542 BRYCE DOWNEY & LENKOV LLC
BRIAN J HINDMAN
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

M. Perez v. The Cheesecake Factory, 12 WC 03735

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

Monica P. Perez
Employee/Petitioner

v.

The Cheesecake Factory Restaurant, Inc.
Employer/Respondent

Case # 12 WC 03735

Consolidated cases: 13 WC 09886

18IWCC0089

An *Application for Adjustment 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 **3/8/2016 and 4/11/2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0089

FINDINGS

On **1/28/2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$29,529.04**; the average weekly wage was **$567.48**.

On the date of accident, Petitioner was **37** years of age, *married* with **3** dependent children.

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of **$1,542.67**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$378.32**/week for **3 1/7** weeks, commencing **1/31/2012** through **2/21/2012**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$340.49**/week for **4.1** weeks, because the injuries sustained caused the **2%** loss of the **right hand**, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner all compensation benefits that have accrued from January 21, 2012 to April 11, 2016 in a lump sum and shall pay the remainder of the award, if any in weekly payments.

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

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

Signature of Arbitrator

August 29, 2016
Date

AUG 29 2016

FINDINGS OF FACT

This matter was tried with a consolidated case, Case No. 13 WC 09886. This case involves the claimed accident date of January 28, 2012. Case No. 13 WC 09886 involves the claimed accident date of May 12, 2011. It is noted that Petitioner previously filed and prosecuted Case No. 11 WC 023812 against Respondent. Case No. 11 WC 023812 involved the claimed accident date of November 22, 2010. The Commission denied Petitioner's claim in Case No. 11 WC 023812, finding that Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent on November 22, 2010 and failed to prove a causal connection, reversing the Arbitrator's award of benefits. The Commission Case No. was 12 IWCC 1253. (Rx. 7)

Prior to the hearing on March 8, 2016, the Arbitrator heard arguments on Respondent's Motion to dismiss Case Nos. 12 WC 03735 and 13 WC 09886, based upon the doctrine of Res Judicata. A record was made and the Motion was denied. Respondent's Motion was admitted as Arbitrator's Exhibit 1. Petitioner's Reply was admitted as Arbitrator's Exhibit 2.

In the present case, on March 8, 2016, Petitioner testified via a Spanish/English interpreter and her testimony was submitted. Respondent's witness, Ryan Cook also testified on March 8. On April 11, 2016, exhibits were submitted.

The issues in dispute in Case No. 12 WC 03735 were: Did Petitioner sustain accidental injuries which arose out of and in the course of her employment by Respondent on January 28, 2012? ; Causal connection; Medical expenses; TTD; Nature and extent; and Res Judicata.

The issues in dispute in Case No. 13 WC 09886 were: Did Petitioner sustain accidental injuries which arose out of and in the course of her employment by Respondent on May 12, 2011? ; Notice; Causal connection; Medical expenses; TTD, TPD; Nature and extent and Res Judicata.

The operative facts in these consolidated matters will be set forth in the Decision in Case No. 12 WC 03735.

Petitioner, Monica P. Perez, was employed by Respondent, The Cheesecake Factory Restaurant, Inc., as a server. She had been so employed for about six years.

Petitioner testified that on May 12, 2011, while Petitioner was working as a server, running food from the kitchen to tables, she noticed increasing pain in her right wrist as she was carrying trays. She testified that she informed her manager, Ryan Cook, of this pain and he instructed her to go to the Concentra Medical Center.

Petitioner had noticed pain in her right wrist and arm for several months before May 12, 2011, having allegedly sustained a right wrist hyperextension injury on November 22, 2010 (the subject of Case No. 12 IWCC 1253). As part of her job duties, Petitioner had to carry plates and trays of food from the kitchen to the customers. She would carry two or three plates of food on her arm, 20 or more times per shift. She would also have to carry filled glasses to the tables. Petitioner said that she experienced pain in her right hand, arm and shoulders while doing these talks. Thinking the pain would go away, Petitioner kept working and did not seek medical attention. However, on May 12, 2011, the pain became so severe that Petitioner could no longer work, carrying plates and trays of food.

The testimony of Ryan Cook in the prior case establishes that on May 12, 2011 another employee, Stephanie, told him that Petitioner had injured her wrist at work in November of 2010. Petitioner later called Cook on May 12 and Cook asked Petitioner to return to work so that accident reporting information could be completed. An accident report was completed on May 12, 2011, setting forth an accident date of 11/22/2010 and stating that the employee developed right hand pain about 6 months ago and the pain has progressively gotten worse, pain is 10/10 and radiating up right arm to back. (Rx. 5) Petitioner was referred by a company nurse to Concentra. (Rx. 4, Rx. 7)

At Concentra Medical Center, Petitioner was diagnosed with right shoulder strain and right wrist tenosynovitis. She was prescribed ibuprofen and physical therapy. She was also given a 10 pound lifting restriction with the right hand, she could not push/pull over 10 pounds with the right hand, she was required to wear a brace and she could not reach above her shoulders. Petitioner attended physical therapy sessions and had two follow-up doctor appointments. At the last appointment on May 20, 2011, Petitioner complained of pain in the right shoulder and wrist. The same restrictions and medications were prescribed. (Px. 1)

On June 9, 2011, Petitioner sought medical treatment at Alivio Physical Therapy and Chiropractic, LLC. On that day, she was examined by Dr. Ravi Barnabas, M.D., who suspected a tendon tear in Petitioner's right wrist and ordered an MRI. The history recorded in the chart for the 6/9/11 visit is poorly transcribed, to say the least ("(t)he patient is a 36-year old Hispanic male works as a surface maker in cheesecake factory in Schamberg got injured at 6PM on 11/22/2010. She went to grab a plate on a countertop. The plate had foot in on it and as she grabbed the plate she felt severe pain on the onset of her finger." Dr. Barnabas also diagnosed lateral epicondylitis of the right elbow. He prescribed physical therapy. The MRI of the elbow taken June 9, 2011 showed either lateral epicondylitis or a partial tear of the common extensor tendon in the right elbow. The MRI of the wrist had findings consistent with ulnar lunate impactation syndrome and tenosynovitis. Dr. Barnabas gave Petitioner a 10 pound lifting restriction and on June 22, 2011, referred Petitioner to Dr. David Schafer, M.D. (Px. 2)

Petitioner saw Dr. Schafer on June 29, 2011. She complained of painful range of motion, decreased function, swelling, warmth and weakness. Symptoms were located in the radial aspect of the wrist radiating to the elbow. The symptoms were exacerbated by grasping, lifting, overhead activity and repetitive motor acts. Dr. Schafer diagnosed Petitioner with right elbow epicondylitis and DeQuervain's tenosynovitis, secondary to repetitive work activities from carrying trays of food. Dr.

Schafer administered steroid injections in the elbow and wrist. He prescribed continued physical therapy and restricted her to no use of the right arm. (Px. 3)

On July 27, 2011, Petitioner returned to see Dr. Schafer, who thought there might be radial nerve involvement. He continued to diagnose DeQuervain's tenosynovitis and lateral epicondylitis, but gave her a steroid injection in the upper right arm near the radial nerve exit site. He continued the restriction of no work with the right hand. (Px. 3)

Petitioner was unable to obtain further treatment from Dr. Schafer after July 27, 2011 because Gallagher Bassett denied any further physical therapy or medical treatment.

Dr. Bermudez, D.C., at Alivio, continued to treat Petitioner with therapy and chiropractic care. The Arbitrator notes that beginning in September of 2011, Alvio began charging $250.00 a session for "transportation" and the charges (later reduced to $100.00) continued through the last visit at Alvio on February 9, 2012. Dr. Bermudez referred Petitioner to ATI Physical Therapy near her home and she began therapy on September 12, 2011. (Px. 2) She received therapy and work conditioning at ATI through February 3, 2012, when she was discharged. The discharge summary from work conditioning notes that Petitioner still had pain with activities that isolate the wrist flexors and extensors, as well as long lever arm activities (Px. 4)

Respondent accommodated Petitioner's restrictions until July 29, 2011. During the eight week time period, the Petitioner's gross pay was $1,558.35. Petitioner's average weekly wage is $567.48. Eight weeks gross earnings are $4,539.84. After July 29, 2011, Respondent did not accommodate Petitioner's restrictions and she was off work from July 30, 2011 until December 7, 2011, when she returned to work as a hostess.

As a hostess, Petitioner had to carry menus, seat customers and assist servers as needed. On January 28, 2012, while setting up serving stations, Petitioner was stacking plates and a co-worker was storing glasses. On that date, the co-worker forcefully struck Petitioner on the dorsal

aspect of her right hand with a plastic glass. This was not an intentional injury. Petitioner felt immediate sharp pain in her right hand, wrist and arm. Petitioner reported the accident and a report was completed. (Rx. 6) She was given the option of seeing the company doctor or going home. Petitioner chose to go home.

Petitioner did not seek immediate emergency care. She did not seek treatment on January 29, 2012 or January 30, 2012. Petitioner did not return to work at Respondent after January 28, 2012.

Following the January 28, 2012 accident, Petitioner returned to Alivio on January 31, 2012, with complaints of pain in her entire right arm, from her shoulder to her wrist. She gave a history of the January 28, 2012 accident (prior to this time the records from Alivio indicate that Petitioner was making some improvement in her condition). The examination that day revealed painful range of motion and tenderness upon palpation. The diagnosis was re-aggravation of the right humeral lateral epicondylitis with tendinitis into the extensor group of the forearm. Petitioner was given a 5 pound restriction or, in the alternative, taken off work. Dr. Bermudez saw Petitioner for right upper extremity treatment on February 9, 2012. Range of motion of the right wrist was full with some complaints of pain at the end stages of flexion and extension. (Px. 2)

On February 15, 2012, Petitioner sought treatment at Alexian Brothers Medical Center emergency department. There she gave a history of right hand pain radiating to her shoulder for more than a year and approximately two weeks before, another employee hit her right hand with a glass and the pain was getting worse. X-rays were negative, but she had tenderness of the right hand and reduced range of motion. It is noted that Petitioner had work conditioning at ATI for 5 hours on 1/30/12 and 2/1/12 and 4 hours on 2/3/2012. (Px. 15) Petitioner was referred for follow-up to the Alexian Brothers Corporate Health Services by the emergency department. (Px. 5)

The morning of February 16, 2012, Petitioner was examined by Dr. Winston Rajendrum, M.D. at Alexian Brothers Corporate Health Services. After conducting an exam, Dr. Rajendrum diagnosed right wrist De Quervain's tenosynovitis. He prescribed a Medrol dose pack, a thumb splint and physical therapy. He ordered Petitioner not to use her right hand at work. (Px. 6)

Petitioner saw Dr. Edward Sclamberg , on a referral from Dr. Barnabas on February 21, 2012. Petitioner related her right upper extremity complaints to the 11/22/2010 incident and a blunt trauma to the dorsal aspect of the right wrist on January 21, 2012. Dr. Sclamberg noted hypo-pigmentation on her right elbow at the site of a cortisone injection. He noted slight tenderness over the lateral epicondyle of the right elbow with diffuse tenderness distal to the elbow including the hand and fingers. Full range of motion of the right shoulder, elbow and wrist was noted. The motor and sensory exam was intact and the patient was neurovascularly intact. The wrist was said to be completely stable. Dr. Sclamberg thought that Petitioner was status post minor sprain of the right wrist with mild lateral epicondylitis which has been treated with a cortisone injection and extensive therapy. Since Petitioner had completely normal strength, sensation and function, Dr. Sclamberg thought she could return to work full duty. No further treatment or splinting or pain management was indicated. (Px. 7)

On cross-examination, Petitioner agreed that Dr. Sclamberg had released her to full duty work.

Petitioner returned to the Alexian Brothers Emergency Department on August 21, 2012 complaining of intolerable right wrist pain after moving some boxes. She was prescribed ultracet and had a diagnosis of tendonitis of the right wrist. She was told not to use her right hand at work. (Px. 5)

On August 22, 2012, Petitioner returned to Alexian Brothers Corporate Health. There, she was diagnosed with De Quervain's tendonitis, prescribed another Medrol dose pack and referred to a hand surgeon. She was instructed not to use her right hand and arm and to use a splint at home and at work. (Px. 6)

Petitioner could not get approval for treatment and had no insurance. Respondent would not take her back to work. The Petitioner started to look for work within her restriction and was finally able to get a job as a cocktail waitress in September, 2012. She had difficulty with her hand, but kept the job for six or seven months.

Petitioner then obtained a job in a factory, soldering wires. She was able to perform that job for a few months, but the fine motor skills work bothered her hand.

More recently, Petitioner obtained a job through a relative at a hair salon. She cuts hair one day per week for about four hours. She stated that the vibration from the clippers bothers her right hand. She also works part-time at Down to the Last Detail, cleaning private airplanes. Petitioner testified that her hand and arm bother her during the plane cleaning job, especially if she is washing the plane by hand. Between the two jobs, Petitioner earned $22,403.75 in 2015 or $430.84 per week.

On March 29, 2013, Petitioner returned to the emergency department at Alexian Brothers Medical Center with complaints of worsening right upper extremity pain for the last two weeks. There she was diagnosed with right arm pain and Ultram was prescribed. (Px. 5)

During late 2013 and early 2014 Petitioner developed depression. She went to the Kenneth Young Center on January 15, 2014 for counseling and gave a history of coping until the work accident and pain began. There she was diagnosed with major depressive disorder, recurrent. Independent therapy was recommended and Petitioner was referred to Dr. Jerry Gibbons, M.D. for a full psychiatric evaluation on February 21, 2014. Dr. Gibbons confirmed the diagnosis and related her issues to the workers' compensation case and lack of money, although Petitioner clearly had several other traumas and challenges in her life. Citalopram was prescribed. (Px. 8)

Petitioner could not continue with psychiatric therapy, because she could not afford to pay for it. She had been referred to the Salvation Army for psychotherapy, but apparently did not follow-up. (Px. 8)

On March 20, 2014, Petitioner again sought treatment at the emergency department at Alexian Brothers Medical Center. There she complained of worsening right arm pain since the day before when she was cutting hair. She was diagnosed with chronic arm pain and prescribed toradol, norco and medrol dose pack. (Px. 5)

Petitioner claimed that she could not return to Alexian Brothers Medical Center because she had no insurance. She then went to Stroger Hospital on April 1, 2014. There she stated she injured her hand three years ago and still has severe wrist pain. Petitioner received a diagnosis of hand pain/wrist pain, carpal tunnel syndrome and adhesive capsulitis. She was referred to Dr. David Levy, M.D., a hand specialist on staff at Stroger. Dr. Levy examined Petitioner on April 11, 2014. Dr. Levy thought that Petitioner might have Complex Regional Pain Syndrome rather than carpal tunnel syndrome because her symptoms were so diffuse. He also wanted to rule out cervical radiculopathy. He made referrals to the Cook County Pain Clinic and the Neurosurgery department. (Px. 9)

Petitioner was unable to obtain that treatment.

Petitioner underwent a physical at Clearing Clinic on April 28, 2015. The examination of the shoulders, elbows, wrists, hands and fingers was normal and unremarkable. She was cleared to perform the essential functions of her job as a plane cleaner. (Rx. 10)

Petitioner was seen, at the request of Respondent, for §12 examinations by Dr. Craig Phillips, M.D. on November 8, 2011 and March 3, 2014. Dr. Phillips testified via evidence deposition. He is a board certified orthopedic surgeon with a hand certification. Dr. Phillips thought that the Petitioner had overwhelming myofascial pain in her right upper extremity, mild right lateral epicondylitis, resolved DeQuervain's tenosynovitis and myofascial pain around the right shoulder. Dr. Phillips

thought that the treatment was reasonable and necessary and he gave her a ten pound restriction in November 2011. In his deposition, he admitted that carrying trays of food might cause epicondylitis. Dr. Phillips did not believe that any structural pathology was related to Petitioner's work. He did believe that the depression and myofascial pain syndrome need to be addressed before Petitioner would get better. He did not know the cause for the myofascial pain or depression. Petitioner had non-structural pain, symptom magnification and positive Waddell's signs. Petitioner's complaints regarding her right upper extremity are likely due to a somatization disorder. (Rx. 3)

Ryan Cook testified for Respondent. He is the General Manager for the Respondent's restaurant. He supervised Petitioner. He testified regarding the circumstances that led to the creation of the Form 45 on May 12, 2011 and the referral of Petitioner to Concentra on that date. (Rx. 5) He prepared the Form 45 regarding the January 28, 2012 accident. (Rx. 6) He thought that Petitioner would be eligible to work about the same hours as a server when functioning as a hostess. He did not know any details regarding the January 28, 2012 accident, as he did not witness the accident. He did think that the cup was a 16oz plastic cup and it probably weighed 2-4 oz. He did not know how forcefully Petitioner's hand was struck.

The Decision of the Commission in Case No. 12 IWCC 1253 was admitted as Respondent's Exhibit 7. The trial transcript (minus exhibits) in that case was admitted as Respondent's Exhibit 4. Petitioner did not testify via an interpreter in the first case. Ryan Cook testified at the 12/21/2011 hearing in Case No. 11 WC 23812 (12 IWCC 1253). The records of Concentra (Px. 1), Allvio (Px. 2), Adult & Pediatric Orthopedics (Dr. Schafer) (Px. 3) and ATI (Px. 4) were admitted at the trial of Case No. 11 WC 23812. (Rx. 4) These records were re-subpoenaed by Petitioner for the trial of the present case.

Petitioner testified that she feels pain in her right hand and arm whenever she grips something or attempts to lift anything heavy. The pain is constant and never really goes away. She is frustrated

and depressed because of the pain and lack of income since the injuries. She wants to get better but there is no insurance to pay for treatment and she does not earn enough money to pay for care.

Petitioner submitted medical bills that total $38,158.71 per the fee schedule. $32,558.58 is related to the May 12, 2011 accident or occurred before the January 28, 2012 accident date. (Px. 10-22)

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

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

The Arbitrator finds that Petitioner sustained accidental injuries, arising out of and in the course of her employment by Respondent on January 28, 2012. On that date, a co-employee accidently and forcefully struck the Petitioner's right hand on the dorsal aspect with a glass. This finding is based upon Petitioner's testimony, Respondent's Exhibit 6, the medical records and the testimony of Ryan Cook.

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

The Arbitrator finds that the Petitioner's condition of ill-being regarding her right wrist (to wit: resolved minor sprain of the wrist as diagnosed by Dr. Sclamberg) is causally related to the injury. The remaining problems regarding Petitioner's right upper extremity and psychiatric condition are not causally related to the injury of January 28, 2012. Dr. Phillips' opinions are credible and persuasive

on this issue. Petitioner's upper extremity complaints are due to myofascial pain, secondary to a somatization disorder and not due to Petitioner's work activities or accidents.

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

The Arbitrator finds that some of the medical services that were provided to the Petitioner were reasonable and necessary and causally related to the injury. The Arbitrator relies on the medical records and the opinions of Dr. Phillips, the Respondent's examining physician, that the treatment was reasonable and necessary. Respondent presented no Utilization Review of the treatment. Petitioner's claims for bill related to treatment after the 2/21/2012 examination by Dr. Sclamberg are denied on the basis of the Arbitrator's finding on the issue of causation, above,

Therefore, the Arbitrator awards the bills as follows:

1.	Alivio	$215.00
2.	Orthopaedics of the North Shore	$391.59
3.	Alexian Brothers Medical Center (facility)	$936.08
	Total:	$1,542.67

The Alvio award is for DOS: 1/31/2012 (minus transportation). The submitted Alivio bill for DOS: 2/9/2012 appears to have been satisfied. (Px. 11) The Alexian Brothers Hospital bill is for the DOS: 2/15/2012. The physician's bill for this date appears to have been satisfied. (Px. 18, 19)

K. What temporary total disability benefits are in dispute?

The Arbitrator finds that the Petitioner is entitled to temporary total disability benefits of $378.32 per week for 3 1/7 weeks, commencing January 31, 2012 through February 21, 2012, based upon the Arbitrator's findings regarding accident and causation, above.

The doctors at Alivio took Petitioner off work on January 31, 2012 (or at least with a 5 pound lifting restriction and limited use of the right upper extremity) and again on February 9, 2012. Respondent had no work for her after January 28, 2012. Further, the doctors at Alexian Brothers Corporate Health gave her restrictions of no use of the right hand and arm on February 16, 2012. Dr. Sclamberg released Petitioner to full duty work, effective February 21, 2012.

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

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

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its determination on the following factors:
- (i) The reported level of impairment;
- (ii) The occupation of the injured employee;
- (iii) The age of the employee at the time of injury;
- (iv) The employee's future earning capacity; and
- (v) Evidence of disability corroborated by medical records.

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a server at the time of the accident and that any limitation regarding return to work in her prior capacity is not as a result of her resolved minor wrist sprain. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 37 years old (DOB 7/5/1974) at the time of the accident. Because of the relatively young age of the Petitioner, there may be some residuals from the injury. This factor is given some weight in determining PPD.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes the Petitioner is currently earning less money with two part-time jobs than she was earning at the time of the accident. The Arbitrator does not believe that any wage loss that Petitioner has experienced is due to the injury. This factor is given no weight in determining PPD.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner is still not pain free. Per Dr. Sclamberg, her wrist sprain condition has resolved. Therefore, this factor is given some weight indetermining PPD.

The determination of PPD is not simply a calculation, but an evaluation of all five factors as stated in the Act. In making this evaluation of PPD, consideration is not given to any single enumerated factor as the sole determinant. Therefore, after apply Section 8.1b of the Act, 820 ILCS 305/8.1b and considering the relevance and weight of all these factors, the Arbitrator concludes that, as a result of the injury, Petitioner has sustained the 2% loss of use of her right hand.

O. Other – Res Judicata

The Arbitrator finds this case is not barred by the doctrine of res judicata as there is no unity of the cause of action between this case and the case 11 WC 23812. This case involves a claim for a specific loss that occurred on January 28, 2012. Case 11 WC 23812 involved a specific loss on the accident date of November 22, 2010.

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

Rita Steinmetz,

Petitioner,

vs. NO: 16WC 18853

Aisin Illinois,

18IWCC0090

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 9, 2017, is hereby affirmed and adopted.

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

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 - 9 2018
o013118
LEC/jrc
043

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

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

STEINMETZ, RITA
Employee/Petitioner

Case# **16WC018853**

AISIN ILLINOIS
Employer/Respondent

18IWCC0090

On 6/9/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1167 WOMICK LAW FIRM CHTD
CASEY VANWINKLE
501 RUSHING DR
HERRIN, IL 62948

0299 KEEFE & DePAULI PC
PATRICK KEEFE
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

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

Rita Steinmetz
Employee/Petitioner

v.

Aisin Illinois
Employer/Respondent

Case # 16 WC 18853

Consolidated cases: _____

18IWCC0090

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Glaub**, Arbitrator of the Commission, in the city of **Herrin**, on **4/13/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, 5/2/16, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $13,587.09; the average weekly wage was $522.58.

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 $0 for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $0.

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

ORDER

The Arbitrator finds that Petitioner's accident arose out of and in the course of Petitioner's employment with Respondent. The Arbitrator finds that the petitioner's bilateral hand condition is causally related to her job duties with the respondent. Respondent is found to be responsible for any outstanding medical bills and for the prospective hand surgeries as recommended by Dr. Ahn pursuant to the Illinois Medical Fee schedule.

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

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

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

Signature of Arbitrator

6/7/17
Date

ICArbDec19(b)

JUN 9 - 2017

RITA STEINMETZ v. AISIN ILLINOIS, IWCC# 16 WC 18853

STATEMENT OF FACTS

Petitioner testified that commenced working for the respondent Aisin, which is an automotive parts manufacturer, on November 16, 2015.

Petitioner testified that her initial job duties for Aisin was working in the center pillars department. These duties required petitioner to snap on four hard plastic pieces with a rubber seal around them on every pillar. Petitioner testified that she then had to coat the edges of the pillars utilizing a bottle to apply an adhesive. Petitioner performed this job approximately 800-900 times a day during an eight-hour shift. Petitioner testified that she worked on center pillars until late January 2016, when she transferred to the roof rails department. Petitioner testified that in the roof rails department, she placed rubber cushions on the roof rails which involved removing the plastic off the back of each cushion and then using a pinching movement to push down and center the cushion on the roof rail. Petitioner testified that she performed this movement with both hands for each roof rail. Petitioner testified that in the roof rails department, she often worked a 12-hour shift, six days a week. Petitioner testified that she worked on anywhere from 850 to 1200 roof rails a day. Petitioner testified that she worked in the roof rail department until approximately the end of June.

Petitioner testified that in the last few months before she left work for Aisin in August 2016, she was transferred to material handling because her quality doing roof rails was going down due to the loss of feelings in her fingers. Petitioner was off work due to an unrelated thumb injury from 8/13/16 until 11/3/16 when she was released for work. Petitioner chose not to return to work for respondent. Petitioner testified that she did wish to risk any further injury to her hands. No claim for temporary total disability benefits was made on this claim.

Petitioner testified that she began to have problems with her hands at the end of January 2016 and went to see the physician's assistant at the Aisin plant. Petitioner testified that Dr. Oakley recommended she take Ibuprofen, to wear a splint at night and to see her own physician if her condition did not improve in a month. Petitioner testified that she subsequently sought medical care her family physician, Dr. Hayes on April 16, 2016, who prescribed a nerve conduction study with Dr. Newell. The nerve conduction study was performed on May 2, 2016. The test was interpreted to reveal severe bilateral medium neuropathy at the wrist or carpal tunnel syndrome. (Px1)

Petitioner was evaluated by orthopedic hand surgeon, Dr. Ahn on May 18, 2016. Dr. Ahn diagnosed petitioner with bilateral carpal tunnel syndrome. Dr. Ahn recommended bilateral carpal tunnel releases. (Px2)

Petitioner testified and presented evidence of a pre-employment physical and pre-employment nerve conduction study that was negative for any evidence of carpal tunnel syndrome or any other hand abnormality. (Px3)

Petitioner also testified that she had not had any hand symptoms or problems with her hands prior to working at Aisin.

Petitioner was examined by Dr. Rotman at Respondent's request on October 24, 2016. He also issued a supplemental report on February 6, 2017, after viewing a video of Petitioner's roof rail job duties. Dr. Rotman agreed Petitioner has bilateral carpal tunnel syndrome and requires surgery. (Rx1)

The parties took the evidence depositions of Dr. Ahn and Dr. Rotman. Both physicians are Board Certified Orthopedic Surgeons.

Dr. Ahn testified that with Petitioner's significant amount of repetitive activity that his opinion was that it either caused or at least worsened the preexisting condition. Dr. Ahn opined that "if she had a pre-existing nerve condition study done that was clear, then, obviously, this is all from work activity." Dr. Ahn also noted that petitioner was not symptomatic prior to her employment for respondent but is severely symptomatic now. Dr. Ahn opined that performing the same motions with the wrist and hand with enough repetition can cause carpal tunnel syndrome because this repetitive motion of bending the wrist back and forth all day long can irritate the nerve if you do it enough. (Px4)

Dr. Rotman opined that Petitioner's condition was indeed bilateral carpal tunnel and needed to be surgically repaired but that after watching videos of her work environment that, "there was no relationship between her idiopathic carpal tunnel condition and the job activities that she did". Dr. Rotman based his opinion that the activities he reviewed on the tape did not involve any heavy gripping or any significant force to the hands. Dr. Rotman also testified that he did not believe the type of work petitioner performed would not have caused the petitioner to go from a normal nerve study to an advanced carpal tunnel study within a period of a few months. Dr. Rotman opined that it would be impossible for petitioner to have a normal nerve study based on the EMG/NCV results of May 2, 2016. When he was asked about the pre-employment nerve conduction study that was performed, Dr. Rotman said that it was not a reliable test, a mediocre test and not the type of test upon which he would rely. On cross examination Dr. Rotman admitted that he didn't even know exactly which nerve test was used. (Rx1)

Petitioner offered the following medical bills into evidence as Petitioner's Exhibit 5:

Dr. Hayes	$183.00
RIC/SIH	$730.00
Orthopedic Center of So. Ill.	$435.00
Total	$1,348.00

CONCLUSIONS OF LAW

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

It is not disputed that the petitioner performed highly repetitive assembly work in a factory setting. All doctors agree that the petitioner has Bilateral Carpal Tunnel Syndrome and that she is a surgical candidate. The Arbitrator relies on the opinions of Dr. Ahn that the repetitive nature of the petitioner's job duties described by the petitioner either caused the petitioner's carpal tunnel syndrome or at least aggravated her carpal tunnel symptomology to the point where a surgical release is needed. The Arbitrator notes that petitioner's testimony that she was not suffering carpal tunnel symptoms prior to her employment is unrebutted. In fact, that testimony is at least somewhat supported by the findings reported in the petitioner's pre-employment testing performed on November 13, 2015.

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

Both physicians involved in this case agreed that the medical services provided to Petitioner have been reasonable and necessary. The Arbitrator finds that medical bills (as set forth in Petitioner's Exhibit 5) are the financial responsibility of the Respondent pursuant to the Illinois Medical Fee schedule.

K). Is Petitioner entitled to any prospective medical care?

The Arbitrator finds that Petitioner is entitled to the bilateral carpal tunnel release procedure (and post-operative care) that has been recommended and by Dr. Ahn.

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

VERA GRANT,

Petitioner,

vs.

NO: 07 WC 10304

CHICAGO TRANSIT AUTHORITY,

18IWCC0091

Respondent.

DECISION AND OPINION ON REVIEW

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

In affirming and adopting the Decision of the Arbitrator, the Commission is not convinced Petitioner sincerely desires to participate in the vocational rehabilitation that she seeks. The arbitration hearing records indicates Respondent provided Petitioner with vocational rehabitation services. Before the Commission on January 8, 2018, Petitioner's attorney acknowledged Petitioner abandoned the provided-for vocational rehabilitation services. No explanation was found in the arbitration hearing records to allow the Commission to believe Petitioner's abandonment of the provided-for vocational rehabilitation services was done for any reason beyond Petitioner's control.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 28, 2016, is hereby affirmed and adopted.

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

18IWCC0091

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

The 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 - 9 2018
KWL/mav
o010818
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GRANT, VERA
Employee/Petitioner

Case# **07WC010304**

07WC044308
09WC002519

CTA
Employer/Respondent

18IWCC0091

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

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

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

0150 DAVENPORT & WHITE
WILLIAM J WHITE
7667 W 95TH ST SUITE 101
HICKORY HILLS, IL 60457

0515 CHICAGO TRANSIT AUTHORITY
ARGY KOUTSIKOS
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

18IWCC0091

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

Vera Grant
Employee/Petitioner

v.

CTA
Employer/Respondent

Case # **07 WC 10304**

Consolidated cases:
07 WC 44308
09 WC 02519

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gary Gale**, Arbitrator of the Commission, in the city of **Chicago**, on **6/13/16**. 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 **2/13/07**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**52,832**; the average weekly wage was $**1,016.00**.

On the date of accident, Petitioner was **49** years of age, ***single*** with **0** dependent children.

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

Respondent *has* 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 $ under Section 8(j) of the Act.

ORDER

On the disputed issue of Causal Connection the Arbitrator finds that because the Petitioner undisputedly did sustain an intervening accident on 1/12/09 to the same knee; where there is a causal connection between Petitioner's current condition of ill-being and the accident; **that there is no causal connection between the accident of 2/13/07; and the current condition of ill-being .**

On the disputed issue of Permanent Partial Disability the Arbitrator finds that as the Petitioner did sustain an intervening accident on 1/12/09 to the left knee prior to reaching MMI **there is no causal connection between the accident of 2/13/07 and the current condition of ill-being;** ~~and the amount of Permanent Partial~~ Disability is addressed under case number 09 WC 0251, **that this issue is moot for this case.**

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

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

Signature of Arbitrator

12/23/16
Date

DEC 28 2016

Attachment A 18IWCC0091

Vera Grant –v- CTA Outstanding Medical Bills

(J) Were the Medical services that were provided to Petitioner reasonable and necessary? Has Respondent?
Petitioner at the time of trial introduced 10 bills that are addressed individually below.

Due to the Gordian Knot presented by her three claimed accidents and the overlapping care in terms of dates of treatment as well as the Arbitrator finding only two of the three claimed accidents compensable; this portion of the decision will be included in each of the three cases at bar.

Regarding the $998.03 balance from Dr. Silver the Arbitrator finds that after reviewing the bill and comparing the doctor's office dictation to the dates of service as well as payments and adjustments made for the same CPT codes with in the same calendar year finds that based upon page 721 of Dr. Silver's records the treatment was for the left knee, and the Respondent is liable for CPT code 99213 for the office visit of October 31, 2012 in the amount of $68.58 noting that based upon the bill presented the doctor accepted that amount in payment for the same CPT code less than a month later on November 28, 2012.

The Arbitrator further finds that based upon the review of the doctor's office dictation on 10/30/13 (page 308), 1/8/14 (page 312), 3/12/14 (page 317), and 5/28/14 (page 323) the treatment was rendered to Petitioner's right knee. The Arbitrator finds Dr. Wolin more credible than Dr. Silver on the question of causation for the right knee condition, finding the right knee condition to be function of Petitioner's body habitus rather than "overcompensation" and therefore non-compensable. As a result the billing for all four of those appointments is denied.

The Arbitrator finds that after reviewing pages 213-436 of the ATI Physical Therapy records that on all of the claimed dates of service the Petitioner was treated for either solely the left knee or arguably both knees during Work Hardening and such exercises as core strengthening it is impossible for the Arbitrator to parse which portions of the charges are attributable to each leg; so all of these physical therapy bills are awarded with the proviso that as indicated on the Commission's own website that pursuant to the National Correct Coding Initiative that CPT code 97010 is always unbundling and the charge should not be payable under the Fee Schedule [upheld by the Appellate Court in Tiburzi Chiropractic, an Ill. Corp. v. Kline, 996 N.E.2d 1164, 375 Ill.Dec. 108 (Ill. App., 2013)] and those charges are specifically disallowed.

The Arbitrator finds that the billing from Instant Care/Royal First Assistants is denied as the Illinois Workers Compensation Medical Fee Schedule under its Assistant at Surgery Chart for the date of surgery states, "0=No payment for assistant unless supporting documentation is submitted to establish medical necessity." and no such supporting documentation was supplied with the bills and records at time of trial. Therefore the billing from Instant Care/Royal First Assistants for the 4/22/09 date of service is denied.

The Arbitrator notes that the Petitioner presented two bills for the 9/19/07 surgery performed by Dr. Silver at the Peterson Surgicenter. The operative report appears at pages 19-20 of Dr. Silver's records and is for the first compensable left knee injury and there is no evidence that the treatment was unreasonable.

The Arbitrator finds that the billing from Dr. Desai Virendra for 9/19/07 for $1,200 under CPT Code 01400 which is for anesthesia during the knee procedure. The Medical Fee Schedule does not provide a

specific dollar amount for Code 01400 for that date of service in an ambulatory surgical center for that geographic area. Section 8.2 states that when a correct code is inputted to the medical fee schedule and no dollar figure results; that for charges incurred prior to September 1, 2011 that a 76% default applies. Therefore the 9/19/07 bill of Dr. Virendra is awarded at $912.00.

The Arbitrator finds that the billing from the Peterson Surgicenter for 9/19/07 to be more problematic. The Arbitrator notes that only one CPT code –29874—was provided. The Arbitrator awards that charge--- $3,350—at the face value amount which is less than the fee schedule amount because Section 8(a) of the Act states:

Section 8. (a) The employer shall provide and pay the negotiated rate, if applicable, or the lesser of the health care provider's actual charges or according to a fee schedule, subject to Section 8.2, in effect at the time the service was rendered for all the necessary first aid, medical and surgical services, and all necessary medical, surgical and hospital services thereafter incurred, limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury, even if a health care provider sells, transfers, or otherwise assigns an account receivable for procedures, treatments, or services covered under this Act.

The remainder of the facility charges from Peterson Surgicenter for 10/19/07 only have revenue codes and not HCPCS and/or CPT codes; despite the Arbitrator specifically requesting that the Petitioner's attorney obtain those codes. Without the CPT/HCPCS codes the bills cannot simply be awarded "pursuant to the fee schedule" as they cannot be reduced to the fee schedule without the proper coding. Further from reviewing the operative report, the Arbitrator is at a complete loss as to how 119 units of medical supplies could have been expended during an arthroscopic debridement with removal of loose bodies or how there could legitimately be an additional $2,019.97 in anesthesia charges which were lacking the necessary data sets to determine the appropriate charge pursuant to the fee schedule. As a result all of the charges for the 9/19/07 surgery other than the $3,350 under CPT code 29874 are denied due to a failure of proof.

The Arbitrator awards all of the charges from Dr. Thornton to be paid pursuant to the Workers Compensation Medical Fee Schedule.

The Arbitrator notes that all of the charges from Oak Park Hospital were for Emergency Room Charges and that for the Petitioner's dates of service under 50 Illinois Administrative Code 7110.90(4) all emergency room charges were being paid at 76% the Arbitrator awards =$3,339.73 ($4,394.38 X 76% =$3,339.73)

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

VERA GRANT,

Petitioner,

vs. NO: 07 WC 44308

CHICAGO TRANSIT AUTHORITY,

Respondent.

18IWCC0092

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 28, 2016 is hereby affirmed and adopted.

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

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

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.

18IWCC0092

DATED: FEB - 9 2018
KWL/mav
O: 01/08/18
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GRANT, VERA
Employee/Petitioner

Case# **07WC044308**

07WC010304
09WC002519

CTA
Employer/Respondent

18IWCC0092

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

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

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

0150 DAVENPORT & WHITE
WILLIAM J WHITE
7667 W 95TH ST SUITE 101
HICKORY HILLS, IL 60457

0515 CHICAGO TRANSIT AUTHORITY
ARGY KOUTSIKOS
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Vera Grant
Employee/Petitioner

v.

CTA
Employer/Respondent

Case # **07 WC 44308**

Consolidated cases:
07 WC 10304
09 WC 02519

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gary Gale**, Arbitrator of the Commission, in the city of **Chicago**, on **6/13/16**. 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 **2/13/07**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$52,832**; the average weekly wage was **$1,016.00**.

On the date of accident, Petitioner was **49** years of age, ***single*** with **0** dependent children.

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

Respondent *has* 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 $ under Section 8(j) of the Act.

ORDER

On the disputed issue of Causal Connection the Arbitrator finds that while the Petitioner did sustain an intervening accident on 1/12/09; that was the undisputed accident where there is no causal connection issue and is adjudicated under case number 9 WC 0251, and as all Permanency is addressed in that matter that this issue is moot.

For Medical See Attachment A.

On the disputed issue of Permanent Partial Disability the Arbitrator finds that as the Petitioner did sustain an intervening accident on 1/12/09 prior to reaching MMI; and the amount of Permanent Partial Disability is addressed in that matter issue and is adjudicated under case number 9 WC 0251, that this issue is moot for this case.

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

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

Signature of Arbitrator

12/23/16
Date

DEC 28 2016

Attachment A

Vera Grant –v- CTA Outstanding Medical Bills

(J) Were the Medical services that were provided to Petitioner reasonable and necessary? Has Respondent? Petitioner at the time of trial introduced 10 bills that are addressed individually below.

Due to the Gordian Knot presented by her three claimed accidents and the overlapping care in terms of dates of treatment as well as the Arbitrator finding only two of the three claimed accidents compensable; this portion of the decision will be included in each of the three cases at bar.

Regarding the $998.03 balance from Dr. Silver the Arbitrator finds that after reviewing the bill and comparing the doctor's office dictation to the dates of service as well as payments and adjustments made for the same CPT codes with in the same calendar year finds that based upon page 721 of Dr. Silver's records the treatment was for the left knee, and the Respondent is liable for CPT code 99213 for the office visit of October 31, 2012 in the amount of $68.58 noting that based upon the bill presented the doctor accepted that amount in payment for the same CPT code less than a month later on November 28, 2012.

The Arbitrator further finds that based upon the review of the doctor's office dictation on 10/30/13 (page 308), 1/8/14 (page 312), 3/12/14 (page 317), and 5/28/14 (page 323) the treatment was rendered to Petitioner's right knee. The Arbitrator finds Dr. Wolin more credible than Dr. Silver on the question of causation for the right knee condition, finding the right knee condition to be function of Petitioner's body habitus rather than "overcompensation" and therefore non-compensable. As a result the billing for all four of those appointments is denied.

The Arbitrator finds that after reviewing pages 213-436 of the ATI Physical Therapy records that on all of the claimed dates of service the Petitioner was treated for either solely the left knee or arguably both knees during Work Hardening and such exercises as core strengthening it is impossible for the Arbitrator to parse which portions of the charges are attributable to each leg; so all of these physical therapy bills are awarded with the proviso that as indicated on the Commission's own website that pursuant to the National Correct Coding Initiative that CPT code 97010 is always unbundling and the charge should not be payable under the Fee Schedule [upheld by the Appellate Court in Tiburzi Chiropractic, an Ill. Corp. v. Kline, 996 N.E.2d 1164, 375 Ill.Dec. 108 (Ill. App., 2013)] and those charges are specifically disallowed.

The Arbitrator finds that the billing from Instant Care/Royal First Assistants is denied as the Illinois Workers Compensation Medical Fee Schedule under its Assistant at Surgery Chart for the date of surgery states, "0=No payment for assistant unless supporting documentation is submitted to establish medical necessity." and no such supporting documentation was supplied with the bills and records at time of trial. Therefore the billing from Instant Care/Royal First Assistants for the 4/22/09 date of service is denied.

The Arbitrator notes that the Petitioner presented two bills for the 9/19/07 surgery performed by Dr. Silver at the Peterson Surgicenter. The operative report appears at pages 19-20 of Dr. Silver's records and is for the first compensable left knee injury and there is no evidence that the treatment was unreasonable.

The Arbitrator finds that the billing from Dr. Desai Virendra for 9/19/07 for $1,200 under CPT Code 01400 which is for anesthesia during the knee procedure. The Medical Fee Schedule does not provide a specific dollar amount for Code 01400 for that date of service in an ambulatory surgical center for that geographic area. Section 8.2 states that when a correct code is inputted to the medical fee schedule and no dollar figure results;

that for charges incurred prior to September 1, 2011 that a 76% default applies. Therefore the 9/19/07 bill of Dr. Virendra is awarded at $912.00.

The Arbitrator finds that the billing from the Peterson Surgicenter for 9/19/07 to be more problematic. The Arbitrator notes that only one CPT code –29874—was provided. The Arbitrator awards that charge--- $3,350—at the face value amount which is less than the fee schedule amount because Section 8(a) of the Act states:

> Section 8. (a) The employer shall provide and pay the negotiated rate, if applicable, or the lesser of the health care provider's actual charges or according to a fee schedule, subject to Section 8.2, in effect at the time the service was rendered for all the necessary first aid, medical and surgical services, and all necessary medical, surgical and hospital services thereafter incurred, limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury, even if a health care provider sells, transfers, or otherwise assigns an account receivable for procedures, treatments, or services covered under this Act.

The remainder of the facility charges from Peterson Surgicenter for 10/19/07 only have revenue codes and not HCPCS and/or CPT codes; despite the Arbitrator specifically requesting that the Petitioner's attorney obtain those codes. Without the CPT/HCPCS codes the bills cannot simply be awarded "pursuant to the fee schedule" as they cannot be reduced to the fee schedule without the proper coding. Further from reviewing the operative report, the Arbitrator is at a complete loss as to how 119 units of medical supplies could have been expended during an arthroscopic debridement with removal of loose bodies or how there could legitimately be an additional $2,019.97 in anesthesia charges which were lacking the necessary data sets to determine the appropriate charge pursuant to the fee schedule. As a result all of the charges for the 9/19/07 surgery other than the $3,350 under CPT code 29874 are denied due to a failure of proof.

The Arbitrator awards all of the charges from Dr. Thornton to be paid pursuant to the Workers Compensation Medical Fee Schedule.

The Arbitrator notes that all of the charges from Oak Park Hospital were for Emergency Room Charges and that for the Petitioner's dates of service under 50 Illinois Administrative Code 7110.90(4) all emergency room charges were being paid at 76% the Arbitrator awards =$3,339.73 ($4,394.38 X 76% =$3,339.73)

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

VERA GRANT,

Petitioner,

vs. NO: 09 WC 002519

CHICAGO TRANSIT AUTHORITY,

Respondent.

18IWCC0093

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 28, 2016 is hereby affirmed and adopted.

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

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

18IWCC0093

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 - 9 2018
KWL/mav
O: 01/08/18
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GRANT, VERA
Employee/Petitioner

Case# **09WC002519**

07WC010304
07WC044308

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

18IWCC0093

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

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

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

0150 DAVENPORT & WHITE
WILLIAM J WHITE
7667 W 95TH ST SUITE 101
HICKORY HILLS, IL 60457

0515 CHICAGO TRANSIT AUTHORITY
ARGY KOUTSIKOS
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

18IWCC0093

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

Vera Grant
Employee/Petitioner

v.

CTA
Employer/Respondent

Case # **09 WC 02519**

Consolidated cases:
07 WC 10304
07 WC 44308

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gary Gale**, Arbitrator of the Commission, in the city of **Chicago**, on **6/13/16**. 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 **Credit for payments made by Petitioner's other employer for the 11 weeks she was working for M3 Medical Management at $18.00/hour while also receiving TTD.**

FINDINGS

On **1/12/09**, 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 **$56,056**; the average weekly wage was **$1,078.00**.

On the date of accident, Petitioner was **51** years of age, ***single*** with **0** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **$242,612.42** for TTD, **$0** for TPD, **$0** for maintenance, and $ for other benefits, for a total credit of **$242,612.42**. Respondent is entitled to a credit of $242,612.42

Respondent is entitled to a credit of **$59,243.82** under Messamore –v- Industrial Commission for overpayment of TTD benefits and that $59,243.82 is an offset against the Permanent Partial Disability award.

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

ORDER

On the issues of (K) TTD the Arbitrator finds that the Petitioner is entitled to TTD for the periods of 10/9/09-1/19/10; and 8/17/10-11/19/14 for a total period of 255 1/7 weeks.

The Arbitrator finds that when the Petitioner felt she needed to work she found a job paying $18.00/hour; and she was able to work that job for 11 weeks until it ended. There is no indication that at that point she attempted to find similar jobs. Her follow up job search was at best half-hearted. By her own testimony during the first year she was only making 1 contact per day using her phone for emails and without a resume; and the second year two contacts per day. Petitioner also testified that fully half the jobs she applied for were beyond her physical abilities. She also testified that many of the 3,000 jobs she applied for required secretarial skills that she did not possess. Her attempts to find work were even when viewed in the most favorable light insufficient. However regardless of how ineffectual the Petitioner's job search was prior to 11/19/14; the Respondnte offered no evidence that she was able to work prior to that date, so the Arbitrator can only speculate as to whether she was unable to work prior to that date which is not allowed under *Arbuckle –v- Industrial Commission.*

The Arbitrator finds that the amount of TTD owed equals $183,368.32 which has already been paid.

On the issue of (L) Nature and Extent the Arbitrator finds that none of her medical records support a finding of total permanent disability.

The Arbitrator notes that due to the date of accident that Section 8.1 regarding the factors to be considered in finning permanent partial disability is inapplicable.

The Arbitrator finds most salient, that while the Petitioner has permanent light duty restrictions, she was when she had those selfsame restrictions able to find a job paying $18.00 per hour. While the Arbitrator believes an 8(d)1 award would have been more appropriate, the Act allows the Petitioner to choose her own remedy and she has opted for an award under Section 8(d)2. Given that the Petitioner has opted for an 8(d)2 award the Arbitrator believes that this is a loss of trade case. In line with other loss of trade awards and the recommendation by Respondent's own counsel in closing arguments the Arbitrator awards 40% Person as a whole (200 weeks) to be paid at the PPD rate of $646.08 X 200 weeks equaling $129,216.00 less the credit of $59,243.82 described below.

On the issue of (N) Credit the Arbitrator finds that as the parties have stipulated that $242,612.44 has already been paid and the Arbitrator found that due to the Petitioner's demonstrated ability to work at an $18.00 hour job and terminated TTD consistent with that date; that the amount of TTD that was due to the Petitioner was $183,368.62 that the Respondent is entitled to a credit of $59,243.82 against the Permanent Partial Disability owed pursuant to Messamore –v- Industrial Commission.

On the issue of (O) Other the Arbitrator finds nothing in the Act that allows him to provide a credit for payment made by an entity other than the employer. He therefore cannot award that money as a credit. As the Arbitrator found that Petitioner's entitlement to TTD was terminated as of the date she started working at M3 Medical Management as addressed above under (N) credit this issue is moot.

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

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

Signature of Arbitrator

12/23/16
Date

DEC 28 2016

Attachment A

18IWCC0093

Vera Grant –v- CTA Outstanding Medical Bills

(J) Were the Medical services that were provided to Petitioner reasonable and necessary? Has Respondent?
Petitioner at the time of trial introduced 10 bills that are addressed individually below.

Due to the Gordian Knot presented by her three claimed accidents and the overlapping care in terms of dates of treatment as well as the Arbitrator finding only two of the three claimed accidents compensable; this portion of the decision will be included in each of the three cases at bar.

Regarding the $998.03 balance from Dr. Silver the Arbitrator finds that after reviewing the bill and comparing the doctor's office dictation to the dates of service as well as payments and adjustments made for the same CPT codes with in the same calendar year finds that based upon page 721 of Dr. Silver's records the treatment was for the left knee, and the Respondent is liable for CPT code 99213 for the office visit of October 31, 2012 in the amount of $68.58 noting that based upon the bill presented the doctor accepted that amount in payment for the same CPT code less than a month later on November 28, 2012.

The Arbitrator further finds that based upon the review of the doctor's office dictation on 10/30/13 (page 308), 1/8/14 (page 312), 3/12/14 (page 317), and 5/28/14 (page 323) the treatment was rendered to Petitioner's right knee. The Arbitrator finds Dr. Wolin more credible than Dr. Silver on the question of causation for the right knee condition, finding the right knee condition to be function of Petitioner's body habitus rather than "overcompensation" and therefore non-compensable. As a result the billing for all four of those appointments is denied.

The Arbitrator finds that after reviewing pages 213-436 of the ATI Physical Therapy records that on all of the claimed dates of service the Petitioner was treated for either solely the left knee or arguably both knees during Work Hardening and such exercises as core strengthening it is impossible for the Arbitrator to parse which portions of the charges are attributable to each leg; so all of these physical therapy bills are awarded with the proviso that as indicated on the Commission's own website that pursuant to the National Correct Coding Initiative that CPT code 97010 is always unbundling and the charge should not be payable under the Fee Schedule [upheld by the Appellate Court in Tiburzi Chiropractic, an Ill. Corp. v. Kline, 996 N.E.2d 1164, 375 Ill.Dec. 108 (Ill. App., 2013)] and those charges are specifically disallowed.

The Arbitrator finds that the billing from Instant Care/Royal First Assistants is denied as the Illinois Workers Compensation Medical Fee Schedule under its Assistant at Surgery Chart for the date of surgery states, "0=No payment for assistant unless supporting documentation is submitted to establish medical necessity." and no such supporting documentation was supplied with the bills and records at time of trial. Therefore the billing from Instant Care/Royal First Assistants for the 4/22/09 date of service is denied.

The Arbitrator notes that the Petitioner presented two bills for the 9/19/07 surgery performed by Dr. Silver at the Peterson Surgicenter. The operative report appears at pages 19-20 of Dr. Silver's records and is for the first compensable left knee injury and there is no evidence that the treatment was unreasonable.

The Arbitrator finds that the billing from Dr. Desai Virendra for 9/19/07 for $1,200 under CPT Code 01400 which is for anesthesia during the knee procedure. The Medical Fee Schedule does not provide a specific dollar amount for Code 01400 for that date of service in an ambulatory surgical center for that geographic area. Section 8.2 states that when a correct code is inputted to the medical fee schedule and no dollar figure results; that for charges incurred prior to September 1, 2011 that a 76% default applies. Therefore the 9/19/07 bill of Dr. Virendra is awarded at $912.00.

The Arbitrator finds that the billing from the Peterson Surgicenter for 9/19/07 to be more problematic. The Arbitrator notes that only one CPT code –29874—was provided. The Arbitrator awards that charge--- $3,350—at the face value amount which is less than the fee schedule amount because Section 8(a) of the Act states:

~~Section 8. (a) The employer shall provide and pay the negotiated rate, if applicable, or the lesser of the health care provider's actual charges or according to a~~ fee schedule, subject to Section 8.2, in effect at the time the service was rendered for all the necessary first aid, medical and surgical services, and all necessary medical, surgical and hospital services thereafter incurred, limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury, even if a health care provider sells, transfers, or otherwise assigns an account receivable for procedures, treatments, or services covered under this Act.

The remainder of the facility charges from Peterson Surgicenter for 10/19/07 only have revenue codes and not HCPCS and/or CPT codes; despite the Arbitrator specifically requesting that the Petitioner's attorney obtain those codes. Without the CPT/HCPCS codes the bills cannot simply be awarded "pursuant to the fee schedule" as they cannot be reduced to the fee schedule without the proper coding. Further from reviewing the operative report, the Arbitrator is at a complete loss as to how 119 units of medical supplies could have been expended during an arthroscopic debridement with removal of loose bodies or how there could legitimately be an additional $2,019.97 in anesthesia charges which were lacking the necessary data sets to determine the appropriate charge pursuant to the fee schedule. As a result all of the charges for the 9/19/07 surgery other than the $3,350 under CPT code 29874 are denied due to a failure of proof.

The Arbitrator awards all of the charges from Dr. Thornton to be paid pursuant to the Workers Compensation Medical Fee Schedule.

The Arbitrator notes that all of the charges from Oak Park Hospital were for Emergency Room Charges and that for the Petitioner's dates of service under 50 Illinois Administrative Code 7110.90(4) all emergency room charges were being paid at 76% the Arbitrator awards =$3,339.73 ($4,394.38 X 76% =$3,339.73)

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Larry Watson,
Petitioner,
vs.

NO: 15WC 29529

Knauz Motor Sales, Inc.,
Respondent.

18IWCC0094

DECISION AND OPINION ON REVIEW

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

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

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $67,000.00. 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.

FEB - 9 2018

DATED:
o121217
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MATSON, LARRY
Employee/Petitioner

Case# **15WC029529**

KNAUZ MOTOR SALES INC
Employer/Respondent

18IWCC0094

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:

4835 MARKHAM M JEEP & ASSOC
GRAHAM J JEEP
200 N MARTIN L KING JR AVE
WAUKEGAN, IL 60085

2623 McANDREWS & NORGLE LLC
MICHAEL P LATZ
53 W JACKSON BLVD SUITE 315
CHICAGO, IL 60604

STATE OF ILLINOIS)
)SS.
COUNTY OF Lake)

☐ 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

Case # 15 WC 29529

Consolidated cases: N/A

Larry Matson
Employee/Petitioner

v.

Knauz Motor Sales, 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 **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Waukegan**, 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 _____

FINDINGS

On **July 7, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$13,316.56**; the average weekly wage was **$289.49**.

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

Petitioner ***has not*** received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **$2,608.57** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$2,608.57**.

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 $220.00/week for 38 4/7 weeks, commencing July 30, 2015 through August 11, 2015 and September 11, 2015 through May 24, 2015, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $2,608.57 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $23,869.41 to the providers as listed in the finding with respect to Medical herein, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $220.00/week for 43 weeks, because the injuries sustained caused the 20% loss of the Left Leg, as provided in Section 8(e)12 of the Act.

Respondent shall pay to Petitioner penalties of **$5,949.31**, as provided in Section 16 of the Act; **$14,873.28** as provided in Section 19(k) of the Act; and **$7,110.00**, as provided in Section 19(l) of the Act.

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

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

Signature of Arbitrator

July 14, 2016
Date

ICArbDec p. 2

JUL 25 2016

18IWCC0094

Statement of Facts

Petitioner Larry Matson testified that he had been employed by Respondent Knauz Motor Sales since 2013 as a manager of the logistics department. His duties included shuttling customers, pick up and delivery of vehicles for service. This was a part time job. He was previously employed for 23 years by the Illinois Department of Transportation initially as a highway maintainer and heavy equipment operator, then as a foreman and engineering technician. He then was employed by the City of Waukegan for 13 years as safety director until he retired in 2009. His duties included writing policy and accident investigation and conducting safety sessions. He also taught Advanced Safety at College of Lake County.

Petitioner testified that on July 7, 2015, he was looking for an employee to locate a missing vehicle. He was in the BMW showroom when he walked into a glass wall. Petitioner testified he broke his nose and bounced back and twisted. He was bleeding from his nose. Petitioner testified that he was walking at a normal pace. He struck the wall with his whole body, nose first. He testified he struck the wall at a 45 degree angle with the right side closer and the left side away from the wall. He testified that he spoke with someone at the time of the impact. He does not know who it was because the person was behind him.

He testified he went to the men's room and pushed his nose back in place. The walk was about 15 feet. He was bleeding but not copiously at that time. The blood was covering his hands, but not falling onto the floor. He had his hands over his face. His nose was to the left side. He testified he has broken his nose three times before. He then walked back to the Mercedes building where his office was located and continued his duties. He spoke with a couple of coworkers about it and they had a good giggle. He testified he was limping and his left knee felt irritated. Petitioner admitted Petitioner's Exhibits 1 and 2, photos of his nose taken by his girlfriend on the date of the accident.

Petitioner testified he had a prior injury to his left knee in 1994 when he struck a gas meter and hyper extended his knee. He has surgery in March, 1995 by Dr. Hamming. Petitioner testified he had a full recovery. Petitioner testified to a back injury in 2005 when he stepped in a hole. He had a two level lumbar fusion. He has had surgery on his left leg in 2002 for a melanoma below the knee. They took lymph nodes out. He had swelling in his ankle. This is separate from his knee. He has also had other cancer surgeries. He did not take any pain medication for that condition. He had been an active distance runner, golfer, and fisherman. He had enjoyed camping and yardwork on his 6 ½ acre property including gardening. He testified that he build a cabin in 2009 including hand carrying the materials. Immediately before July 7, 2015 he had no problems with his left knee.

Petitioner testified that on July 14, 2015, he was having pain in his left knee and it was hard to walk. He reported the injury to his supervisor Joe Coleman, head of parts and service. Mr. Coleman told him to report the accident to Traci Weaver in Human Resources. He reported the accident to Ms. Weaver that same day. He testified that on July 29, 2015 that he spoke with Tracy Weaver and told her he was not coming into work because of pain and was going to see his own doctor.

Curt Laczniak testified by evidence deposition taken December 17, 2015 (PX 7). He is employed by Respondent as the used car manager. His desk is on the north end of the BMW showroom. He testified he was at his desk when he heard a loud noise. He turned and it was Larry who had walked into a glass wall behind him. His back was to the wall. He did not see Petitioner actually walk into the wall. He testified he was 10 feet from where Petitioner was standing. He testified Petitioner uttered profanity and was holding his face.

Mr. Laczniak asked him if he was OK and Petitioner said, "yeah, and then embarrassed." Bob Geisheker was also in view and made light of the situation. Mr. Laczniak testified he did not see any blood. He did not notice Petitioner limping. Petitioner did not complain of any injury other than his nose. His entire observation was less than 30 seconds. He is sure he saw Petitioner in the weeks after the accident. He did not see him limping. He has no clear memory of seeing Petitioner walk at any time after July 7, 2015.

John Getner testified by evidence deposition taken December 17, 2015 (PX 5). He is employed by Respondent as driver. His employment is centered in the Mercedes building. Mr. Getner testified he observed Petitioner on the afternoon of July 7, 2015. He observed blood on his nose. Later, after Petitioner sat down, Mr. Getner noticed Petitioner had some trouble getting started walking when he was leaving. He observed Petitioner limping. Over the next several days, he noticed Petitioner limping here and there. He does not remember which leg he was favoring.

Thomas Ehlen testified by evidence deposition taken December 17, 2015 (PX 15). He is employed by Respondent doing pick up and delivery. He testified he saw Petitioner in the early afternoon on July 7, 2015 in the Mercedes building. Petitioner came in with blood around his nose and he was limping. Petitioner told him he ran into a glass panel in the BMW building. Over the next few days, Mr. Ehlen observed Petitioner. He had his nose cleaned up, but he was still limping.

Joseph Coleman testified by evidence deposition taken December 17, 2015 (PX 6). He is employed by Respondent as the parts and service manager. He knows Petitioner. He is Petitioner's boss. He recalls Petitioner came into his office and told him, "I feel so stupid. I walked into a glass wall and I broke my nose and I hurt my knee." Petitioner said it was a few days ago. Mr. Coleman testified he told Petitioner to report to the HR Manager Traci Weaver. They have a very strict policy. He testified Petitioner told him he broke his nose a few times before. Mr. Coleman testified that his impression was that Petitioner thought it was not big deal. Mr. Coleman testified he did not notice Petitioner limping on that date. He did observe him limping and using crutches some time afterwards.

Traci Weaver testified that she is the HR Manager for Respondent. She testified that Petitioner received orientation including the need to report accidents promptly. Petitioner was called Safety Larry because of his prior experience. On July 14, 2015, Petitioner came to her office. He hung his head and was embarrassed. Petitioner told her he had walked into a glass wall. He told her his nose was OK. His leg has been bothering him; his knee has been hurting. She testified she called Lake Forest Acute Care to see Petitioner. Ms. Weaver testified that she prepared a hand written Form 45 (identified as PX 4). The typed Form 45 (PX 3) contains the same information. The Form 45 states "employee walked into a window, injuring nose and knee." Ms. Weaver testified that she received a telephone call from Petitioner on July 30, 2015. He told her he was putting on his socks and his knee popped. He was calling Illinois Bone & Joint to see if he could get in and that he was not coming in to work.

Petitioner testified that on July 30, 2015 he had his left leg over his outstretched right leg and heard a pop in his left knee followed by excruciating pain. Between July 7, 2015 and July 30, 2015, the pain and swelling in the left knee were gradually getting worse.

Petitioner was seen at Lake Forest Acute Care beginning July 14, 2015. The records of Lake Forest Acute Care were admitted as Petitioner's Exhibit 11. Petitioner reported the accident on July 7, 2015. The history was that he walked into a plate glass window. He hit his nose, but not his knee, but twisted his left knee.

Petitioner reported his nose was now better. It was a little crooked, but it was always that way from a prior broken nose. He complained of left knee pain with full flexion, standing from a chair, and walking. The examination noted a positive drawer test, reduced range of motion, and swelling and tenderness of the knee. X-rays noted no acute fracture. Petitioner was diagnosed with a knee sprain and given an ace bandage. He was released to return to duty with restrictions on kneeling, squatting, running and prolonged sitting and standing. On July 21, 2015, Petitioner was advancing the same complaints. He was continued on the same restrictions. Dr. Edelstein noted that he would request an MRI if no improvement in the next week or two. On July 28, 2015, Petitioner's complaints remained the same. He was scheduled for physical therapy and remained on the same restrictions.

Petitioner testified that he sought treatment from Dr. Chams beginning July 29, 2015. He saw Dr. Chams on July 30, 2015 (PX 12) with a history of a work injury on July 7, 2015. Petitioner reports that he ran into a window and twisted his knee approximately one month ago. Petitioner also reported the he woke up this morning and felt a pop in his left knee. Following the pop, the knee swelled up. The physical examination noted swelling and effusion with loss of range of motion. Dr. Chams' assessment was left knee pain, rule out meniscus tear. He ordered an MRI and physical therapy He provided an off work note.

The report of the MRI performed on August 11, 2015 notes an impression of osteoarthritis, a medial patellar plica, a full thickness erosion of the medial femoral articular weigh bearing cartilage, a ganglion cyst, an intraarticular ossicle posterior to the posterior horn of the medial meniscus, and possible mild medial collateral and prepatellar bursitis (PX 9). Dr. Chams impression was a meniscus tear, loose body and patellofemoral chondromalacia. He recommended surgery (PX 9). He allowed Petitioner to return to work pending surgery. He was to continue with physical therapy (PX 12). Dr. Cham's records include a September 11, 2015 note stating Petitioner contacted the office stating his knee pain has gotten significantly worse. He was offered light duty with restrictions, but claims the bathroom is hundreds of feet away. Petitioner is adamant about being off work. He states his restrictions cannot be accommodated. A note was provided for off work, desk work only with no prolonged standing or walking, lifting, carrying, climbing or stairs.

Petitioner was examined at Respondent's request by Dr. Brian Cole on September 24, 2015. His records include a Knee Intake Survey describing the injury as "walked into unmarked full window, twisted knee on impact." A handwritten Initial Intake Survey lists the mechanism of injury as "Fell." Dr. Cole's records also include correspondence received by him prior to the September 24, 2015 examination that states the injury occurred when Petitioner walked into a window, the Form 45 describing the accident as walking into a window, and the medical records of Lake Forest Acute Care, Kenosha Radiology Center and Dr. Chams with the history of accident included (PX 12).

Dr. Cole prepared a report of the examination which was admitted as Respondent's Exhibit 1. The report includes a history of injury that on July 7, 2015, claimant fell while at work fracturing his nose in the process and having immediate onset of left knee pain. Petitioner reported that he had a cortisone injection with temporary relief. He reported constant knee pain as 6/10, ranging in impairment from moderate to extreme. The physical examination reported tenderness to palpation with range of motion from 0-120 degrees with an effusion. Dr. Cole opined that Petitioner's need for treatment is related to the injury. He may have incurred an aggravation of a preexisting condition, but in either regard he has arrived at the need for treatment as a result of this injury. He agrees that arthroscopic surgery is reasonable and necessary as a result of the injury. He states that Petitioner is restricted to sedentary desk work. He needs to get off the crutch.

Petitioner returned to Dr. Chams on December 8, 2015. He continued to walk with an antalgic gait and use of crutches. The note states that Workers Compensation denied surgery due to inconsistencies with the medical history. Petitioner continues to complain of pain, locking and instability of the knee and would like to proceed with surgery under his own insurance (PX 9). Surgery was performed on December 10, 2015. The operative report states that the procedure performed was a left knee arthroscopy with partial medial and lateral meniscectomy and partial chondroplasty of the patellofemoral joint and medial compartment (PX 9). Petitioner testified that he underwent follow up and physical therapy. He testified he had swelling and pain after surgery and a venogram was performed due to concerns about a blood clot. The study performed on December 21, 2015 at the order of Dr. Chams was negative for DVT (PX 9).

Dr. Cole authored an addendum report on February 23, 2016 in response to additional inquiries posed (RX 1). He states that Petitioner's history to him was that he slipped and fell, but also indicated that he twisted in the process with immediate onset of left knee pain. Dr. Cole notes the first report of injury indicates that he walked into a window. This is the history provided to Dr. Chams on July 30, 2015. He notes that Dr. Chams history is somewhat more consistent with what the claimant told him. Dr. Cole opines that twisting is a plausible mechanism to incite knee pain and bring on the need for care. Dr. Cole states that there is certainly some inconsistency in the exact description of the mechanism of injury. There seems to have been enough of an event to incite knee pain such that Petitioner seems to have arrived at a need for care as a result of this injury at work.

Petitioner underwent a Functional Capacity Evaluation at Creative Rehab on May 11, 2016. The report indicates that Petitioner's prior occupation would be sedentary physical demand level with the duties requiring walk, sit and drive. A valid test found Petitioner performed at the medium physical demand level with lifting maximum of 50 pounds, 25 pounds frequently and 10 pounds constantly (PX 13). Petitioner last saw Dr. Chams on May 24, 2016. The Petitioner continued to complain of knee pain. The physical examination noted no swelling or effusion. Range of motion was symmetrical at 0/140 degrees. The left knee is noted to have a positive patellar grind test/crepitus. Petitioner received an injection. Petitioner was placed at MMI and given permanent restrictions per the FCE (PX 10).

Petitioner testified that he is not working. Petitioner does not take pain medication. He does not like them. His knee is painful. In the morning, he is cautious with concerns his left knee will give out. He testified he limps. Walking is difficult. He uses a cart for golf instead of walking the course. He now sleeps on his side with a pillow between his legs. He is limited in doing his yard work. He does not feel comfortable on a ladder. The knee affects his weeding and hand mowing. He uses a utility cart to assist in his work.

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident, the Arbitrator finds as follows:

Petitioner is alleging an accidental injury on July 7, 2015. To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that he suffered an injury that arose out of and in the course of his employment. An injury occurs "in the course of' employment when it occurs during employment and at a place where the claimant may reasonably perform employment duties, and while a claimant fulfills those duties or engages in some incidental employment duties. An injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which

he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties. A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties.

Petitioner testified that on that date, he was looking for an employee to locate a vehicle and while in the BMW showroom, he walked into a glass wall. The accident was confirmed by the testimony of Curt Laczniak, John Getner and Tom Ehlen. Their testimony also confirms that Petitioner sustained injuries when he struck the wall. Petitioner has provided consistent reporting to Respondent on July 14, 2015 and to all of his medical providers. Petitioner's testimony as to his duties is uncontested by Respondent. His accident occurred at a place where he was performing his duties and occurred during the performance of his duties and prerforming acts which he might reasonably be expected to perform incident to his assigned duties..

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that he sustained accidental injuries arising out of and in the course of his employment on July 7, 2015.

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

Based on the Arbitrator's finding with respect to Accident, the Arbitrator finds that Petitioner did sustain an accident arising out of and in the course of his employment when he walked into the glass wall on July 7, 2015. The evidence is uncontested and compelling that he injured his nose at that time. The dispute raised by Respondent is whether Petitioner's condition of ill being in the left knee is causally connected to this accident. Based upon the overwhelming preponderance of the evidence the Arbitrator finds this condition causally connected.

Petitioner admits to a significant prior history of physical injuries and complaints. He testified to a 1994 left knee surgery and surgery on his left leg in 2002 for a melanoma below the knee. He admitted to a 2005 back fusion, several previous broken noses and multiple cancer surgeries. This extensive history is provided to the medical providers as well. Petitioner testified credibly to his physical abilities and activities prior to the July 7, 2015 accident. He was working and performing his other activities at home without problem prior to the accident. Respondent presented no evidence of recent medical care to Petitioner's left knee or leg prior to the accident.

Petitioner testified that after the impact and his initial visit to the men's room, he then walked back to his office. He testified he was limping and his left knee felt irritated. His testimony was corroborated by John Getner and Tom Ehlen. Curt Laczniak testimony that he did not notice Petitioner limping during his brief observation of the Petitioner immediately after the impact is not inconsistent or persuasive that Petitioner did not injure his knee.

The Arbitrator does not find the one week delay in reporting the accident significant given Petitioner's embarrassment at his injury. The immediate reaction from Mr. Laczniak and Bob Geisheker confirm the embarrassing nature of the event, particularly given Petitioner's reputation for safety. When Petitioner reported the injury on July 14, 2015, both Mr. Coleman and Ms. Weaver confirmed the description of the accident, Petitioner's embarrassment at its occurring, and that Petitioner reported injuries to both the nose and left knee. Petitioner's treatment at Lake Forest Acute Care contains a consistent history of accident and notes findings in the left knee sufficient to suggest work restrictions and a recommendation for an MRI. Petitioner's history to

Dr. Chams is also consistent. Although Ms. Weaver testified that she received a telephone call from Petitioner on July 30, 2015 telling her he was putting on his socks and his knee popped, the Arbitrator finds Petitioner's explanation of that event persuasive and views this as a manifestation of the symptoms from the July 7, 2015 accident and not an intervening event.

A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. The rationale justifying the use of the 'chain of events' analysis to demonstrate the existence of an injury would also support its use to demonstrate an aggravation of a preexisting injury.

In the present case, not only does the chain of events analysis produce a sufficient nexus to find causal connection of Petitioner's knee injury to the July 7, 2015 accident, but the medical opinions also support causation. The Lake Forest Acute Care records detail treatment related to the history of the July 7, 2015 accident. Dr. Chams records relate the condition to a work related accident on July 7, 2015. In his September 24, 2015 report, Dr. Cole also specifically finds causal connection of the knee injury and the need for surgery to the July 7, 2015 accident. Even in his addendum requested to address the history he recorded of a fall, Dr. Cole still opines that the twisting reported by Petitioner is a plausible mechanism to incite knee pain and bring on the need for care. Dr. Cole states that there seems to have been enough of an event to incite knee pain such that he seems to have arrived at a need for care as a result of this injury at work.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that he suffered injuries to the nose and left knee causally connected to the accidental injuries sustained on July 7, 2015.

In support of the Arbitrator's decision with respect to (J) Medical, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Accident and Causal Connection, the Arbitrator finds that reasonable and necessary medical treatment for Petitioner's conditions of ill being to the nose and left knee are causally connected to the accidental injuries sustained on July 7, 2015. Petitioner testified he had no treatment for his nose. Petitioner submitted Petitioner's Exhibit 14 alleging medical bills for treatment to Petitioner left knee. Respondent's Exhibit 5 lists payments made by Respondent for treatment rendered. These payments are reflected in the balances listed on PX 14. Petitioner provided revised Medical Expense Summary with his proposed decision. There is no documentation of the analysis contained and the Arbitrator notes that with respect to the bill of Dr. Chams, the proposal is actually higher that the bill submitted. Further, Respondent has had no opportunity to address this proposal or address negotiated rate for the charges.Therefore, the Arbitrator does not give Petitioner's analysis any evidentiary value.

The Arbitrator has reviewed the Exhibits and notes that there are no records in evidence to support the bill of Athletico for treatment from April 7, 2016 through April 27, 2016. This bill is therefore denied. The remaining bills included in PX 14 are for treatment to the left knee supported by the medical records submitted, including:

Northwestern Medical Lake Forest Hospital	$1,402.00
Hawthorn Surgery Center	$10,920.00
Dr. Chams	$2,924.00

United Hospital System	$4,777.50
Dr. Pallin	$1,115.83
Dr. Lichtenberg	$1,350.00
Dr. Mendelson	$206.00
Creative Rehab	$1,174.08

Based upon the record as a whole, the Arbitrator finds that Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $23,869.41 to the providers as listed above, as provided in Sections 8(a) and 8.2 of the Act.

In support of the Arbitrator's decision with respect to (K) Temporary Compensation, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Accident and Causal Connection, the Arbitrator finds that Petitioner is entitled to temporary total compensation for the periods he was disabled as a result of the condition of ill being in his left knee. Petitioner has alleged entitlement to temporary total disability for the periods July 29, 2015 through August 12, 2015 and September 1, 2015 through May 24, 2016, totaling 40 weeks.

Petitioner was initially allowed to work with restrictions by Lake Forest Acute Care. Petitioner was taken off work by Dr. Chams on July 30, 2015. He was returned to full duty pending surgery on August 11, 2015. Petitioner is therefore entitled to temporary total disability benefits from July 30, 2015 through August 11, 2015, a period of 1 6/7 weeks.

Thereafter, Petitioner was again disabled by Dr. Chams beginning September 11, 2015 at Petitioner's request. The note indicates that light duty was offered, but the bathroom was hundreds of feet away. The evidence offered describing Petitioner's job duties and the multiple buildings in which he was required to work confirms the extensive walking required in his job. Dr. Cole confirms in his September 24, 2015 report that Petitioner is restricted to sedentary desk work. The Arbitrator finds that Petitioner was again disabled as of September 11, 2015. Petitioner remained off work and under the care of Dr. Chams until after the completion and review of the FCE and Dr, Chams finding Petitioner at Maximum Medical Improvement on May 24, 2016, an additional period of 36 5/7 weeks.

Based upon the record as a whole, the Arbitrator finds that Petitioner is entitled to a total of 38 4/7 weeks of temporary total disability for the periods from July 30, 2015 through August 11, 2015 and from September 11, 2015 through May 24, 2016 at the minimum rate in effect on the date of accident of $220.00 per week. Per the stipulation of the parties, Respondent shall be given a credit of $2,608.57 for temporary total disability benefits that have been paid.

In support of the Arbitrator's decision with respect to (L) Nature and Extent, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Accident and Causal Connection, the Arbitrator has found that Petitioner sustained injuries to his nose and left knee as a result of the July 7, 2015 accident.

Petitioner testified that he has broken his nose on several prior occasions. His testimony and medical records state that it was crooked before the July 7, 2015 accident. He sought no medical treatment for his nose. Other that his statement that his nose was broken; there is no evidence that he suffered any fracture. The photos taken the same day as the accident depict only that his nose was scraped. They demonstrate no other injury. The Arbitrator finds that Petitioner has failed to prove any permanent partial disability as a result of the injury to his nose suffered on July 7, 2015.

With respect to Petitioner's left knee, Petitioner's date of accident was after September 1, 2011 and therefore the provisions of Section 8.1b of the Act are applicable to the assessment of partial permanent disability in this matter.

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was retired from his employment with the State of Illinois and City of Waukegan. Petitioner also has experience in teaching. He was employed by Respondent part time as a manager of logistics and Red Carpet Valet at the time of the accident. Although he has not returned to work, this job was considered sedentary and the FCE found Petitioner could perform at the medium physical demand level. He is therefore able to return to work in his prior capacity as a result of said injury. Because of these facts, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 60 years old at the time of the accident. This would make Petitioner an older worker. Petitioner had previously retired from his primary employment in safety. He was working part time for Respondent. While Petitioner has not returned to work, he provided no evidence of a job search since being released from medical care. Because of these facts, 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 Petitioner had previously retired from his primary employment in safety. He was working part time for Respondent and has not returned to work or provided any evidence of a job search since being released from medical care. The evidence does not prove that any effect on Petitioner's earning was caused by the work accident. Because of these facts, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner suffered an injury to his left knee requiring left knee arthroscopy with partial medial and lateral meniscectomy and partial chondroplasty of the patellofemoral joint and medial compartment. The FCE released him with restrictions in the medium physical capacity level. While Petitioner advanced significant subjective complaints at trial and outlined the limitations he now experiences in his activities of daily living, hobbies and gardening, the May 24, 2016 notes from Dr. Chams records only complaints of soreness. No swelling or effusion is found and full range of motion. Petitioner does have crepitus. He received an injection and was released to work within the FCE restrictions. Because of these facts, the Arbitrator therefore gives greater weight to this factor, noting the restrictions of the FCE, the subjective limitations testified to by Petitioner, but also the limited objective findings noted by Dr. Chams and the release from care in May, 2016.

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 20% loss of use of the Left Leg pursuant to §8(e)12 of the Act.

In support of the Arbitrator's decision with respect to (M) Penalties, the Arbitrator finds as follows:

Petitioner has filed a Penalty Petition seeking penalties under Sections 19(l) and 19(k) of the Act and attorneys fees pursuant to Section 16 of the Act (PX 16).

Penalties imposed under section 19(l) are in the nature of a late fee. The award of section 19(l) penalties is mandatory if the payment is late, for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay. The standard for determining whether an employer has good and just cause for a delay in payment is defined in terms of reasonableness. The employer bears the burden of justifying the delay, and its justification is sufficient only if a reasonable person in the employer's position would have believed the delay was justified.

Respondent paid timely temporary compensation and medical bills only through August 11, 2015. Thereafter, benefits were stopped pending the receipt of the Section 12 report from Dr. Cole. The Arbitrator finds that this delay was reasonable. But upon receipt of the report which found causal connection and surgery as a reasonable and necessary course of care, benefits were not initiated despite Petitioner's October 30, 2015 demand for medical authorization and reinstatement of temporary total disability. The case was delayed to obtain the addendum report from Dr. Cole, but even this report did not deny causal connection. The Arbitrator finds no reasonable basis to deny benefits after delivery to Petitioner's counsel of Dr. Cole's opinions on October 30, 2015. Petitioner is entitled to Section 19(l) penalties of $30.00 per day from October 30, 2015 through the date of trial on June 22, 2016, a period of 237 days totaling $7,110.00.

The standard for awarding penalties and attorney fees under sections 19(k) and 16 is higher than the standard for awarding penalties under section 19(l) because sections 19(k) and (16) require more than an "unreasonable delay" in payment of benefits. For the award of penalties and attorney fees under sections 19(k) and 16, it is not enough for the claimant to show that the employer simply failed, neglected, or refused to make payment or unreasonably delayed payment without good and just cause. Instead, penalties and attorney fees under sections 19(k) and 16 are intended to address situations where there is not only delay, but the delay is deliberate or the result of bad faith or improper purpose. In addition, while section 19(l) penalties are mandatory, the imposition of penalties and attorney fees under sections 19(k) and 16 is discretionary. In the present case, the Arbitrator finds that Respondent engaged in deliberate delay despite the accumulated evidence clearly demonstrating that Petitioner sustained the accident in question, that the condition of ill being in the left knee was causally connected and that the proposed medical treatment including surgery was reasonable and necessary.

While there may have been initial questions raised in this matter, Respondent's own witnesses confirm that the Petitioner struck the glass wall. He was limping and reported the knee injury within days of the accident. The medical histories are completely consistent as to the mechanism of injury. Any question on this matter was put to rest months before trial during evidence depositions of the co employees taken in December, 2015. More damning, Respondent's own Section 12 examination found the left knee condition causally connected and found the surgery reasonable and necessary. While there was

never any uncertainty as to the Petitioner's statements as to how the injury occurred, Respondent maintained its denial based upon an erroneous history listed in Dr. Cole's report.

During trial evidence was introduced concerning a prior knee injury and surgery. No medical evidence of this prior treatment was offered and Dr. Cole noted this prior condition in his initial report, but still provided an opinion finding causation to the July 7, 2015 accident. Respondent also presented testimony from Ms. Weaver concerning her conversation with Petitioner concerning increased symptoms on July 30, 2015 at home. But Dr. Cole was never presented any question concerning whether this incident would impact his causation opinion and provided an addendum report reasserting his opinion of causal connection to the work injury.

Even after receiving the addendum report which continued to relate Petitioner's need for surgery to the July 7, 2015 work accident, Respondent continued to refuse benefits, despite not one shred of evidence to support the denial from its own employees, the treating medical records or their own evaluating physician. As a result of this unsupported intransigence, Petitioner was unable to obtain medical treatment for months and was without benefits for almost a year. Such delay reaches the level of deliberate and bad faith.

The unpaid temporary total disability is $5,877.14 ($8485.71-$2608.57). The unpaid medical is $23,869.41. Total unpaid benefits owing therefore total $29,746.55.

Based upon the record as a whole, the Arbitrator finds that Petitioner is entitled to attorneys fees of $5,949.31 (20% of $29,746.55), as provided in Section 16 of the Act; $14,873.28 (50% of $29,746.55), as provided in Section 19(k) of the Act; and $7,110.00, as provided in Section 19(l) of the Act.

STATE OF ILLINOIS)
)
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Scott Mitelsztet,
Petitioner,

vs.

No: 05 WC 5253

Logistics Shipping,
Respondent.

18IWCC0095

DECISION AND OPINION PURSUANT TO SECTION 8A

This matter comes before the Commission on petitions filed by both parties. Petitioner has filed a petition for medical benefits under Section 8(a) and seeks penalties and fees. Respondent in turn seeks to terminate "all benefits" under Section 8(a). A hearing was held in Chicago on March 22, 2017 before Commissioner Luskin.

By way of background, the underlying claim arose from work-related injury to the lumbar spine sustained by Petitioner during a June 24, 2004 motor vehicle accident, for which Petitioner eventually underwent lumbar fusion surgery on January 4, 2006. Petitioner's claim was settled by contract approved by the Commission on September 9, 2010. Pursuant to the settlement contract, Petitioner's medical rights were kept open under Section 8(a) pending the funding of an approved Medicare set-aside account.

After considering the entire record, the Commission denies Petitioner's petition for Section 8(a) medical benefits except for the prescription for Flexeril. The petition for penalties and fees is denied. Respondent's motion for termination of remaining Section 8(a) benefits is granted only to the extent that the Commission finds that Petitioner's narcotics regimen is no longer indicated and that he is now an appropriate candidate for a detoxification program, for which program Respondent has offered to pay. Should the detoxification program prove ineffective, nothing in this Opinion and Order precludes Petitioner from filing a new Section 8(a) petition for other or additional treatment. (In other words, the Commission is not terminating "all benefits.")

I. PROCEDURAL HISTORY

Petitioner was involved in a work-related motor vehicle accident on June 24, 2004. Afterwards, Petitioner experienced severe and persistent back pain, and eventually underwent lumbar fusion surgery in January 2006. Petitioner received a lump sum settlement of $402,168.50, and, pursuant to the contract, his medical rights under §8(a) were kept open pending Respondent's funding of an approved Medicare set-aside account ("MSA").

From the date of accident through the present, Respondent paid expenses for Petitioner's chronic back pain (which was reported to be ongoing even after the lumbar surgery). These expenses largely derived from pain management treatment consisting principally of opiate therapy. Additionally, up until around spring 2013, Respondent paid expenses for Petitioner's post-accident deep vein thrombosis (DVT), low testosterone (hypogonadism), sleep dysfunction, and constipation, which conditions were asserted -- then as now -- to be sequelae from the June 2004 injury.

In May 2013, Respondent began discontinuing payment for Petitioner's medications for DVT, low testosterone, sleep dysfunction and constipation. As grounds, Respondent cited the opinions of its medical experts, who deemed these conditions to be unrelated to the June 2004 injury. Respondent continued to pay for Petitioner's opioid medications.

On April 9, 2014, Petitioner filed his original petitions for Section 8(a) benefits and for penalties and fees under Sections 19(k), 19(l) and 16 (amended petitions were filed in June 2014). Specifically, Petitioner alleged Respondent's wrongful refusal to authorize or pay for the following medications: (1) Coumadin (a/k/a Warfarin), an anticoagulant for treatment of his DVT; (2) AndroGel, a testosterone replacement product for treatment of hypogonadism; and (3) Ambien (a/k/a zolpidem), the sleep medication. Currently, Petitioner also seeks payment for: (4) Flexeril (cyclobenzaprine), a muscle relaxant; and (5) Senna, a medication to treat constipation reported to be a side effect of the opiates.

On March 22, 2016, Respondent filed a motion to terminate benefits under Section 8(a). In that motion, in addition to arguing that many of Petitioner's prescription medicines were not related to his work-related back injury, Respondent contended that Petitioner was no longer a candidate for the narcotics regimen that he has been on for years. According to Respondent's independent medical examiner (IME), Petitioner has become opioid tolerant to the point where the opiates have no effect and may even be increasing his pain. In its motion (and at hearing), Respondent made reference to its offer to pay for Petitioner to be enrolled in addiction therapy or an alternative pain management program to wean him off opiates, i.e., a detoxification program. Currently, as set out in Respondent's post-hearing brief, Respondent contends that even Petitioner's current chronic pain is unrelated to the work-related back injury and wholly arises from non-lumbar issues including diabetic neuropathy. Thus, Respondent seeks to terminate "all benefits" under Section 8(a).

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II. FACTUAL BACKGROUND

At the March 22, 2017 hearing before Commissioner Luskin, Petitioner presented live testimony.[1] Also admitted were voluminous medical records. Regarding expert medical testimony, Respondent submitted the evidence depositions of two IME physicians: pain specialist Dr. Howard Konowitz and neurologist Dr. Francisco Espinosa. (RX 3; RX 5). As well, Respondent presented the written report of Dr. Gregory Bales after medical records review. (RX 1). Petitioner submitted the evidence depositions of two treating physicians: pain specialist Dr. Jeffrey Oken and family practitioner Dr. Jay Thakkar. (PX 5; PX 7). The expert testimony is discussed in Section III of this Opinion and Order.

Accident and lumbar surgery: On June 24, 2004, Petitioner, then 37, was making deliveries for Respondent when he was involved in a motor vehicle accident. The next day, he had onset of pain in his lower back, neck, and right shoulder. (Tr. 10-11). Most severe and persistent was his back pain. After conservative treatment, including physical therapy and lumbar injections, failed to relieve the pain, on January 4, 2006, he underwent a two-level lumbar fusion at L4-5 and L5-S1 and laminectomy at L3-4. This surgery was performed at Delnor Hospital by Dr. Craig Popp of Fox Valley Orthopedics. (PX 2; RX 13).

After the surgery, Petitioner noticed burning and stinging pain in both anterolateral thighs. He underwent additional physical therapy, which again was not helpful. In December 2006, Dr. Popp indicated that there was nothing more he (Dr. Popp) could do for Petitioner's ongoing complaints. (Tr. 65). During this time, Petitioner was seeing Dr. Wayne Polek of Delnor Hospital for pain control. Around January 2007, Dr. Polek referred Petitioner to Marionjoy Medical Group / Marionjoy Rehabilitation Hospital (Marionjoy) for continued pain management. (PX 5 at 8-9, 36-37; RX 13).

Chronic low back pain (failed back syndrome) and opiates therapy: Petitioner made his first visit to Marionjoy on January 7, 2007, where he was seen by Dr. Jeffrey Oken. Dr. Oken diagnosed Petitioner with "failed back syndrome." Dr. Oken would be Petitioner's primary pain treatment physician for years, up until Dr. Oken left the medical group not long before the hearing. At one point, as Dr. Oken (and Petitioner) testified, Dr. Oken attempted to place Petitioner on non-opioid medications, but this attempt was unsuccessful, and Petitioner was returned to opioids (currently OxyContin and Opana). (PX 5 at 20-21). As attested by Dr. Oken and Dr. Thakkar, Petitioner's pain management treatment has been virtually unchanged since 2007. Petitioner has been taking the essentially same kinds of narcotics, at the

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[1] The only other live witness was Nathan Lopez, a private investigator who performed video surveillance in April 2015 at Respondent's request. The video consists of about 30 minutes' worth of clips from the first day of surveillance, and about 15 minutes from surveillance a day later. On both days, Petitioner is seen shoveling dirt out of the back of his pick-up truck for some minutes. There is also video of him walking about briefly. The Commission notes that Petitioner is not asserting incapacity and currently is not invoking any nature and extent of disability claim. However, the activities captured in the video certainly suggest to the Commission that, contrary to Dr. Menini's opinion letters, Petitioner is not spending 18 to 20 hours per day immobile.

18IWCC0095

same dosages, since 2007. Petitioner continues to see, on a monthly basis, providers at Marionjoy, who continue today to refill his opioid prescriptions. (PX 5 at 15).

Dr. Oken also prescribed medications for Petitioner's sleep difficulties, also asserted to be caused by his chronic pain. Petitioner has been taking Ambien and also uses the muscle relaxant Flexeril. At some point, Dr. Oken prescribed Senna to treat constipation, a side effect of opiates. Marionjoy continues to be the source of the Ambien and Flexeril prescriptions for Petitioner.

Deep vein thrombosis (DVT or recurrent blood clots): During an early visit with Dr. Oken on March 13, 2007, Dr. Oken noticed that Petitioner's legs below the knee were swollen. A venous doppler ultrasound test found an acute venous thrombosis, or blood clot, in Petitioner's left leg. Petitioner was diagnosed with DVT. Dr. Oken felt the thrombosis had to be resolved before Petitioner could get clearance for intense opiate therapy at Marionjoy. Petitioner was sent to hematologists for DVT treatment at Cadence Physicians Group Oncology, including Dr. Perry Menini. On March 20, 2007, Dr. Menini started Petitioner on Coumadin, after which Petitioner was able to begin opiate therapy at Marionjoy. Later, the blood clots recurred. In January 2013 and again in January 2014, Dr. Menini provided brief opinion letters to Petitioner's counsel. In these letters, Dr. Menini wrote that Petitioner needed lifelong anticoagulation medicine for DVT and that this condition was caused by his sedentary lifestyle secondary to chronic back pain.[2] (RX 8; RX 9).

Later, Petitioner's treatment for blood clots would be transferred in part to Petitioner's primary care physician, Dr. Jay Thakkar. (PX 7 at 11-12). Dr. Thakkar has continued to keep Petitioner on Coumadin. (Petitioner sees Dr. Menini periodically for his INR test – International Normalized Ratio test -- to determine the amount of Coumadin he will need.) Dr. Thakkar and Dr. Oken would opine at their evidence depositions that the cause of Petitioner's DVT was immobility or "sedentary lifestyle" due to chronic pain, and that this chronic pain was related to the June 2004 accident and/or the 2006 surgery. (PX 7 at 12-13, 19). Notably, no doctor opined that Petitioner's alleged immobility was due to any sedative effect of the opiates. Rather, Petitioner's difficulty with engaging in physical activity was due to his pain – pain that the opiates apparently could not completely eliminate, even while they prevent his pain from getting worse. Dr. Menini, Petitioner's treating hematologist, was not deposed.

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[2] The more complete of these two letters is dated January 6, 2014 and reads as follows:

> Mr. Mitelsztet is a 47-year-old male on life-long Coumadin for recurrent left lower extremity DVTs. The decision for life-long anti-coagulation was made secondary to his sedentary lifestyle because of chronic back pain from an accident. He spends 18-20 hours per day either sitting or lying down which significantly increases his risk of further blood clots. He is encouraged to ambulate as often as he can for his physical and mental well being thus, he is encouraged to get out when he can. This being the case, he is still severely limited in his daily activity and thus he is required to continue life-long anticoagulation secondary to his disabilities.

(RX 9).

Low testosterone (hypogonadism): On February 6, 2009, during blood testing, it was found that Petitioner's testosterone reading was 101 (the normal range is 250-1100). Petitioner was sent to endocrinologist Dr. Paul Menet for this condition of low testosterone, also known as hypogonadism. In August 2009, Petitioner began seeing Dr. Menet. (PX 11). On August 26, 2009, Dr. Menet wrote as follows: "This is a 42-year-old white male seen for hypogonadism.... This has been present at least 2 years...." Dr. Menet also wrote, "the patient has markedly decreased testosterone levels, the most likely cause for this is the high-dose opiates for his chronic back pain" and that "the obvious treatment for this would be to stop using opiate painkillers which is unlikely to occur." On September 21, 2009, Dr. Menet started Petitioner on testosterone replacement therapy, i.e., AndroGel. (PX 11).

Later, Petitioner's monitoring and treatment for hypogonadism would be transferred to Dr. Thakkar. Dr. Thakkar tests Petitioner's testosterone levels with blood tests about twice a year and has kept Petitioner on AndroGel. (PX 7 at 21-23). Dr. Thakkar and Dr. Oken would opine at their evidence depositions that the hypogonadism was due to Petitioner's long-term use of opiates for chronic pain secondary to the June 2004 accident. Dr. Menet, the treating endocrinologist, was not deposed.

Settlement contract of 2010: Against this backdrop of Petitioner's ongoing opiate therapy for chronic back pain, treatment for DVT, and treatment for hypogonadism, the parties entered into a settlement contract. As mentioned above, this settlement contract was approved on September 9, 2010. (PX 1). Petitioner's claim was settled for a lump sum of $402,168.50. All medical care was paid for through the date of settlement, including the back surgery of January 4, 2006 and all treatment at Marionjoy.

As part of the settlement, Respondent was to either fund an MSA or keep open Section 8(a) medical rights. Respondent kept medical rights open. As already mentioned, up through around spring 2013, Respondent paid for all medical expenses submitted, including not just for chronic low back pain (the opiates), but for DVT, hypogonadism, sleep dysfunction and constipation as well.

Respondent discontinues certain prescriptions in 2013: Precipitating the parties' current motions, in May 2013, Respondent stopped paying for Coumadin. In September 2013, it stopped paying for AndroGel, Ambien and Flexeril. In January 2014, Respondent stopped paying for Senna. (PX 9). Respondent cited opinions from its medical experts that these medications were not related to the June 2004 back injury. Petitioner filed his original Section 8(a) petition in April 2014, seeking the resumption of these benefits. Respondent moved to terminate benefits in March 2016.

As of the time of the hearing before Commissioner Luskin, Petitioner was still being prescribed – and Respondent continued to pay for – opiates including OxyContin and Opana. During the hearing, Respondent referred to its offer to pay for Petitioner's treatment at a non-opiate pain treatment program. Petitioner attested to a desire to get off opiates, but he angrily exclaimed that he does not "trust his employer for jack shit." (Tr. 109, 113).

III. EXPERT MEDICAL OPINIONS

Petitioner's Section 8(a) petition centers on whether his DVT, low testosterone, sleep dysfunction and constipation are causally related to his motor vehicle accident of June 2004. To relate these conditions to what began as a back injury, Petitioner provided the medical testimony of Dr. Jeffrey Oken and Dr. Jay Thakkar. With respect to his response to the employer's motion to terminate all benefits including the opiate therapy, Petitioner relies primarily on Dr. Oken's testimony.

A. Petitioner's Experts

1) Dr. Jeffrey Oken. Since the June 2004 accident, Petitioner has been continuously on high dose opiates. As already noted, Dr. Jeffrey Oken was Petitioner's primary treating doctor for pain management after the lumbar surgery, beginning in January 2007 and up through shortly before the hearing. Dr. Oken was deposed in October 2014. (PX 5). He testified that he diagnosed Petitioner with failed back syndrome at the initial visit mostly based on Petitioner's subjective complaints and clinical presentation. (PX 5 at 37-39). He testified that the pain treatment at Marionjoy over the years was reasonable and necessary, and that Petitioner would have stayed bedridden without the opiates. (PX 5 at 31). Dr. Oken testified that Petitioner's back pain is ongoing and also acknowledged that Petitioner over the years has developed problems in other body parts and systems – including, for example, osteoarthritis in his knee, carpal tunnel syndrome due to diabetes, episodes of reported pain in his shoulder and neck, as well as possible diabetic nerve pain, or diabetic polyneuropathy. (Among other co-morbidities, Petitioner has long-standing, uncontrolled diabetes.) Dr. Oken could offer no opinion as to apportioning percentages of Petitioner's overall current pain to these various conditions. (PX 5 at 54-56).

Dr. Oken testified that Petitioner's pain medications and their high dosages had remained "pretty much" unchanged for the nearly 8 years between the lumbar surgery and the date of Dr. Oken's deposition. (PX 5 at 31, 81-82). When asked whether it would be advisable by now to send Petitioner to an alternative pain treatment program that did not involve opiates, Dr. Oken testified that, some time ago, it had been attempted to get Petitioner on different pain medications, but the attempt was unsuccessful. (PX 5 at 20-21, 42-44). Dr. Oken opined that Petitioner needed to remain on the narcotics at current levels (which happened to be the same as past levels) to maintain his current physical state, limited though it may be. (PX 5 at 48-49). Dr. Oken attested that Petitioner has a "physiological addiction" to opiates now, and were he to just quit them, he would suffer withdrawal symptoms. (PX 5 at 45-47). He is anticipated to be on opiates for life. (PX 5 at 25).

Regarding DVT, Dr. Oken asserted his first-hand knowledge of Petitioner's (subjectively reported) chronic pain over the years, and offered his opinion that the chronic pain caused Petitioner to adopt a more sedentary lifestyle, which in turn led to the development of his DVT. However, Dr. Oken testified that he did not have any knowledge as to the actual number of hours per day that Petitioner was sedentary. (PX 5 at 49-50). Dr. Oken appeared to adopt the causation opinion of the hematologist, Dr. Menini, who had

written that, as of January 2014, Petitioner spent 18 to 20 hours per day sitting or lying down.[3] (PX 5 at 27-30). Dr. Oken acknowledged that chronic pain itself does not cause blood clots. (PX 5 at 69-70).

Regarding Petitioner's sleep dysfunction, Dr. Oken opined that the chronic pain hindered Petitioner's ability to fall and stay asleep, and so Dr. Oken prescribed Ambien as well as Flexeril to help Petitioner sleep. (PX 5 at 22).

Regarding hypogonadism, Dr. Oken offered his belief that this condition was caused by Petitioner's ongoing opiates use. However, it is apparent from Dr. Oken's testimony and his treatment records that, beyond referring Petitioner to an endocrinologist, Dr. Oken had no involvement with Petitioner's low testosterone treatment, nor does he have any expertise in that field. (PX 5 at 70-76). The endocrinologist, Dr. Menet, was not deposed.

2) Dr. Jay Thakkar: Dr. Thakkar was deposed in February 2017, about a month before the hearing. Dr. Thakkar is board certified in family practice and has been treating Petitioner since May 2004. Dr. Thakkar testified that he currently sees Petitioner for his diabetes, blood pressure, cholesterol, blood clots or DVT, low testosterone level and chronic pain. (PX 7 at 7). Dr. Thakkar testified that, of these conditions, the ones that were related to the June 2004 accident were the blood clots, low testosterone, and chronic pain. Dr. Thakkar continues to maintain Petitioner's prescriptions for Coumadin and AndroGel, having taken over monitoring of Petitioner's DVT and testosterone level after Petitioner's treatment with the specialists, Dr. Menini and Dr. Menet. As mentioned above, Dr. Thakkar tests Petitioner's testosterone levels with blood tests about twice a year. (PX 7 at 21-23).

Dr. Thakkar attested that Petitioner's OxyContin and Opana regimen from Marionjoy has remained the same up to the date of his deposition. He opined that continued use of these medications was necessary to treat Petitioner's reported chronic back pain, and that the fact that this regimen has remained constant goes to the Petitioner's condition being "stabilized." (PX 7 at 48-49.) Dr. Thakker also offered causation opinions favorable for Petitioner as to the blood clots and low testosterone.

B. Respondent's Experts

Regarding the issue of continued use of opiates, Respondent relied particularly on the opinion of pain specialist and anesthesiologist Dr. Howard Konowitz.[4] Regarding the nature of Petitioner's current pain, Respondent relied particularly on the opinion of neurologist Dr. Francisco Espinosa, who opined as

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[3] Dr. Menini's assertion here is not credible. It is almost certainly inaccurate at the time of the April 2015 video surveillance. See footnote 4. However, this exaggeration of Petitioner's inactivity level is of limited relevance to the current motions under Section 8(a).

[4] Dr. Konowitz is an anesthesiologist and pain specialist of Comprehensive Pain Management Group of Morton Grove. He is board-certified in internal medicine and pain management.

to Petitioner's peripheral neuropathy.[5] Both of these doctors also opined that Petitioner's DVT was not related to the lumbar surgery, insofar as the blood clots were diagnosed more than a year after surgery. Regarding the issue of low testosterone, Respondent relied on the opinion of urologist and University of Chicago professor Dr. Gregory Bales, who did a records review only.

1) **Dr. Francisco Espinosa.** Petitioner underwent the first Section 12 exam when he was seen on November 6, 2012 by Dr. Espinosa. Dr. Espinosa noted that Petitioner had not worked since the June 2004 accident. Dr. Espinosa, in his narrative report, offered the opinion that the only medications that had ever been related to the June 2004 accident were the OxyContin, Opana, and Flexeril.[6] (RX 4).

As to Petitioner's current leg pain, Dr. Espinosa opined that this is likely not from lumbar radiculopathy but from diabetic peripheral neuropathy. Dr. Espinosa cited records including a November 2, 2006 record from Dr. Popp (the surgeon who performed the lumbar fusion) indicating that Petitioner's leg symptoms were likely due to diabetic peripheral neuropathy; and EMG reports from 2004 and 2006 that disclosed no lumbar radiculopathy. Dr. Espinosa also noted an MRI of August 2007 showing a solid fusion and disclosing no objective explanation for lumbar pain. (RX 5 at 34-35).

As to current pain management, although Dr. Espinosa is not a pain specialist, he asserted that the effect of Petitioner's Oxycontin and Opana use was quite likely lost by now, and he suggested that it would be appropriate for these narcotics to be tapered off.[7] (RX 4; RX 5 at 30). (This opinion -- that Petitioner has reached some terminal state of opioid tolerance -- and the recommendation for alternative pain management would also be reiterated by Dr. Konowitz.)

Dr. Espinosa did not challenge the diagnosis of DVT or Coumadin therapy. Instead, he disputed causation, writing that "the Coumadin that he takes is for deep vein thrombosis which likely developed because of his varicose veins," which is known to predispose one to DVT. (Dr. Espinosa himself noted numerous varicose veins in Petitioner's lower legs during the physical examination.) Further, because the DVT first developed more than a year after surgery, this condition could not be related to that surgery (or the back injury). (RX 4).

At deposition, Dr. Espinosa provided testimony consistent with the opinions in his written report. Dr. Espinosa also pointed out that Ambien is to treat insomnia, not back pain. (RX 5 at 31).

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5 Dr. Espinosa is a board-certified neurological surgeon at Neurological Surgery & Spine Surgery.

6 Dr. Espinosa allowed that the Senna would "be a reasonable drug to counteract the side effects [of constipation] from the opiates. (RX 5 at 31).

7 In his report, Dr. Espinosa also makes reference to a tentatively-made decision from around 2008 where Dr. Oken apparently might have indicated that he could no longer treat Petitioner. At his deposition, Dr. Oken stated only that, at one time, they tried to find Petitioner a pain management specialist that was located closer to his home but could not locate one. (PX 5 at 16-17).

2) Dr. Howard Konowitz. Dr. Konowitz saw Petitioner for an IME on January 10, 2014 and authored a 21-page report. (RX 2). He was deposed on January 10, 2014. (RX 2). In a nutshell, Dr. Konowitz's opinion is that Petitioner is now opiate-tolerant -- at least insofar as he has been on the same, high dosages of these drugs for several years -- and, as such, the opiates not only no longer have an effect on his pain, but the continued opiate use can actually increase the pain. Thus, Dr. Konowitz believed that Petitioner was no longer a candidate for opiates-based pain management and recommended that Petitioner be referred for addiction treatment or an alternative pain management program so that he can be safely weaned off the opiates. (RX 2; RX 3 at 37-45, 93). He also opined that opioids are generally not the most appropriate treatment to relieve pain from peripheral diabetic neuropathy, and that Ambien is not appropriate for long-term use. (RX 3 at 34-36, 94).

Regarding DVT, Dr. Konowitz drew upon his experience as a spinal surgery anesthesiologist and agreed with Dr. Espinosa's no-causation opinion. Dr. Konowitz opined that any surgery-related blood clots would have occurred within 6 weeks or so post-surgery. (RX 3 at 29). He also emphasized that any "sedentary lifestyle" of Petitioner purportedly giving rise to blood clots could be due to many contributing causes, including his thyroid condition, obesity, and diabetic neuropathy. (RX 3 at 70).

Regarding hypogonadism, Dr. Konowitz acknowledged that opiate use could contribute to low testosterone; however, he did not think it advisable to prescribe AndroGel to Petitioner, given the cardiovascular risk to him. Dr. Konowitz also commented that, in his experience, the population of opioid patients was "a little bit angry, and I don't know I like giving testosterone to an angry man." (RX 3 at 33).

As to the medications being taken by Petitioner, Dr. Konowitz opined that the medications that were related to the June 2004 injury was the opiates (which, again, are no longer recommended for Petitioner given his opioid tolerance), Senna (which would no longer be required once Petitioner is taken off the opiates), AndroGel (which Dr. Konowitz believes is too risky for Petitioner to take) and Flexeril. (RX 1). Regarding Flexeril, Dr. Konowitz allowed that, while it was related to the June 2004 injury, he would caution against its long-term use for Petitioner, particularly at the high dose currently being taken by him. (RX 3 at 34-35)

3) Dr. Gregory Bales. Dr. Bales was retained by Respondent to render an opinion regarding Petitioner's hypogonadism. Based on review of medical records only, Dr. Bales authored a brief report dated March 29, 2016. (RX 1). Dr. Bales believed that any man with a testosterone level outside the normal range (such as Petitioner) should consider testosterone replacement therapy, but Petitioner's low level is mainly due to his morbid obesity[8], renal failure, and diabetes. Petitioner's smoking history might also play a role. (PX 1). In short, Dr. Bales' opinion was that Petitioner's opiate use was not the source of his androgen deprivation.

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[8] Petitioner is 5' 7" and his weight is close to 300 pounds; BMI is about 48. He was diagnosed with adult onset diabetes 8 or 9 years prior to the June 2004 accident. (Tr. 45-46).

IV. DISCUSSION

Regarding Petitioner's current DVT and hypogonadism, it should be kept in mind that Respondent does not really take issue with these particular diagnoses (or their treatment). Instead, Respondent disputes causal relatedness to the original back injury of June 2004. The Commission finds the opinions of Respondent's IME physicians to be persuasive. In particular, the Commission relies on the opinion of Dr. Espinosa as to the non-relatedness of Petitioner's DVT. The Commission relies upon the opinion of Dr. Bales as to the non-relatedness of his low testosterone. Petitioner's experts – treating physicians Dr. Oken and Dr. Thakkar – have only limited or else no experience in directly treating Petitioner for these conditions. (Again, neither treating hematologist Dr. Menini nor treating endocrinologist Dr. Menet were deposed.) Respondent's experts were also able to point to Petitioner's multiple comorbidities, including his obesity and diabetes, as likely bases for these conditions.

With respect to chronic pain, for which Petitioner has remained on opiates for years, Respondent argues that there is no current objective evidence to link any extant chronic pain to his lumbar spine. Respondent points to complaints of pain in other body parts reported by Petitioner over the years since the accident – including osteoarthritis in his knee, (diabetes-related) carpal tunnel syndrome in his arm, episodes of pain in his shoulder and neck, as well as likely peripheral diabetic neuropathy -- and suggests that these other sources of non-lumbar ill-being are the sole drivers of his ongoing pain now. Respondent's contention here is less compelling, and the Commission finds that Petitioner has proven that he currently suffers from pain related to the June 2004 accident.

However, the Commission is persuaded -- in particular by the opinion of Dr. Konowitz -- that Petitioner is no longer a candidate for his current narcotics regimen for this pain. Even Dr. Oken acknowledged that Petitioner has reached a level of opiate tolerance to the extent that he is now physiologically addicted to narcotics. The Commission believes that Petitioner's degree of opiate tolerance has now rendered him an appropriate candidate for alternative, non-opiate pain management (a detoxification program), whereby an attempt can be made to wean him off these drugs. Insofar as constipation would no longer be an issue when the opiates are stopped, Senna would no longer be indicated.

Lastly, the Commission relies on Dr. Konowitz's opinion as well regarding whether the sleep aid Ambien and muscle relaxant Flexeril sought by Petitioner are sufficiently related to the June 2004 back injury. In accordance with Dr. Konowitz's opinion, the Commission finds that Ambien is not causally related, but that the Flexeril is related, albeit tenuously so. (Regarding Flexeril, the Commission underscores that Dr. Konowitz advised caution).

Given the Commission's finding that Petitioner's DVT, hypogonadism, and sleep dysfunction are not related to Petitioner's original work-related accident, there is no warrant for penalties and fees against Respondent.

18IWCC0095

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's petition for medical benefits under §8(a) is denied, with the exception of the prescription for Flexeril. Petitioner's request regarding other prescription medications, including for Coumadin, AndroGel, Ambien, and Senna are denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent's motion to terminate the remaining §8(a) benefits -- including for the opioid medications OxyContin and Opana -- is granted only to the extent that, while Petitioner's narcotics regimen for pain is no longer indicated, he is now an appropriate candidate for a detoxification program, for which program Respondent has offered to pay. Should any detoxification program accepted by Petitioner prove ineffective, nothing in this Opinion and Order precludes Petitioner from filing a new Section 8(a) petition for other or additional treatment.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's petition for penalties and attorney's fees under §19(l), §19(k) and §16 are denied.

DATED: FEB - 9 2018

Joshua D. Luskin

Charles J. DeVriendt

Elizabeth L. Coppoletti

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jdl/ac
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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

Cherry Patterson,

Petitioner,

vs. NO: 14WC 34380

Illinois District Council of the Assembilies of God,

18IWCC0096

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 16, 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.

18IWCC0096

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 13 2018

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CJD/rlc
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Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

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

PATERSON, CHERRY
Employee/Petitioner

Case# **14WC034380**

ILLINOIS DISTRICT COUNCIL OF THE ASSEMBLIES OF GOD
Employer/Respondent

18IWCC0096

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:

4620 ADWB LLC
JOHN WINTERSCHEIDT
51 EXECUTIVE PLAZA COURT
MARYVILLE, IL 62082

3998 ROSARIO CIBELLA LTD
JANE RYAN
116 N CHICAGO ST SUITE 600
JOLIET, IL 60432

18IWCC0096

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Cherry Paterson
Employee/Petitioner

v.

Illinois District Council of the Assemblies of God
Employer/Respondent

Case # 14 WC 34380

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Springfield, IL**, on **April 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. ☒ 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 12, 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 partially causally related to the accident.

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

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

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

Respondent shall be given a credit of **$20,356.07** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$20,356.07**.

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

ORDER

The Petitioner is entitled to temporary total disability benefits from May 13, 2014 through November 4, 2014, a period of 25 1/7 weeks.

Petitioner' request for the prospective medical (surgery) is denied.

Respondent shall be given a credit of $2,610.95 for medical benefits that have been paid.

Respondent shall be given a credit of $20,356.07 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.

D. Dylan McCarty

6/9/2016

JUN 16 2016

STATEMENT OF FACTS

Petitioner, Cherry Paterson, is a 60 year old female who has worked as a housekeeper for the Respondent, a retreat center, since June 2011. She alleges that on May 12, 2014 she was pulling wet laundry out of a washer and heard a pop and felt a burning sensation in her right shoulder.

Petitioner admitted she had prior problems with and treatment to her right shoulder. She was seen at the Air Force Medical Facility on October 24, 2012. There, she complained of right shoulder pain for one year. She reported that her shoulder "hurts most of the time." Petitioner admitted on cross-examination that her right shoulder pain began in 2011. Physical examination revealed decreased elevation of arm overhead. X-rays were performed which showed arthritic changes. Physical therapy was recommended. Petitioner's diagnosis was bursitis and possible impingement (Pet.Ex.2, Resp.Ex.2).

Petitioner had physical therapy at Apex on October 31, 2012. At her therapy visit on November 9, 2012, she reported "severe pain" and she could "barely move her arm." (Pet.Ex.6)

She returned to the Air Force facility on November 16, 2012. She again complained of right shoulder pain for more than a year. She alleged that therapy was increasing her pain. Her pain was lateral and ran into the bicep. She rated her pain at a 6 out of 10. X-rays were performed which revealed moderate degenerative change at the acromioclavicular joint and old granulomas disease. It was noted that her "pain was out of context with xray finding." An MRI was performed (Pet.Ex.2, Resp.Ex.2).

The MRI was performed on November 20, 2012. It revealed – (1) supraspinatus and subscapularis tendinopathy, (2) superior labral tear and (3) arthropathy of the acromioclavicular joint (Pet.Ex.2)

Petitioner was discharged from Apex physical therapy on November 20, 2012 as she complained of "severe emergency room pain with light touch" (Pet.Ex.6)

Petitioner was seen by Dr. Brett Grebing on January 8, 2013. There, she complained of a "gradual onset" of right shoulder pain. She described her pain as aching, sharp and throbbing. It was noted there was no injury. On physical examination, Petitioner had active painful range of motion with limiting factors of pain. There was also pain in the impingement arc with limiting factors of pain. A glenohumeral joint injection was performed. The MRI from November 2012 was reviewed and interpreted to show a superior labral tear with degenerative cyst formation anteriorly, probable partial tear of the rotator cuff and acromioclavicular degeneration. She was told to take NSAIDS, ice her shoulder, stretch and perform a home exercise program. Surgery was also discussed at that time (Pet.Ex.8). Petitioner admitted at trial that surgery on her right shoulder was prescribed prior to the May 2014 work incident.

Petitioner sought medical treatment on the date of the alleged accident, May 12, 2014, at Carlinville Area Hospital's emergency room. She reported pain in her right lateral shoulder which she rated as a 7 out of 10. She reported that her shoulder "felt like she had been pitching for 20 hours." Any act of adduction caused severe pain. On physical exam, the right shoulder was negative for swelling,

ecchymosis, deformity, and dislocation. She had normal passive range of motion and any abduction caused severe day. X-rays of the right shoulder were performed which revealed no acute osseous abnormality and degenerative changes in the acromioclavicular joint. Petitioner reported no history of musculoskeletal problems. Petitioner was diagnosed with shoulder sprain. She was prescribed Hydrocodone and told to take Motrin (Pet.Ex.1).

Petitioner returned to the Scott Air Force Base on May 13, 2014. At that time, Petitioner complained of *bilateral* shoulder pain for one year (emphasis added). She reported right shoulder pain and left shoulder pain which radiated into her left shoulder and numbness into her left hand. MRIs of the bilateral shoulders were prescribed. X-rays of the cervical spine were also performed on that date. X-rays of the right shoulder were also performed on that date. It was again noted that Petitioner had pain for one year and had a progression of symptoms. The x-rays revealed no acute bony abnormality, degenerative change of the acromioclavicular joint and granulomatous disease in the region of the right hilum. Physical examination of the right shoulder revealed no swelling, no warmth, no misalignment, no instability and motion was normal. No pain was elicited on motion. In addition, it was noted that "no weakness of the right shoulder was observed." She was released with no limitations and told to follow up as needed (Resp.Ex.2).

On May 27, 2014, Petitioner presented to Dr. Michael Milne of Motion Orthopedics. Petitioner reported a history of the work injury occurring on May 12, 2014. She reported that she went to the ER at which time x-rays were performed and she was given a sling. She followed up with her primary care physician at Scott Air Force Base where x-rays were taken again which were negative. She reported having trouble sleeping and weakness. Petitioner reported having prior problems with her right shoulder necessitating physical therapy, 2 cortisone injections, and an MRI. Petitioner reported that surgery was recommended in 2013. Dr. Milne was "not sure that any structural change in her shoulder had occurred from this new injury." He wanted to review the pre-injury MRI and pre-injury medical records and compare them to a new MRI study. He stated that "if no structural change is noted, she would likely continue her care under her private insurance with her private doctor" as opposed to under workers' compensation. Petitioner was diagnosed with right shoulder pain. The doctor recommended work restrictions of no lifting more than 5 pounds and no overhead work. He prescribed a right shoulder "MRI for causation" (Pet.Ex.3).

Petitioner had the prescribed MRI at Emerson Road Imaging Center that same day, May 27, 2014. The impression was: moderate foci of the degenerative tendinopathy signal within the supraspinatus and subscapularis without a tear and acromioclavicular arthropathy without impingement (Pet.Ex.5).

Petitioner returned to Dr. Milne on June 3, 2014 in follow up for the new right shoulder MRI. She reported that her shoulder felt like it was "on fire". The doctor compared the pre-injury 2012 MRI study to the post-injury 2014 MRI study and stated that there "does not appear to be any structural changes." The doctor prescribed an EMG/NCV study due to complaints of numbness and pain in the left hand. She was kept on the same restrictions of no lifting more than 5 pounds and no overhead work (Pet.Ex.3).

On June 5, 2014, Petitioner was seen at Scott Air Force Base in follow up from labs. She rated her pain at 0 out of 10 and reported her overall health as "very good." Petitioner mentioned no complaints of right shoulder pain when seen. Her musculoskeletal examination revealed no limb swelling (Resp.Ex.2).

The EMG/NCV studies were performed on June 9, 2014 by Dr. Phillips. The complaints were right shoulder pain and left hand numbness. She reported an injury on May 3, 2014. The impressions were: severe left carpal tunnel syndrome and moderate left cubital tunnel syndrome (Pet.Ex.4). The Arbitrator notes that Petitioner testified that she is not claiming her carpal or cubital tunnel syndrome is related to the May 2014 work injury.

Petitioner returned to Dr. Milne on June 10, 2014. It was noted that she was a right-hand dominant housekeeper who developed deep pain in the right shoulder. She also complained of numbness in the left hand. The doctor specifically stated that after reviewing the EMG/NCV studies that the carpal tunnel and cubital tunnel were "preexisting and unrelated". It was also noted at that time that she had a prior carpal tunnel release on the right hand. The doctor performed an injection into the Petitioner's right shoulder. His diagnoses were bilateral carpal tunnel syndrome - which was preexisting, bilateral cubital tunnel syndrome - which was preexisting and right shoulder impingement. She was given work restrictions of no overhead work, no lifting more than 15 pounds and was prescribed physical therapy (Pet.Ex.3).

Petitioner was seen for initial physical therapy evaluation on June 13, 2014 at Apex Network. It was noted that she was injured when lifting wet towels out of a washing machine at work. She went to the ER. The NCV studies revealed severe carpal tunnel syndrome. Petitioner also reported pain in the right shoulder for one year which was gradually building. Retitioner reported that she had not experienced the burning sensation until May 12, 2014. It was noted that she had had two prior injections and prior physical therapy at the same facility. Petitioner also had physical therapy on June 18, June 20 and June 26.

Petitioner returned to Dr. Milne on June 30, 2014. Petitioner continued to complain of right shoulder pain. She reported "mild improvement" from the previous injection. Dr. Milne suggested she try full duty work but "she just does not feel she can do this" (Pet.Ex.3). Petitioner admitted at trial that she told Dr. Milne she could not return to work. He instructed Petitioner to continue with physical therapy and suggested the possibility of an arthroscopic surgery. She was prescribed Naprosyn and NSAIDs. She was to continue a home exercise program, continue physical therapy two times a week for three weeks and ice. She was given same work restrictions of no overhead work and no lifting more than 15 pounds (Pet.Ex.3).

Petitioner returned to Dr. Milne on July 21, 2014. She had been in PT and had an injection with no relief to her right shoulder pain. He reviewed the MRI and found it to show degenerative changes and tendinopathy of the supraspinatus and subscapularis. She was told she can live with her pain or consider an arthroscopic subacromial decompression, distal clavicle resection, rotator cuff debridement,

and possible biceps tenodesis. Petitioner was considering her options. She was given work restrictions of no lifting more than 15 pounds (Pet.EX.3).

From July 2014 until November 2014, Petitioner sought no treatment.

Petitioner was seen by Dr. Bruce Vest for the first time on November 4, 2014 (Pet.Ex.7). Petitioner told the FCE examiner that her attorney sent her to Dr. Vest (Pet.Ex.9 at 3). It was noted that her arm was painful before the work injury and that she was told she needed surgery (Pet.Ex.7). Dr. Vest reviewed the November 2012 MRI which showed partial thickness rotator cuff tear and a tear at the superior glenoid labrum. He did not review the post-injury 2014 MRI at that time yet, still, recommended surgery. Her diagnosis was right shoulder rotator cuff tear and moderate DJD of the AC joint. A right shoulder arthroscopy with rotator cuff repair and acromioplasty was recommended. She was taken off work for the first time (Pet.Ex.7).

On November 5, 2015, Petitioner was examined by Dr. James Williams of Midwest Orthopedic Center for an independent medical examination at Respondent's Request. He authored of report of the same date (Resp.Ex.3 at Dr. Williams Exhibit 2). Dr. Williams opined that Petitioner could work her full duty job and had reached maximum medical improvement. He opined the need for surgery was not causally related to the May 12, 2014 work injury, but, rather related to her preexisting right shoulder condition as evidenced by his review of the 2012 and 2014 MRI films.

Petitioner was seen by Dr. Vest on January 5, 2015. She rated her pain at a 9 out of 10. Dr. Vest reviewed the 2014 MRI report for the first time, but, he did not have the films. She was kept off work and was prescribed Norco. On January 27, 2015, Petitioner returned to Dr. Vest. Surgery continued to be recommended and her Norco was refilled. She also saw Dr. Vest on March 2, 2015 (Id.)

Dr. Vest testified via evidence deposition on March 31, 2015. He testified that twenty percent of his practice involved upper extremities (Pet.Ex.11 at 25). He also treats hips, knees, lower extremities and the lumbar spine (Id.). He testified that Petitioner relayed a history of problems to the right shoulder from before May 2014: "She reported a prior history of pain in the right arm, and described a heavyweight sensation in the biceps, which was evaluated by an orthopedic doctor in Maryville, and treated with cortisone injections about a year prior" (Id. at 10). He also testified that surgery was discussed before May 2014. Dr. Vest reviewed the November 2012 and the May 2014 study. He testified that "There was at least a partial thickness rotator cuff tear on both MRIs, and there was arthritic change with degenerative arthritis of acromioclavicular joint (Id. at 11)." He testified – "I can't say there was a dramatic difference between the two MRIs (Id. at 19)."

Petitioner returned to Dr. Vest on May 4, 2015. She reported constant pain in the anterior and lateral aspects of the right shoulder. She was taking two Norco pills per day. Surgery continued to be recommended. She was diagnosed with a rotator cuff tear, degenerative joint disease of the shoulder and pain in the shoulder. She was kept off work (Pet.Ex.7).

At the time of trial, Petitioner testified that she had not seen Dr. Vest in nearly a year.

Dr. James Williams, Respondent's Independent Medical Examiner, was deposed on August 13, 2015 (Resp.Ex.3). He testified that he is a board certified orthopedic surgeon with an added qualification in hand and upper extremity surgery (Id. at 5). Dr. Williams examined the Petitioner on November 5, 2014 (Id. at 7). Petitioner gave him a detailed description of her job duties as a housekeeper and specifically explained the amount of laundry she would do per day, the hours she worked and the items she would launder (Id. at 7-8). Petitioner reported to Dr. Williams that as of November 2014, she hurt "all the time" (Id. at 8). She reported that she felt like her right shoulder "weighed 150 pounds" (Id.).

Dr. Williams specifically asked whether she had any prior problems with her right shoulder, she denied any prior problems (Id. at 8-9, 26-7). He knew that to be a false statement since he reviewed medical records from 2012 and 2013 in addition to the 2012 MRI study. At trial, Petitioner testified that she did tell Dr. Williams about her prior right arm problems. Dr. Williams refuted that statement in his report and at his deposition.

Dr. Williams noted that her diagnosis in 2012 was degenerative arthritis of the AC joint which was "exactly what was shown in May of 2014" (Id. at 11). Dr. Williams specifically noted that in 2013, she complained of constant hurting, popping and weakness (Id. at 12). Dr. Williams opined that the complaints made and objective test results from the ER on May 12, 2014 were "identical" to those from Petitioner's 2012 and 2014 treatment (Id. at 16). He also reviewed films from the November 2012 right shoulder MRI. He also reviewed films from the May 2014 right shoulder MRI. He compared the two sets of MRI films and found that "essentially the MRIs were identical" (Id. at 13). He opined that the two studies showed "no significant differences" (Id. at 17).

After performing a physical examination, Dr. Williams noted that Petitioner had exaggerated responses throughout the exam and tenderness at the AC joint (Id. at 22). He testified that she jumped when he barely touched her shoulder (Id at 26). She also grimaced during physical exam and guarded (Id. at 26). Also, she reported not having motion, yet, in fact had full range of motion on physical examination.

He diagnosed Petitioner with preexisting right shoulder AC joint arthritis and right shoulder bursitis/tendinitis (Id. at 23). He noted those were "absolutely" the same diagnoses that Petitioner was given in 2012 and 2013 – before the work injury (Id.). Therefore, Dr. Williams concluded that the need for surgery was "absolutely not" causally related to the work incident of May 12, 2014 (Id. at 24). He explained:

> "I believe that the issues she had with her right shoulder are the same issues she had back in 2012 which she sought treatment for throughout 2012, throughout 2013, and actually noted in 2012 that she had had this problem for over a year. So really it's preexisting probably even to 2011 at least. That she had been seen for this quite significantly over a period of time. She was seen again in 2013. It was bad enough in 2012 they actually ordered an MRI of the right shoulder. And at that time her statements were that she had the pain for over a year. And so I feel anything she would have

done here she didn't complain of – she simply lifting laundry on one occasion and then had probably a temporary elicitation of symptoms which should have resolve on their own. There is no finding on the MRI that she had any type of significant bursitis. There was no finding on the MRI of any significant inflammation. There was no finding on the MRI of anything but arthritis and a little tendinopathy, which is exactly what she had back in 2012" (Id. at 24-5).

Dr. Williams found only the physical therapy and a cortisone injection to be related to the May 2014 work incident (Id. at 25). He opined she had reached maximum medical improvement and found Petitioner to be capable of working regular duty without restrictions, with full and detailed knowledge of what Petitioner's job duties entailed (Id. at 25, 41-2). He reiterated that Dr. Milne had talked to Petitioner about working regular duty as well (Id.).

On December 4, 2015, Petitioner had a functional capacity examination at SSM Physical Therapy. It revealed Petitioner could lift six pounds. She reported that she was unable to lift an empty box and would not allow the therapist to move her arm (Pet.Ex.9 at 1). It was further noted that she self-limited during the testing especially the musculoskeletal exam, material handling and positional tolerance (Id.). The examiner noted that there was "minimal to no heart rate increase during material handling despite reports of increased R shoulder pain." The therapist stated – "This should be considered her minimal functional ability" (Id.). As such, the therapist was "unable to classify" her physical demand level. Petitioner reported that "any use of her R arm aggravates her symptoms and that nothing provides relief" (Id. at 3). She further reported that she was independent with activities of daily living and drove herself to the FCE appointment which was 40 minutes from her home.

In the material handling portion of the test, Petitioner reported that her arm felt "exhausted" when lifting a four pound empty crate yet there was minimal to no change in her heart rate (Id. at 5). It was further noted that she expressed increased complaints of pain with "any movement of the R UE, even in a very small ROM (>45 degrees away from the body)" (Id.at 7).

Respondent had the FCE report reviewed through BenchMark Functional Testing (Resp.Ex.4). The report concluded that due to "lack of consistent reliable effort and the presence of self-limited effort, the "U.S. Department of Labor's Physical Demand Category" levels listed in the report do not reflect the true capabilities of this claimant" (Id.) It was recommended by the examiner that Petitioner should be returned to work (Id.).

CONCLUSIONS OF LAW

Causal Connection

The parties agree that the Petitioner sustained a right shoulder injury as the result of an accident on May 12, 2014. The issue is whether the Petitioner's current condition for which surgery has been prescribed is causally related to said accident. The Arbitrator finds that while the Petitioner may

have some ongoing residuals from her accident, the condition for which surgery has been recommended is not causally related to the accident.

The only evidence of an exacerbation of the right shoulder condition is Petitioner's subjective complaints. Her subjective complaints are not substantiated by objective evidence. The May 2014 MRI study showed no acute findings. Her physical exam showed no swelling, no warmth, and no instability either the day of or the day after the injury. Doctors Milne, Vest and Williams all agree that there are no changes between the November 2012 and May 2014 right shoulder MRI studies. All doctors agree that her diagnosis of a partial rotator cuff tear and degenerative arthritis of the AC joint (Pet.Ex.11 at 12) which is the same diagnoses made in 2012 and 2013 by the Scott Air Force Base doctors and Dr. Grebing. All doctors further agree that surgery for Petitioner's right shoulder was prescribed before May 2014.

Moreover, when you compare the examination findings from the Petitioner's examination with Dr. Grebing on January 13, 2013 with those of Dr. Milne's during his last two exams on June 30 and July 21, 2014, you will find them nearly identical. The Petitioner reported to Dr. Grebing that she had an aching, sharp, throbbing pain in the shoulder. She was tested positive for a labral tear by both the Speed's and O'Brien's tests. Three tests were seen as positive for a rotator cuff injury. She had abnormal strength in the supraspinatus tendon along with decreased ranges of both active and passive motion. She reported that after a course of physical therapy, she felt worse with no improvement. (PX 8)

On June 30, 2014, after a course of physical therapy, she was examined by Dr. Milne. He found a full range of motion, 5/5 strength and positive tests for a rotator cuff problem. His notes indicate he talked with her about trying to return to her regular work, but she did not feel she could do it. At his next examination one month later, the Doctor noted the Petitioner had pain during range of motion testing, strength at 4/5 and, again, positive testing for a rotator cuff injury. (PX3)

Dr. Vest's initial examination produced similar results. On November 4, 2014, he found 5/5 strength, positive impingement signs and decreased motion. (PX 7)

So, not only were the pre and post MRI's identical, the examinations findings were as well. Petitioner argues that since the Petitioner was able to do her job after January 2013 but not after her accident, that she has proven an aggravation and causation for her proposed surgery. The Arbitrator does not believe that is a reasonable presumption, given the above medical evidence. It is just as likely that she continued to work with the same levels of pain and discomfort that she exhibited to Dr. Grebing on January 13, 2013.

In addition, when first seen after the injury at Scott Airforce Base on May 13, 2014, Petitioner mentions nothing about a work injury and reports that she had been experiencing pain for over one year. A one year history of pain is inconsistent with Petitioner's trial testimony that she was fine until an acute event occurred on May 12, 2014. Also, at that same visit the day after the work injury, there are no acute findings at all on physical examination – no swelling, erythema, warmth, misalignment or weakness was shown (Resp.Ex.2).

The Arbitrator questions Petitioner's credibility. There are multiple findings of inconsistent effort on the FCE. The therapist conducting the study specifically states on the first page of the report that she had no heart rate change despite complaints of pain and that the concluded level of ability should be considered her "minimal functional ability." Also, it was noted in the FCE report that the therapist could not assess Petitioner's true range of motion as "client actively resisted all PROM and would not allow therapist to move her arm, reporting increased pain" (Pet.Ex.9). She also refused to pick up an empty box with her bilateral hands at the FCE (Id.). This opinion is supported by Respondent's FCE review report which finds the FCE to not be a valid study.

In summary, the Arbitrator finds that while the Petitioner may still have residuals from her accident, she has not shown by a preponderance of the evidence that her current surgical condition was causally related to said accident.

Medical Expenses

The Arbitrator notes that the unpaid amount of $672.00 on Petitioner's Exhibit 12 does not correspond to the attached bill showing $538.00 unpaid to Dr. Vest.

The Arbitrator also notes that Respondent presented proof that the December 4, 2015 Functional Capacity Examination bill was paid (Resp.Ex.5). Respondent was sent a bill for $1,492.96 and paid said bill per the fee schedule. It is unclear why the $1,492.96 charge is listed twice on Petitioner's Exhibit.

With the above qualifications, the Arbitrator orders the Respondent to pay the remainder of the bills contained in PX 12, pursuant to the fee schedule. They do appear to be for treatment causally related to the accident.

Temporary Total Disability

The evidence shows that the Petitioner reached a point of maximum medical improvement on or about November 4, 2014, when she was examined by Dr. Vest. Her examination findings after that date show no real changes.

Accordingly, the Arbitrator finds that the Petitioner was entitled to receive TTD benefits from May 13, 2014 through November 4, 2014, a period of 25 1/7 weeks.

Prospective Medical Treatment

Based on the Arbitrator's findings on causal connection, the request for right shoulder surgery is denied. Dr. Grebing previously prescribed the same procedure in 2013 for the same diagnoses. The MRI studies show no objective changes from 2012 to after the work incident in 2014. The Arbitrator adopts the opinion of Dr. Williams that the need for surgery is "absolutely" not related to the May 2014 work incident and it is hereby denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DEBORAH PEARLMAN,

Petitioner,

vs.

NO: 12 WC 24884

LTD COMMODITIES, LLC,

18IWCC0097

Respondent.

DECISION AND OPINION ON REVIEW

This matter comes before the Commission pursuant to timely Petitions for Review filed by the Petitioner and the Respondent herein. Issues at arbitration included causation, medical expenses, temporary disability, permanent disability, and prospective treatment. The Arbitrator found Petitioner's broken nasal bone, lip scar, septal deviation, sinusitis, hearing loss, and C. diff to be causally related to her February 21, 2012 work accident, but denied causation for Petitioner's psychiatric condition of ill-being. For the reasons set forth below, the Commission, being advised of the facts and law, affirms the Arbitrator's finding that a causal relationship exists between Petitioner's work accident and her septal deviation but reverses the Arbitrator with respect to causation of Petitioner's sinusitis, hearing loss, and C. diff.

As a preliminary matter, the Commission notes the Application for Adjustment of Claim and Request for Hearing identify the claimant as "Debra Perlman," however, all the medical documentation in the record, including multiple forms completed by Petitioner herself, reflect Petitioner's name is "Deborah Pearlman." This was brought to the parties' attention during argument, and an oral motion was made, and granted, to amend the filings. Therefore, pursuant to the parties' stipulation, the Commission amends the pleadings to properly identify Petitioner as Deborah Pearlman.

FINDINGS OF FACT

The parties stipulated Petitioner sustained an accidental injury arising out of and in the

course of her employment on February 21, 2012. ArbX1. Petitioner indicated she was leaving work, walking on the sidewalk by the building entrance, when she tripped on rock salt and fell onto her face. T. 13. When she arose from the ground, she was bleeding "from my nose and my lip and lower face..." T. 13. Petitioner testified her front teeth ripped through her upper lip from the inside. T. 14. She went inside, spoke to the receptionist, who is the first aid person, cleaned up, and then went home. T. 14.

Petitioner testified she presented to Advocate Condell Acute Care the next morning. T. 14. The records reflect Petitioner described the fall and complained of headache and numbness to the left side of her face. Workup included head and maxillofacial CT scans. The head CT was unremarkable. On the maxillofacial scan, the radiologist identified a possible nondisplaced left nasal bone fracture; the nasal septum was also noted to be slightly rightward bowed. The emergency room physician diagnosed fall with blunt trauma to the face, headache, and paresthesia. The doctor authorized Petitioner off work pending re-evaluation the next day and possible referral to an ear, nose and throat specialist; in the meantime, Petitioner was advised to take Tylenol and treat her abrasion with Bactrin. PX1.

On February 23, 2012, Petitioner followed up at Condell. Petitioner testified she had a lot of facial pain and nose pain as well as a "terrible" sore on her upper lip. T. 17. After an examination, the physician determined Petitioner was status post facial/head trauma, improving. The doctor recommended icing the bruised area and Tylenol, and released Petitioner to modified duty through March 1, 2012. PX1.

Petitioner testified Respondent provided an accommodated position and she thereafter resumed full duty. T. 18. Petitioner further testified she was told to return to the clinic on March 1, 2012 if her condition markedly worsened. T. 17-18.

The next medical record in evidence is a June 5, 2012 consultation with Mishail Shapiro, D.O., of Medical Arts Unlimited. This report indicates Petitioner lacerated her upper lip during a fall at work and was being evaluated for the resultant "unsightly lip scar." Dr. Shapiro also noted she sustained other injuries as well which had resolved. Dr. Shapiro observed a horizontal scar in the middle of the upper lip extending to the philtrum on both sides of the cupid bow, which he described as a depressed widened scar with a very irregular appearance at the left lateral end. Nasal examination, oral examination, palpation of the neck, salivary glands, and thyroid were noted to be unremarkable. Dr. Shapiro concluded improvement could be obtained from cosmetic excision and reapproximation of the scar margins and recommended proceeding with corrective plastic surgery. PX4.

On August 9, 2012, Dr. Shapiro performed a Z-plasty re-excision and closure of upper lip scar. PX4. Petitioner testified the doctor authorized her off work as of the procedure date. T. 23.

On August 16, 2012, Petitioner returned for her first post-op evaluation. Upon removal of the sutures, Dr. Shapiro noted the results were "quite encouraging." Dr. Shapiro advised Petitioner to minimize facial movement and apply scar cream, and released her to full duty as of August 20, 2012. That office note also reflects Petitioner complained of congestion and chronic rhinitis following her nasal injury, which the doctor labelled a "new" complaint. Dr. Shapiro ordered a CT

of the sinuses to evaluate her nasal obstruction and sinusitis. PX4.

Petitioner returned to full duty work as directed on August 20, 2012. She continued working her regular position until Respondent terminated her employment on September 5, 2012. T. 18.

The recommended sinus CT scan was performed on September 11, 2012. Findings included mild mucosal thickening in the ethmoid air cells; trace mucosal thickening in the left sphenoid sinus, slightly more pronounced than in prior scan; large polyp or retention cyst at the floor of the left maxillary sinus; mild mucosal thickening in the right maxillary sinus, with additional opacification within the vicinity of the uncinate process; and a small septation at the posteroinferior right maxillary sinus, unchanged from the prior study. PX4.

Later on, September 11, 2012, Petitioner followed up with Dr. Shapiro. On review of the CT, Dr. Shapiro identified a "significant" right-sided midseptal deformity as well as what appeared to be a mucoid plug obstructing the right ostiomeatal complex, but no evidence of sinusitis. In response to Petitioner's stated belief that after her facial injury she experienced exacerbation of nasal obstruction and rhinitis, Dr. Shapiro noted, "To degree *[sic]* of that is hard to evaluate. Hypothetically, the patient's facial injury could have lad *[sic]* to septal displacement." Dr. Shapiro indicated surgery would be reasonable and Petitioner was to decide if she wished to proceed. PX4.

On November 15, 2012, Dr. Shapiro authored a letter to Petitioner's counsel. Therein, the doctor stated Petitioner presented with a significant septal deviation, which she believed was a result of a facial/nasal injury. The doctor detailed the diagnostic findings and opined Petitioner would benefit from correction of nasal septal deformity and bilateral maxillary sinuplasty to improve her airway and ventilation and eliminate the obstruction. PX4.

On November 28, 2012, Dr. Jessica Blomeke conducted a disequilibrium evaluation of Petitioner; the reason for the evaluation was Petitioner's report of hearing difficulties and dizziness dating back to her February fall and increasingly worsening since June. At arbitration, Petitioner testified she began noticing the hearing loss in May or June: "Because we wore headsets. I thought it was my headset, that there was a problem with my headset because I couldn't hear well on the left, and I would ask for another headset." T. 27. Dr. Blomeke noted Petitioner described episodes of dizziness occurring multiple times a day with associated nausea, blurry vision, lightheadedness, imbalance, double vision, and feeling panicked. Petitioner's medical history was positive for bilateral, non-pulsatile tinnitus and vision problems. Audiometry results were abnormal and revealed mild sloping to severe mixed hearing loss, bilaterally. Concluding the findings were suspicious for orthostatic hypertension, Dr. Blomeke recommended vestibular rehabilitation therapy. PX4.

When Petitioner next saw Dr. Shapiro, on December 20, 2012, she complained of cough, congestion, and diminished hearing on the left side. Examination findings included "effusion on the left acute sinusitis, posterior nasal drainage." Dr. Shapiro prescribed prednisone, Robitussin, and Augmentin, and directed Petitioner to return in 10 days. PX4.

On January 3, 2013, Petitioner was re-evaluated by Dr. Shapiro. She reported her hearing

on the right had improved but her left was significantly diminished, her sinusitis was improved but rhinitis persists, and she had persistent nasal congestion and pain. Audiology demonstrated a significant drop in hearing on the left side secondary to middle ear effusion; nasal exam showed obstruction and rhinitis without clear evidence of sinusitis. Dr. Shapiro again recorded Petitioner's belief her nasal, sinus, and ear symptoms were related to her injury. Dr. Shapiro noted Petitioner had a "significant septal deformity which may be related to the trauma, however at this point that is challenging to prove without having access to the prior medical records." Dr. Shapiro again recommended nasal/sinus surgery. PX4.

On January 7, 2013, Dr. Kevin Hulett conducted an examination at Respondent's request pursuant to Section 12 of the Act. His evaluation included an anterior rhinoscopy, which was positive for a "significant" right septal deviation, and record review. Dr. Hulett concluded the February 21, 2012 fall did not contribute to Petitioner's nasal obstruction or chronic sinusitis. Dr. Hulett felt the septal deviation was likely preexisting, and although there was a "mild" septal deviation, the paranasal mucosal thickening and obstruction was likely not the result of any type of facial fracture. RX1, DepX2.

On January 10, 2013, Dr. Shapiro performed a left myringotomy. PX4. Petitioner stated a tube was placed in her left ear during that procedure. T. 26. Petitioner testified that at the time of the surgery, she could not hear out of her left ear at all. T. 27.

Petitioner presented to Dr. Rafa Adi, her primary care physician, on January 21, 2013. Dr. Aldi's notes are handwritten and difficult to read, but it appears Petitioner complained of diarrhea. Dr. Adi diagnosed C. diff. PX1.

On January 24, 2013, Petitioner followed up with Dr. Shapiro who noted Petitioner was status post myringotomy, and the ventilation tube was in excellent position; repeat audiology revealed significant improvement in hearing in the left ear. Petitioner additionally complained of rhinitis and nasal congestion, for which the doctor recommended over-the-counter decongestants. Dr. Shapiro again noted Petitioner's nasal anatomy was conducive to surgical repair and reiterated his recommendation for same. PX4.

In late January, Dr. Adi continued to manage Petitioner's C. Diff. Multiple lab tests were conducted at Advocate Condell Medical Center, each of which revealed the presence of the C. diff toxin. PX2A, PX2B. On January 31, 2013, Dr. Adi prescribed a course of Flagyl. PX1.

On February 12, 2013, Petitioner presented to the emergency room at Advocate Condell. The history indicates Petitioner was being treated for C. diff and complained of worsening symptoms. After initial workup, Petitioner was admitted and an infectious disease specialist was consulted. The history noted during that initial evaluation reflects that in December Petitioner was prescribed Augmentin to treat a middle ear infection; she developed diarrhea while on Augmentin, was diagnosed with C. diff colitis, and was treated with a two-week course of Flagyl. She completed Flagyl three days prior with resolution of her symptoms, but the previous day developed recurrent symptoms. Petitioner was diagnosed with recurrent C. diff and remained inpatient until February 15, 2013. PX2A.

On April 9, 2013, Dr. Shapiro re-evaluated Petitioner complained of diminished hearing in the left ear and nasal obstruction. Dr. Shapiro referenced Petitioner's February 2012 facial injury and her belief her "nasal structure and exacerbated *[sic]*" since that time. Dr. Shapiro further indicated diagnostic imaging demonstrated septal deviation to the right and a mucous plug of the right ostiomeatal complex, and subsequent medical management had failed. Dr. Shapiro indicated surgical correction of the nasal deformity would improve her nasal airway and reduce sinus pressure. Dr. Shapiro further offered a causation opinion:

> As there *[sic]* my previous notes there is a high probability that septal deformity is related to her facial injury. It is my professional opinion that surgery should be covered. In multiple previous records and communications the link between septal deviation to the right and patient's facial injury has been established. Physical examination findings and CAT scan results are consistent with history of facial trauma. PX4.

Petitioner testified Dr. Shapiro would not perform the surgery without authorization. T. 28. She applied for and was granted Public Aid, and surgery proceeded under her Medicaid coverage. T. 28-29.

On July 11, 2013, Dr. Shapiro performed surgery to address Petitioner's nasal obstruction: septoplasty, sinuplasty of frontal and maxillary sinuses bilaterally, and submucous resection and outfracture of inferior turbinate. PX2A.

On July 16, 2013, Dr. Shapiro conducted Petitioner's first post-operative evaluation and noted Petitioner was doing well and had no complaints. Dr. Shapiro removed the splint and directed she remain off work until July 18, 2013. PX4.

On August 1, 2013, Dr. Shapiro evaluated Petitioner for a final time and indicated Petitioner was progressing as expected. Petitioner was to return in two weeks for nasal endoscopy. PX4. Petitioner testified she followed up with Dr. Shapiro by phone but did not return to his office. T. 30. She did not have any further substantial medical care following the nasal surgery. T. 31.

On January 13, 2015, Dr. Jeffrey Coe examined Petitioner at Respondent's request for the purpose of performing an AMA impairment rating. For the diagnoses of facial laceration with scarring and nondisplaced nasal bone fracture, Dr. Coe's assessment was impairment of 3% of the person and 0% of the person, respectively. RX2, DepX3.

The evidence deposition of Dr. Kevin Hulett, taken on June 26, 2013, was admitted as Respondent's Exhibit 1. Dr. Hulett is an ear, nose and throat doctor, board certified in otolaryngology, head and neck surgery. RX1, p. 4. Dr. Hulett reviewed his January 7, 2013 Section 12 report wherein he concluded neither Petitioner's chronic sinusitis nor her septal deviation were causally related to the work accident.

Questioning then turned to causation. Dr. Hulett confirmed his opinion that Petitioner's chronic sinusitis was not a result of her work injury. RX1, p. 11. Dr. Hulett explained the basis of his opinion: "Due to the fact that on the CT scan there's no significant fractures that affected the

drainage pathways of her sinuses. On exam there is little evidence of chronic sinusitis other than her history, and it just seems unusual for the injury that she sustained to result in the conditions that she was describing." RX1, p. 11.

When Dr. Hulett was asked to address causation of Petitioner's nasal septal deviation, he conceded the fall could be an aggravating factor: "That is more difficult to delineate due to the fact that no one has a perfectly straight septum. So yes, her septal deviation could have been affected by the fall, but it's hard to say what degree was already there versus what she sustained during that fall." RX1, p. 12. Dr. Hulett further testified a septoplasty to straighten the septum would be reasonable and that treatment would be causally related to the work accident. RX1, p. 12-13.

On cross-examination, Dr. Hulett agreed he reached the same diagnosis as Dr. Shapiro. RX1, p. 18. Dr. Hulett further agreed his causation opinion was partially the same and clarified his disagreement is with causal connection for chronic sinusitis. RX1, p. 19.

Dr. Hulett then reviewed the documents contained in his file. RX1, p. 21-24. The doctor testified he was not provided with the report from the CT performed on February 22, 2012. RX1, p. 25. Dr. Hulett was presented with the report of the February 22, 2012 maxillofacial CT scan and asked to compare it with the September 2012 scan: "...it's not identical. There is a little bit more mucosal - - what they consider mucosal thickening on the CT scan that's dated September 11, 2012, compared to February 22, 2012." RX1, p. 26. Dr. Hulett explained the thickening could occur after a viral upper respiratory tract infection, recent sinus infection, or chronic sinus infection; he did not "believe trauma would cause worsening of mucosal thickening on that date." RX1, p. 26. Dr. Hulett testified he is unaware of any data showing injury to the nasal mucosal lining will cause susceptibility to recurrent sinus infections but conceded a person can get a sinus infection following trauma. RX1, p. 26-27.

Dr. Hulett was asked if he found it significant Petitioner had no history of significant nasal obstruction, nasal swelling, or sinus infection prior to her fall, and he responded: "Certainly the nasal obstruction and the nasal swelling is a significant finding. As far as the recurrent sinus infections, no, I find that less relevant due to the fact that I still don't see a cause and effect with her examination, her history, and the onset of her sinus infections." RX1, p. 28.

The evidence deposition of Dr. Jeffrey Coe was conducted on July 13, 2015 and admitted as Respondent's Exhibit 2. Dr. Coe is trained to perform AMA impairment ratings and has done approximately 200 in the last few years. RX2, p. 13-14. Of those, 10 to 15 were for injuries to the head. RX2, p. 14.

Dr. Coe performed an impairment rating examination on Petitioner on January 13, 2015. RX2, p. 21. The doctor testified the purpose of his evaluation was strictly an impairment rating; he was not asked to comment on causation. RX2, p. 24.

Dr. Coe's exam focused on Petitioner's nose, throat, ears, and lip. RX2, p. 32. Dr. Coe did not comment on Petitioner's ear, as the condition had not reached maximum medical improvement. RX2, p. 37. Dr. Coe rated Petitioner's lip scar as an impairment of three percent of the whole person, and her air passage abnormalities at zero impairment. RX2, p. 40.

On cross-examination, Dr. Coe identified which of Dr. Shapiro's records he reviewed; he was not provided with the September 11, 2012 record. RX2, p. 45. Asked if any of the records made reference to chronic sinusitis, Dr. Coe stated Petitioner denied a history of chronic sinusitis prior to the work injury. RX2, p. 49. The doctor also noted "the question was also addressed in terms of CT scans," then discussed the February 22, 2012 and September 11, 2012 scans:

> The radiologist compared those two CT scans, and this is also discussed in Dr. Shapiro's records, among other places. She does appear to have had some degree of sinus change at least in her left sphenoid sinus at the time of the first CT scan. Now, again, she reports no significant sinus problems. This may be simply an incidental finding on the CT scan. But that earliest CT scan, at least according to the later comparison, does suggest that she may have had some degree of sinus inflammation. I would also add this is quite common in the Midwest. This is something seen all the time. RX2, p. 49-50.

Dr. Coe agreed sinus inflammation is also commonly found in people who have suffered facial injuries "if the facial injuries are sufficient to cause significant swelling or obstruction, so there needs to be some obstruction to cause sinus inflammation." RX2, p. 50. Dr. Coe then agreed Petitioner's initial medical records describe swelling of the left side of her face and jaw. RX2, p. 50. Those records do not indicate Petitioner's sinuses were examined. RX2, p. 50.

Asked if there was anything in the records which would lead him to believe Petitioner did not have a septal injury in addition to the nondisplaced nasal fracture, Dr. Coe stated:

> Well, the only thing that's in these treatment medical records that's at all in my opinion helpful to even answering that question is the fact that the nasal fracture was described as nondisplaced in all these treatment medical records; and when Ms. Pearlman first saw Dr. Shapiro on June 4th of 2012 - - and just by chronology, this is about three and a half months after the accident - - Dr. Shapiro's nose and throat examination includes no specific complaints and resolution of problems other than the laceration of the lip, includes an ear, nose and throat and nasal examination that was described as unremarkable.
> So I could only tell you that at three and a half months after the injury, this doctor, who appears to have been capable of carrying out a careful nose and throat examination, describes no abnormalities of septal collapse at that time, something that I would have anticipated if it had been something arising from a nasal fracture. RX2, p. 51-52.

Dr. Coe then clarified if the septum was deviated as a result of the fall, at the three and a half-month point, "there was no longer any internal nasal structural abnormality that was identified." RX2, p. 52. Dr. Coe testified the operative report describes a C-shaped septal deformity but agreed he had no opinion as to the cause of that, stating he could only say it was not reported in the records at or around the time of the accident. RX2, p. 54-55.

On re-direct examination, Dr. Coe was reminded of the questions Petitioner's counsel asked about Petitioner's nasal passage and deviated septum, then asked, "Is it fair to say from your

answers that you doubt that it was related to the fall?" When Petitioner's counsel objected, Respondent's counsel noted he had opened the door to causation; the Arbitrator overruled the objection. RX2, p. 59. Dr. Coe confirmed he does doubt causation:

> I do want to say I do doubt that just based on the initial examination of Dr. Shapiro. Dr. Shapiro is the treating physician, Dr. Shapiro is an ear, nose and throat specialist as we've established here, the doctor certainly is capable of carrying out an adequate examination of the upper airway, respiratory passages…
> But the examination of June 4th of 2012 was of particular significance to me. This is the first specialist examination of Ms. Pearlman, it's three and a half months after her accident, it showed no focal abnormalities within her nose, no really significant abnormalities other than this lip scar which certainly was present and did require surgical correction. RX2, p. 59-60.

Dr. Coe also noted at the August 16, 2012 visit, Dr. Shapiro described Petitioner's nasal congestion and sinusitis as new complaints. RX2, p. 61.

On re-cross examination, Dr. Coe testified there was nothing in the record to indicate what instruments Dr. Shapiro may or may have not used during the exam, "He only comes to the general conclusion that the nasal exam is unremarkable." RX2, p. 63. An unremarkable exam does not necessarily mean it was perfect. RX2, p. 63.

CONCLUSIONS OF LAW

I. Causation

On review, the causation dispute concerns Petitioner's septal deviation/nasal obstruction, sinusitis, hearing loss, and C. diff. At trial, Petitioner also claimed a causal connection to her psychiatric condition of ill-being; this was denied and Petitioner does not challenge that denial on review. The Commission will address each of the disputed conditions of ill-being in turn.

A. Septal Deviation/Nasal Obstruction

The Commission notes the February 22, 2012 maxillofacial CT demonstrates Petitioner's nasal septum is slightly rightward bowed. PX1. This is also documented on the September 11, 2012 CT scan: "a small septation is seen at the posteroinferior right maxillary sinus, unchanged." PX2A. As such, the diagnostic imaging establishes the presence of a septal deviation. The question before the Commission is whether that deviation occurred in, or was exacerbated by, Petitioner's fall. Three physicians offered opinions on this issue: Drs. Shapiro, Hulett, and Coe.

In his April 9, 2013 office note, Dr. Shapiro opined "there is a high probability that septal deformity is related to her facial injury" and further indicated, "In multiple previous records and communications the link between septal deviation to the right and patient's facial injury has been established. Physical exam findings and CAT scan results are consistent with history of facial trauma." PX4. The Commission observes, however, the "link" Dr. Shapiro asserts was established in previous records is primarily his parroting of Petitioner's belief her symptoms are related

coupled with his verification such a connection is possible:

> September 11, 2012: "The patient does believe that after her facial injury she experienced exacerbation of nasal obstruction and rhinitis. To degree of that is hard to evaluate. Hypothetically, the patient's facial injury could have lad *[sic]* to septal displacement."
>
> January 3, 2013: "The patient believes that her nasal, sinus, ear symptoms are related to her injury. She does have significant septal deformity which may be related to the trauma, however, at this point that is challenging to prove without having access to the patient's prior medical records." PX4.

Certainly, Dr. Shapiro's recitation of Petitioner's belief is not relevant. However, the Commission does afford considerable weight to Dr. Shapiro's statement that Petitioner's mechanism of injury and objective findings are consistent with the septal deviation/nasal obstruction being related to the fall.

Dr. Hulett also addressed causation of the septal deviation. What the Commission finds significant about Dr. Hulett's opinion, however, is it changed between the date of his report and his deposition. Dr. Hulett's report contains a definitive denial of causal connection: the doctor acknowledged the existence of a significant right septal deviation, but opined the deviation was likely preexisting. Dr. Hulett further concluded the paranasal mucosal thickening and obstruction was likely not the result of any type of facial fracture. Dr. Hulett concluded Petitioner was suffering from nasal obstruction and chronic sinusitis, neither of which were related to the fall. RX1, DepX2. At his deposition, however, Dr. Hulett reversed himself:

> Q. Were you able to form an opinion as to whether her nasal septal deviation was related to the fall that she described?
>
> A. That is more difficult to delineate due to the fact that no one has a perfectly straight septum. So yes, her septal deviation could have been affected by the fall, but it's hard to say what degree was already there versus what she could have sustained during that fall. RX1, p. 12.

In other words, Dr. Hulett concedes causation based on an aggravation theory. See *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193, 205, 797 N.E.2d 665 (2003) (It is well established that an accident need not be the sole or primary cause—as long as employment is a cause—of a claimant's condition), and *Caterpillar Tractor Co. v. Industrial Commission*, 92 Ill. 2d 30, 36, 440 N.E.2d 861 (1982) (A claimant with a preexisting condition may recover where employment aggravates or accelerates that condition).

Finally, there is Dr. Coe. While Dr. Coe did not address causation in his impairment report, during his deposition, Dr. Coe was asked whether anything in the medical records "would make you believe that Ms. Pearlman did not have a septal injury in addition to the nondisplaced nasal fracture injury?" As Dr. Coe provided a causation opinion, the Commission must weigh it and determine to what, if any, weight it is entitled. Dr. Coe testified he doubted a causal connection

existed because Dr. Shapiro's June 5, 2012 note indicates the nasal examination was unremarkable; therefore, if the septum was deviated in the fall, as of June, "there was no longer any internal nasal structural abnormality that was identified." RX2, p. 52. Dr. Coe also noted the operative report describes a C-shaped septal deformity and stated that "was not reported in the records at or around the time of the accident." RX2, p. 55. The Commission finds Dr. Coe's statements do not comport with the record. For instance, his assertion no deformity was reported at the time of accident is rebutted by the February 22, 2012 CT. PX1. Moreover, the notion no structural abnormality existed as of June is incompatible with the September 11, 2012 CT finding of an "unchanged" septation. PX2A. Therefore, the Commission finds Dr. Coe's causation opinion is entitled to little weight. *See, e.g., Sunny Hill of Will County v. Illinois Workers' Compensation Commission*, 2014 IL App (3d) 130028WC, ¶36, 14 N.E.3d 16 (Expert opinions must be supported by facts and are only as valid as the facts underlying them.)

Given the diagnostic evidence of deviation noted on the CT scans, Dr. Shapiro's conclusion, and Dr. Hulett's concession he could not delineate what to degree the septal deviation was pre-existing versus what Petitioner sustained in the fall, the Commission finds Petitioner established her work accident was a factor in causing her septal deviation/nasal obstruction. *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193 (2003).

B. Sinusitis

Initially, the Commission observes Petitioner did not provide any specifics as to the instances of sinusitis after the accident. Petitioner certainly testified she did not have nasal problems or treatment prior to the accident (T. 35-36), however no details were provided as to when the recurrent bouts of sinusitis began, how often they occurred, or what treatment she had.

Further, while Dr. Shapiro's records mention complaints of congestion and chronic rhinitis, the Commission finds it significant those complaints were not voiced until August 16, 2012, nearly six months after her fall. PX4. The Commission additionally finds Dr. Shapiro's September 11, 2012 and January 3, 2013 records notable. As detailed above, on those dates the doctor documented Petitioner's belief all her symptoms were related to her fall; the Commission highlights that while Dr. Shapiro linked Petitioner's fall to her septal deviation/nasal obstruction, the doctor did not offer a similar link to Petitioner's sinusitis.

The only causation opinion in the record regarding sinusitis is that of Dr. Hulett. Dr. Hulett denied a causal connection and testified as to the basis of his opinion: "Due to the fact that on the CT scan there's no significant fractures that affected the drainage pathways of her sinuses. On exam there is little evidence of chronic sinusitis other than her history, and it just seems unusual for the injury that she sustained to result in the conditions that she was describing." RX1, p. 11. Dr. Hulett later explained the lack of sinus infections prior to the fall did not mean recurrent sinusitis afterward was causally related: "As far as the recurrent sinus infections, no, I find that less relevant due to the fact that I still don't see a cause and effect with her examination, her history, and the onset of her sinus infections." RX1, p. 28. The Commission finds Dr. Hulett's opinion is persuasive and affords it significant weight.

The Commission finds Petitioner failed to prove by a preponderance of the evidence that

her sinusitis is causally related to her work injury.

C. Hearing Loss

Petitioner testified she noticed diminishing hearing in May or June of 2012. She explained she wore a headset at work and began to notice she could not hear well in her left ear; she initially thought there was a problem with her headset but when she had the same problem with a new headset she realized it was her hearing. T. 27. The first mention of hearing difficulties in the medical records is not until the November 28, 2012 evaluation by Dr. Jessica Blomeke. Petitioner reported "having hearing difficulties and dizziness" since the fall which had become increasingly worse since June; the note also reflects a history of "bilateral, non-pulsatile tinnitus." PX4. Audiometry revealed bilateral hearing loss. PX4. Petitioner saw Dr. Shapiro one month later, on December 20, 2012, for evaluation of "cough, congestion, and diminished hearing on the left side." PX4. Petitioner was prescribed steroids and Augmentin. When Petitioner followed up on January 3, 2013, her hearing on the left was significantly diminished and audiology showed "significant drop in hearing on the left side secondary to middle ear effusion." PX4. On January 10, 2013, Dr. Shapiro performed a myringotomy and tube placement in the left ear. PX4.

The Commission emphasizes there is no medical evidence regarding causation of Petitioner's hearing loss. To be clear, Dr. Shapiro associates the hearing loss to middle ear effusion, but nowhere does the doctor opine the ear infection was caused by a sinus infection. "Although medical testimony as to causation is not necessarily required [citation omitted], where the question is one within the knowledge of experts only and not with the common knowledge or comprehension of laymen, expert testimony is necessary to show that a claimant's work activities caused the condition complained of. [Citation omitted]." *Interlake Steel Co. v. Industrial Commission*, 136 Ill. App. 3d 740, 744, 483 N.E.2d 979 (1985). The Commission finds this is not an issue to be resolved on an inference. Rather, this is a medical question which required some expert opinion to explain a) if a sinus infection can cause fluid retention in the inner ear; b) why Petitioner would begin losing her hearing in June when she had no treatment for sinus infection at that time; and c) how permanent hearing loss can result from an ear infection which was treated. Given the lack of medical evidence to support causation, the Commission finds Petitioner failed to prove her hearing loss is causally related to the work injury.

D. C. diff

The evidence demonstrates Petitioner developed C. diff after Dr. Shapiro prescribed a course of Augmentin to treat an ear infection. As the C. diff was a consequence of treatment for an unrelated condition of ill-being, the Commission finds no causal relationship exists between the C. diff and Petitioner's work accident.

II. Temporary Disability

Petitioner claimed entitlement to three periods of temporary disability benefits: August 9, 2012 through August 19, 2012; February 12, 2013 through February 15, 2013; and July 11, 2013 through July 18, 2013. Respondent stipulated Petitioner is entitled to TTD benefits from August 9, 2012 through August 19, 2012, but disputed liability for any other temporary disability benefits.

The first disputed off work period covers February 12, 2013 through February 15, 2013, when Petitioner was admitted to Advocate Condell for treatment of C. diff. Having found this condition of ill-being is not causally connected to Petitioner's work accident, the Commission denies TTD benefits for this period.

The remaining period at issue, July 11, 2013 through July 18, 2013, is associated with Dr. Shapiro's surgical correction of Petitioner's septal deviation. As detailed above, the Commission finds a causal relationship exists between Petitioner's work accident and the septal deviation/nasal obstruction. As such, Petitioner is entitled to temporary disability benefits concomitant to the treatment of that condition.

Therefore, the Commission finds Petitioner is entitled to 2 5/7 weeks of temporary total disability benefits. This award represents August 9, 2012 through August 19, 2012, as well as July 11, 2013 through July 18, 2013.

III. Medical Expenses

Having found a causal relationship exists between Petitioner's work accident and her nondisplaced nasal bone fracture, lip laceration and scar, and septal deviation/nasal obstruction, the Commission finds Petitioner is entitled to the reasonable and necessary medical expenses associated with those conditions of ill-being pursuant to Sections 8(a) and 8.2. The Commission denies expenses associated with Petitioner's sinusitis, hearing loss, and C. diff and further denies Petitioner's request that Respondent provide hearing aids.

IV. Nature and Extent

Petitioner's work accident occurred after September 1, 2011; therefore, Section 8.1b applies. Section 8.1b(b) requires permanent partial disability be determined following consideration of five factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. *820 ILCS 305/8.1b(b)*.

Section 8.1b(b)(i) – PPD impairment report

Respondent submitted a §8.1b(a) AMA impairment report prepared by Dr. Coe subsequent to his January 13, 2015 examination of Petitioner. The Commission observes Dr. Coe limited his assessment to injuries "specifically identified as arising from the accident of February 21, 2012 (facial scar and nondisplaced nasal bone fracture)." Dr. Coe examined Petitioner's scar and described it as "a 1-inch, horizontal, slightly depressed, well-healed scar immediately above the upper lip. There was a slight decrease in sensation over and surrounding the scar line. The scar…remained visible from all angles." Nasal examination revealed no evidence of septal deviation or obstruction. Dr. Coe assessed a final facial scar impairment rating of 3% of the person. Dr. Coe additionally determined Petitioner had no air passage deficits and therefore assessed a 0%

impairment for her nondisplaced nasal bone fracture.

As the Commissioners did not view Petitioner's scar, we rely heavily on Dr. Coe's description. The Commission finds the report weighs in favor of increased impairment resulting from Petitioner's lip scar, and further is indicative of minimal impairment resulting from Petitioner's nasal fracture and surgically corrected septal deviation.

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

Petitioner did not testify what her occupation was nor was she asked what her job duties were for Respondent. The medical records document various job titles, including executive assistant (PX3), secretarial (PX4), and sales person (RX2, DepX3). The Commission observes Dr. Shapiro did not impose any permanent restrictions and no physician has indicated Petitioner's facial injuries rendered her physically limited or prohibited from resuming her career, whatever it was. The Commission finds Petitioner's release to unrestricted duty evidences a good recovery. The Commission places significant weight on this factor as being indicative of reduced impairment.

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

Petitioner was 57 years old on the date of her accidental injury. Petitioner will therefore face her residual disability for a shorter period. The Commission finds this factor weighs in favor of reduced impairment.

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

Petitioner no longer works for Respondent, however the reason for the termination of Petitioner's employment was not adduced at trial, and the Commission declines to infer Petitioner's termination was a consequence of any residual physical disability. The Commission finds no evidence of a negative impact on Petitioner's future earning capacity, which weighs heavily in favor of reduced impairment.

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

Petitioner underwent two surgical procedures at Dr. Shapiro's hands: Z-plasty scar revision as well as septoplasty/sinuplasty. Post-operative care following the August 9, 2012 cosmetic procedure was minimal: when Dr. Shapiro removed the sutures on August 16, 2012, he observed the results were "quite encouraging"; Petitioner was to minimize facial movement and apply scar cream but was cleared to resume full activity on August 20, 2012. PX4. Petitioner's convalescence following the July 11, 2013 sinus surgery was similarly short: the splint was removed on July 16; Petitioner able to work as of July 19; and on August 1, Dr. Shapiro noted Petitioner was doing well. PX4. Although the doctor recommended a nasal endoscopy be conducted two weeks later, Petitioner did not return for that test. The Commission finds these facts evidence positive surgical results and assigns significant weight to this factor.

Petitioner described ongoing symptoms associated with her lip and nose. She has no feeling

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in her upper lip: "The muscle was torn, and the damage was done there. So there's really no feeling in my lip." T. 32. Her smile is affected; she has no control over the portion of her mouth directly below her nose. T. 32. Regarding her nose: "I blow my nose a lot; I'm congested a lot; I have sinus problems now. But I can breathe out of both sides of my nose." T. 32.

The Commission observes Petitioner's lip injury resulted not only in a scar, but also caused nerve damage which has left her unable to feel her lip. Under these circumstances, the Commission finds that rather than a Section 8(c) disfigurement award, Petitioner's disability is properly assessed under Section 8(d)2. Upon consideration of the above factors, the Commission finds Petitioner's nondisplaced nasal fracture, lip scar, and septal deviation/nasal obstruction resulted in a 7.5% loss of the person as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $315.13 per week for a period of 2 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 the reasonable and necessary medical expenses associated with treatment of Petitioner's nasal fracture, lip laceration and scar, and septal deviation/nasal obstruction, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall hold Petitioner harmless for all claims for reimbursement by the Illinois Department of Health and Family Services for those sums it paid for treatment for Petitioner's work-related conditions of ill-being.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $283.62 per week for a period of 37.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 7.5% loss of the person as a whole.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. It is noted the parties stipulated to a credit of $270.12 for temporary total disability benefits paid, and $7065.84 for medical expenses paid.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $6,100.00. 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 13 2018

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

LEC/mck

O: 12/13/17

Charles J. DeVriendt

Charles J. DeVriendt

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Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PERLMAN, DEBRA
Employee/Petitioner

Case# **12WC024884**

LTD COMMODITIES LLC
Employer/Respondent

18IWCC0097

On 9/12/2016, 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 0.47% 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:

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STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

☐ 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

Deborah S. Pearlman
Employee/Petitioner

v.

LTD Commodities, LLC
Employer/Respondent

Case # **12 WC 24884**

Consolidated cases: _____

18IWCC0097

An *Application for Adjustment 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 **Waukegan, Illinois**, on **July 25, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was 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 18IWCC0097

On February 21, 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 $24,580.40; the average weekly wage was $472.70.

On the date of accident, Petitioner was 57 years of age, *single* with 2 dependent children.

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

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

Respondent shall be given a credit of $270.12 for TTD, $0 for TPD, $0 for maintenance, and $7,065.84 for other (medical) benefits, for a total credit of $7,335.96.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $315.13 for 2-5/7 weeks, August 9, 2012, through August 19, 2012 and from July 11, 2013 through July 18, 2013, as provided in section 8(b) of the Act. Respondent shall be given a credit of $270.12 for temporary total disability benefits previously paid.

Respondent shall pay Petitioner permanent partial disability benefits of $283.62 per week for a further period of 59.742 weeks, as provided in Section 8(c), 8(e) and 8(d)2 of the Act, because the injuries sustained caused 27.3% loss of use of the left ear (14.742 weeks); 20 weeks of disfigurement; and 5% loss of use of woman as a whole (25 weeks).

Respondent shall pay to Petitioner reasonable and necessary medical expenses of $2,379.01 as provided in Section 8(a) of the Act, subject to the fee schedule of Section 8.2 of the Act. Respondent shall hold Petitioner harmless and indemnified from all liability, attorney fees, costs and expenses arising as a result of all claims for reimbursement by the Illinois Department of Health and Family Services for those related sums it paid for Petitioner's medical care. Respondent shall further authorize and pay for a hearing aid for Petitioner's left ear.

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

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

Signature of Arbitrator

9/05/16
Date

SEP 12 2016

Findings of Fact.

Petitioner worked for Respondent in a customer service capacity. On February 21, 2012, she sustained an undisputed accidental injury on Respondent's premises. Petitioner was leaving work for the day walking across a sidewalk to her car when she slipped and fell on a mound of rock salt. She described falling "flat on her face." Petitioner testified that she struck her nose on the ground and the force of the impact to her face was sufficient to drive her front teeth completely through her upper lip. Petitioner testified that she had never had any prior problems with or medical treatment to her face, nose, sinuses, maxilla or the hearing in her left ear. She reported the accident immediately. Respondent administered first aid on the spot, and Petitioner went home.

The next day, Petitioner sought medical attention at Advocate Acute Care with a history of falling on her face injuring the left side of her face, nose and maxillae. A CT scan performed demonstrated findings of a nondisplaced left nasal bone fracture. Her sinus walls were intact. There was slight sinus coastal thickening with no fluid level. Also noted was a slight rightward bowed nasal septum. The impression was possible nondisplaced left nasal bone fracture. The emergency room attending physician's impression was trauma to the face, an abrasion to the upper lip, a headache, and a possible nasal fracture. Petitioner was treated, prescribed Tylenol, and released. She returned to the clinic on February 23, 2012, and was referred to an ear/nose/throat ("ENT") specialist. (PX 1) Petitioner testified that returned to work on February 24, 2012

Petitioner testified that she next followed-up with her primary care physician, Dr. Adi. She continued with Dr. Adi who ultimately referred her to Dr. Mishail Shapiro of Medical Arts Unlimited.

Petitioner testified that "it took a while" before she could get authorization for further treatment. She had no way to pay for this on her own and had no health insurance that would authorize and/or pay for it. Treatment stalled for a time, however, she kept working.

Petitioner first presented to Dr. Shapiro on June 5, 2012. Dr. Shapiro noted Petitioner was seen for evaluation of an "unsightly" lip scar. Dr. Shapiro noted the history of accident, and added, "[t]he patient did have other injuries as well which have resolved." The doctor provided that she voiced no other complaints. On exam, he found a horizontal scar in the middle portion of Petitioner's upper lip that had an irregular appearance at the end. He noted that that rest of his exam, which included Petitioner's nose and eardrum, was unremarkable. Dr. Shapiro assessed irregular scar secondary to facial injury. Dr. Shapiro recommended cosmetic excision and reapproximation of the scar margins. (PX 4)

Dr. Shapiro performed a "Z-plasty" in his office on August 9, 2012. Petitioner returned to the doctor for removal of the stitches one week later on August 16, 2012. On this date, Dr. Shapiro recorded that Petitioner complained of congestion and chronic rhinitis. Dr. Shapiro noted "this is a "new" complaint." He ordered a CT scan of Petitioner's sinuses but made no other recommendations. (PX 4)

Petitioner was off work from August 9, 2012, through August 19, 2012. She returned to work on August 20, 2012. She testified that Respondent terminated her employment on September 5, 2012.

Petitioner underwent a CT scan of her sinuses on September 11, 2012. The results, which were compared to the prior CT scan in February 2012 showed mild mucosal thickening in the ethmoid air cells similar to prior exam. There was trace mucosal thickening in the left sphenoid sinus which appeared slightly more pronounced. A large polyp or retention cyst was seen at the floor of the left maxillary sinus, which the radiologist felt was from the prior study. Also noted was mild mucosal thickening seen in the right maxillary

sinus with opacification within the vicinity of the uncinate process and a small septation was seen at the posteroinferior right maxillary sinus which was unchanged. The impression was paranasal sinus disease as described, increased from prior study. (PX 4)

Petitioner consulted Dr. Shapiro on the same day. He noted that the CT scan shows significant right-sided midseptal deformity, an apparent mucoid plug obstructing the right ostiomeatal complex, and an inclusion cyst along the floor of the left maxillary sinus. He saw no evidence of sinusitis. The doctor noted Petitioner believed that after her facial injury she experienced exacerbation of nasal obstruction and rhinitis. He stated "To [sic] degree of that is hard to evaluate. Hypothetically, [her] facial injury could have [led] to septal displacement." He noted that she was otherwise doing well, and that her lip revision scar was healing and would continue to improve with time. He recommended nasal spray and discussed the possibility of surgery on her sinuses. (PX 4)

On November 15, 2012, Dr. Shapiro wrote a letter to counsel for Petitioner. The doctor indicated that Petitioner was interested in proceeding with a bilateral maxillary sinuplasty that would correct her nasal septal deformity and improve her airway. He reiterated Petitioner had a significant septal deviation, which she believes is a result of a facial/nasal injury. The doctor stated that from a surgical prospective, Petitioner would benefit from correction of nasal septal deformity to improve her airway, submucous resection and outfracture of inferior to serve the same purpose. He also provided that she would benefit from bilaterally maxillary sinuplasty to improve ventilation and to clear up obstruction. (PX 4)

Dr. Shapiro sent Petitioner for an audiogram which was performed on November 28, 2012. Both Dr. Shapiro and the audiologist, Dr. Jessica Blomeke, reported their findings in an office note of November 30, 2012. The report indicated Petitioner was evaluated for disequilibrium, dizziness, and hearing difficulties, which she reported began with her work accident and had become increasingly worse since June 2012. Her medical history was noted to be positive for bilateral tinnitus and vision problems for which she did not wear glasses. She reported that she had a mixed drink the night before, which was noted could affect the results of the test. Testing showed mild sloping to severe mixed hearing loss bilaterally and orthostatic hypertension. It was recommended that Petitioner enroll in vestibular rehabilitation therapy focusing on fall precautions and balance stability in dynamic positions without vision. A cardiac workup was also recommended. (PX 4)

Petitioner returned to Dr. Shapiro on December 20, 2012 for evaluation of a cough, congestion, and diminished hearing in her left ear. Examination revealed effusion/acute sinusitis on the left and posterior nasal drainage. Dr. Shapiro prescribed prednisome, Robittusin with codeine for cough management and Augmentin 50 mg twice a day for a week. His plan was to see her again in 10 days. He noted that at that point, her effusion should resolve and further plans for vestibular rehabilitation and possibly sinus procedure would be considered. (PX 4)

Petitioner returned to Dr. Shapiro on January 3, 2013. The doctor indicated that Petitioner's hearing on the right side had improved, but hearing on the left was significantly diminished. Her sinusitis had improved, however rhinitis persisted. She still had nasal congestion and pain. Audiology showed significant drop in hearing on the left side secondary to middle ear effusion. Nasal examination showed obstruction and rhinitis without clear evidence of sinusitis. Dr. Shapiro recorded that Petitioner believed that her nasal, sinus, and ear symptoms were related to her injury. He indicated that she did have significant septal deformity which may be related to the trauma, however at that point he felt it was challenging to prove without having access to her prior medical records. He again felt Petitioner would benefit from nasal/sinus surgery. (PX 4)

At Respondent's request, Petitioner submitted to a Section 12 exam with Dr. Kevin Hulett on January 7, 2013. In his report dated same, Dr. Hulett noted that Petitioner was currently treating for nasal obstruction and chronic sinusitis. Dr. Hulett opined that the injury sustained in February 2012 did not contribute to the nasal obstruction and chronic sinusitis. He provided that the nasal septal deviation was likely pre-existing. He

indicated that although there was a mild septal deviation, the paranasal mucosal thickening and obstruction was likely not the result of any type of facial fracture. (RX 1, dep #2)

On January 10, 2013, Dr. Shapiro performed a myringotomy on Petitioner's left ear and installed a tube. (PX 4) Three days later, she presented to the emergency room at Condell Medical Center complaining of abdominal problems. The attending physician noted a history of Augmentin prescribed for an ear infection and tube placement. She was diagnosed with Clostridium difficile colitis ("c. diff.") and admitted for two days. (PX 2A, PX 2B)

Dr. Shapiro examined Petitioner on January 24, 2013. He noted that the position of the tube was excellent and an audiology showed significant improvement in hearing in Petitioner's left ear. He noted Petitioner still had rhinitis and nasal congestion. Dr. Shapiro again indicated that Petitioner had nasal anatomy which could be improved by surgical correction. (PX 4)

On April 9, 2013, Petitioner returned to Dr. Shapiro complaining of diminished hearing in left ear and nasal obstruction. The doctor indicated Petitioner wanted to proceed with the recommended surgery to correct her airway. The doctor wrote, "[a]s there my previous notes there is a high probability that septal deformity is related to her facial injury. It is my professional opinion that surgery should be covered. In multiple previous records and communications the link between septal deviation to the right and patient's facial injury has been established. Physical examination findings and CAT scan results are consistent with history of facial trauma." He gives a causal opinion between her accident and the condition he was seeing, the surgery he recommended and the facial injury. (PX 4)

Petitioner testified that she had been awarded Medicaid benefits by the State. On July 11, 2013, Dr. Shapiro performed a septoplasty, frontal and bilateral sinuplasty, and submucous resection and outrastructure of the inferior turbinate. (PX 2A, PX 2B, PX 4). Petitioner returned to the doctor on July 16, 2013 for splint removal. Dr. Shapiro noted Petitioner was doing well with no complaints. Petitioner returned to the doctor on August 1, 2013. At that time, the doctor recorded Petitioner was progressing as expected. Petitioner was to follow-up in two (2) weeks for nasal endoscopy and to start nasal irrigation. (PX 4) Petitioner testified that she has not seen Dr. Shapiro since August 1, 2013.

At Respondent's request, Petitioner also submitted to a Section 12 exam with Dr. Jeffrey Coe on January 13, 2015. The purpose of Dr. Coe's exam was to determine an impairment rating under the AMA Guidelines, Sixth Edition. Based on his exam and review of the medical records, Dr. Coe determined that Petitioner had reached maximum medical improvement "with regard to any facial/head injury suffered in her accident …on February 21, 2012." He felt "[Petitioner] is in need of no further medical treatment from injuries specifically identified as arising from the accident of February 21, 2012 (facial scar and nondisplaced nasal bone fracture)." Dr. Coe determined that Petitioner sustained an impairment equivalent to 3% loss of use of the whole body based on the diagnoses of facial laceration with scarring and nondisplaced nasal bone fracture. (RX 2, dep.#3)

Respondent's Section 12 examiner, Dr. Hulett testified via evidence deposition in this matter on June 26, 2013. Dr. Hulett testified that he has been an ENT physician for more than ten years and is board certified in otolaryngology. Dr. Hulett testified that Petitioner's chronic sinusitis was not related to her work accident. Dr. Hulett explained that the CT scan after the accident did not show "significant fractures that affected the drainage pathways of her sinuses." He also indicated that his examination provided little evidence of chronic sinusitis other than her history stating, "…it just seems unusual for the injury that she sustained to result in the conditions that she was describing." (RX 1, p.11)

With respect to Petitioner's nasal septal deviation, Dr. Hulett testified that it was "…more difficult to delineate due to the fact that no one has a perfectly straight septum. So yes, her septal deviation could have been affected by the fall, but it's hard to say what degree was already there versus what she could have sustained

during that fall." (RX 1, p.12)

At the time of deposition, Dr. Hulett testified that Petitioner's chronic sinusitis required further treatment, albeit not related. (RX 1, pp.12-13) On cross-examination, Dr. Hulett , when comparing the findings of the CT scans, testified that the September 11, 2012 findings identified a "little bit more mucosal thickening" as compared to the February 2012 scan. The doctor provided that thickening could occur after a viral tract infection, a recent sinus infection or due to a chronic sinus infection. When asked if an injury to the mucosa of the nasal passages cause a susceptibility to infection, the doctor replied that he was not aware of any data to suggest that an injury to nasal mucosal lining would make a person susceptible to recurrent sinus infections. He added, upon further questioning, that "you can get a sinus infection following trauma." (RX 1, pp.25-27) The doctor also testified that although there was an outside possibility that the accident caused Petitioner's chronic sinusitis or aggravated a pre-existing condition, it was less likely. (RX 1, p.29) The doctor further stated that a septum can contribute to chronic sinusitis. (RX 1, p.31) Lastly, Dr. Hulett testified that turbinate hypertrophy is an indication of inflammation and that chronic sinusitis is a known cause of inflammation and hypertrophy, also known as swelling and enlargement. It could, he agreed, cause airway obstruction. (RX 1, pp.42-43)

Dr. Coe testified via evidence deposition in this matter on July 13, 2015. Dr. Coe testified that the sole purpose of his exam was to determine an impairment rating under the AMA Guidelines, Sixth Edition. (RX 2, pp.21, 24) He provided that the conditions he rated only applied to Petitioner's facial laceration scarring of her upper lip and nondisplaced nasal fracture. He did not consider any hearing loss in her left ear, chronic sinusitis, dizziness, headaches and periodic c-dif consequences. (RX 2, pp. 37-43) Based on his exam and review of the medical records, Dr. Coe determined that Petitioner sustained impairment equivalent to 3% loss of use of the whole body as a result of her facial laceration and nasal fracture. (RX 2, p.43)

Petitioner testified that she began seeing a psychiatrist, Dr. Anatoliy Pyslar, for anxiety, depression, and sleep disorders. Dr. Pyslar completed a mental residual functional capacity statement in June 2016. (PX 8) Petitioner testified that she experiences dizziness when she gets up out of bed quickly, pain, gastrointestinal problems, and depression. She currently takes prescription medication for depression, pain, and sleep. She has had at least two jobs since she stopped working for Respondent.

With regard to Issue (F.), Is Petitioner's current condition of ill-being causally related to the injury?, the Arbitrator finds as follows:

The parties agree that as a causal relationship exists between Petitioner's broken nose (nondisplaced fracture) and upper lip conditions of ill-being and the accident sustained on February 21, 2012. As such, the Arbitrator will make no comment on the causal connection between Petitioner's accident and the injuries to those specific body parts.

The Arbitrator, however, makes the following findings with regard to the other claimed injuries Petitioner relates were caused by her accident:

Relating to the claimed sinus conditions that followed the injury, Petitioner fell striking her nose, her upper lip and the left side of her face in a compensable accident as she was leaving work on February 21, 2012. Petitioner testified that the force of the impact to her face was sufficient to drive her front teeth completely through her upper lip. Petitioner testified that she had never had any prior problems with or medical treatment to her face, her nose, her sinuses, her maxilla or the hearing in her left ear. She also testified that she had never had any prior problems with her abdomen or bowels. This testimony remained unchallenged and unrefuted.

Petitioner was initially treated at Advocate Condell Acute Care Center the next day. She was sent to Advocate Condell Hospital for a CT scan of her head. She was advised to return for a visit with an ENT.

specialist the next day, February 23, 2012. She was kept off all work until February 24, 2012 and then allowed to go back to work on a limited basis. Respondent accommodated this until March 1, 2012. The CT scan of February 22, 2012 was read to show a left nasal bone fracture, a slightly bowed septum, slight coastal sinus thickening but no fluid buildup. Aleve was added to her medication regimen. Thereafter, for a time, Petitioner was treated by her P.C.P., Rafa Adi, M.D. She developed sinus complaints. These were diagnosed as sinus infections and were treated conservatively.

According to Petitioner, she continued to have sinus complaints and began to lose hearing in her left ear. Dr. Adi prescribed Augmentin and Amoxicillin Clavilunate. This caused Petitioner to have a C.Dif infection with pronounced gastric distress, rectal bleeding and diarrhea. This resolved. She was hospitalized at Advocate Condell Medical Center for this and, throughout the course of her treatment had many "emergency room only" visits to Advocate Condell Medical Center.

Dr. Adi referred Petitioner to a physician who is boarded in both ENT work and plastic surgery. She was not able to see him initially due to a lack of authority for treatment by Respondent. Petitioner testified that she had no way to pay for this on her own and had no health insurance that would authorize and/or pay for it. Treatment stalled for a time. Petitioner, however, kept working.

On June 5, 2012, Petitioner first saw Mishail Shapiro, D.O., the E.N.T. and plastic surgery specialist. He examined her lip and prescribed surgery to repair her lip only. He ordered a pre-surgical physical and waited for authorization.

On August 9, 2012 Petitioner had the plastic surgery procedure (a "Z-plasty"). It was performed by Dr. Shapiro at Medical Arts Unlimited, Corp. The surgical procedure is described both in Dr. Shapiro's records and the records of Medical Arts Unlimited, Corp. Respondent, having accepted responsibility for this injury consequence, paid for it.

On August 16, 2012 Petitioner returned to Dr. Shapiro in follow-up to have her sutures removed. Petitioner complained of nasal congestion and chronic rhinitis. She related this to her fall at work. Dr. Shapiro ordered a CT scan of her face to include her sinuses. Dr. Shapiro wrote in his office note of the day that this was a "new complaint" (The Arbitrator notes that the CT scan of February 22, 2012 showed some, but slight, thickening of the coastal sinus and a slight deviated septum). The CT scan was performed at Advocate Condell Hospital on September 11, 2012. The CT scan test was used for comparison with the prior February 22, 2012 scan. The findings of significance were 1.)"mild mucosal thickening in the ethmoid air cells," 2.)"trace mucosal thickening in the left sphenoid sinus appears slightly more pronounced," 3.) "large polyp or retention cyst is seen at the floor of the left maxillary sinus, new from the prior study" and, 4.) "mild mucosal thickening is seen in the right maxillary sinus with opacification within the vicinity of the uncinate process" and, "a small septation is seen at the posteroinferior right maxillary sinus – unchanged." The impression was: "paranasal sinus disease as described, increased from prior study."

On September 11, 2012, Dr. Shapiro noted that the CT scan "indeed shows significant right-sided midseptal deformity," an apparent mucoid plug obstructing the right ostiomeatal complex, and an inclusion cyst along the floor of the left maxillary sinus. The doctor noted Petitioner believed that after her facial injury she experienced exacerbation of nasal obstruction and rhinitis. He stated "To [sic] degree of that is hard to evaluate. Hypothetically, [her] facial injury could have [led] to septal displacement." He recommended nasal spray and discussed the possibility of surgery on her sinuses.

On November 15, 2012, Dr. Shapiro reiterated Petitioner had a significant septal deviation. The doctor stated that from a surgical prospective, Petitioner would benefit from correction of nasal septal deformity to improve her airway, submucous resection and outfracture of inferior to serve the same purpose. He also

provided that she would benefit from bilaterally maxillary sinuplasty to improve ventilation and to clear up obstruction.

On November 28, 2012, given Petitioner's ongoing complaints of left ear hearing loss, Dr. Shapiro sent Petitioner for an audiogram. It was performed and both Dr. Shapiro and the audiologist reported their findings in an office note of November 30, 2012. They reported that Petitioner reported that she had been "having hearing difficulties and dizziness since the accident which became increasingly worse since June 2012...." Testing showed mild sloping to severe mixed hearing loss bilaterally and orthostatic hypertension. It was recommended that Petitioner enroll in vestibular rehabilitation therapy focusing on fall precautions and balance stability in dynamic positions without vision.

On December 20, 2012, Dr. Shapiro recorded Petitioner complained of cough congestion, headache and diminished hearing on the left side. His exam showed "effusion on the left, left acute sinusitis, posterior nasal drainage – otherwise unchanged from multiple previous visits. He prescribed both prednisome, Robittusin with codeine for cough management and Augmentin 50 mg twice a day for a week. His plan was to "see her again in 10 days. At that point, her effusion should resolve and we can make further plans for vestibular rehabilitation and possibly sinus procedure."

On January 10, 2013, having obtained authorization from the Illinois Department of Health and Family Services, Dr. Shapiro both performed a mygrigotomy surgery in Petitioner's left ear to release the fluid build-up, swelling and pressure and to install an Armstrong Grommet (medical drain tubes) within the open area of the myringotomy surgical wound.

On January 24, 2013, Petitioner returned and the office note indicates that the tube was still in place and working, that the swelling was down and that the left ear hearing had shown significant improvement (mild to severe). A review of the audiologist's report following the repeat audiogram of that day reveals a different result. The audiologist's report of that day shows "... an improvement in L.E. (left ear) hearing however still down compared to RE (right ear) and a mixed component. L.E. showed a mild sloping to severe mixed H.L. (hearing loss)."

Dr. Shapiro, again, recommends surgery to correct Petitioner's "nasal anatomy" but, in the meantime, she is to "take over-the-counter nasal decongestants.

On April 9, 2013, Petitioner returned to Dr. Shapiro complaining of diminished hearing in left ear and nasal obstruction. The doctor wrote, "[a]s there my previous notes there is a high probability that septal deformity is related to her facial injury. It is my professional opinion that surgery should be covered. In multiple previous records and communications the link between septal deviation to the right and patient's facial injury has been established. Physical examination findings and CAT scan results are consistent with history of facial trauma."

On July 11, 2013, Dr. Shapiro performed the nasal/facial surgery at his office. The procedures were septoplasty, frontal and bilateral sinuplasty, and submucous resection and outrastructure of the inferior turbinate. Petitioner followed up with Dr. Shapiro. Healing progressed as expected.

Petitioner's hearing on the left continued to diminish. She claims total deafness in the ear now.

Respondent's Section 12 examiner testified that Petitioner's chronic sinusitis was not related to her work accident. Dr. Hulett explained that CT scan after the accident did not show "significant fractures that affected the drainage pathways of her sinuses." He also indicated that his examination provided little evidence of chronic sinusitis other than her history stating, "...it just seems unusual for the injury that she sustained to result in the conditions that she was describing." With respect to Petitioner's nasal septal deviation, Dr. Hulett testified that

it was "...more difficult to delineate due to the fact that no one has a perfectly straight septum. So yes, her septal deviation could have been affected by the fall, but it's hard to say what degree was already there versus what she could have sustained during that fall." Dr. Hulett testified that Petitioner's chronic sinusitis required further treatment, albeit not related. On cross-examination, Dr. Hulett , when comparing the findings of the CT scans, testified that the September 11, 2012 findings identified a "little bit more mucosal thickening" as compared to the February 2012 scan. The doctor provided that thickening could occur after a viral tract infection, a recent sinus infection or due to a chronic sinus infection. When asked if an injury to the mucosa of the nasal passages cause a susceptibility to infection, the doctor replied that he was not aware of any data to suggest that an injury to nasal mucosal lining would make a person susceptible to recurrent sinus infections. He added, upon further questioning, that "you can get a sinus infection following trauma." The doctor also testified that although there was an outside possibility that the accident caused Petitioner's chronic sinusitis or aggravated a pre-existing condition, it was less likely. The doctor further stated that a septum can contribute to chronic sinusitis. Lastly, Dr. Hulett testified that turbinate hypertrophy is an indication of inflammation and that chronic sinusitis is a known cause of inflammation and hypertrophy, also known as swelling and enlargement. It could, he agreed, cause airway obstruction. Dr. Hulett opined that on the date he examined Petitioner, she was not done with all treatment. She was, however, done with all treatments related to her accident. He was of the opinion that when he saw her she was not yet at MMI. He stated that with more time and conservative care with over-the-counter medications her condition would continue to improve.

At Respondent's request, Petitioner submitted to a Section 12 exam with Dr. Jeffrey Coe on January 13, 2015. Dr. Coe testified that the sole purpose of the exam was to determine an impairment rating under the AMA Guidelines, Sixth Edition. Based on his exam and review of the medical records, Dr. Coe determined that Petitioner had reached maximum medical improvement "with regard to any facial/head injury suffered in her accident ...on February 21, 2012." He felt "[Petitioner] is in need of no further medical treatment from injuries specifically identified as arising from the accident of February 21, 2012 (facial scar and nondisplaced nasal bone fracture)." Dr. Coe determined that Petitioner sustained an impairment equivalent to 3% loss of use of the whole body based on the diagnoses of facial laceration with scarring and nondisplaced nasal bone fracture.

The Arbitrator, based on all of the records and reports in evidence, and all of the unchallenged testimony of Petitioner, finds that Petitioner experienced a compensable on-the-job accident while working for the Respondent on February 21, 2012 that caused her the following injuries:

1. A broken left nasal bone.
2. A "teeth fully through the upper lip "scar that is clearly visible upon examination and which creates a deformity of the upper lip most noticeable when she talks or attempts to smile "this notwithstanding a "Z plasty" surgery to her upper lip by Dr. Shapiro.
3. A deviated septum (bowed to the right)
4. Sinus infections that lead to and caused swelling in the form of fluid retention in her left inner ear and subsequent (now) alleged complete hearing loss in the left ear
5. Periodic bouts of abdominal pain, cramps and severe, and, at times, prolonged diarrhea, this as a consequence of two challenges of sinus infection treatment with Augmentin.

The Arbitrator specifically notes Dr. Shapiro's, Petitioner's treating physician, April 9, 2013 notation wherein the doctor wrote, "[a]s there my previous notes there is a high probability that septal deformity is related to her facial injury. It is my professional opinion that surgery should be covered. In multiple previous records and communications the link between septal deviation to the right and patient's facial injury has been established. Physical examination findings and CAT scan results are consistent with history of facial trauma." The Arbitrator further notes Respondent's Section 12 examiner testimony that when comparing the findings of the CT scans, the September 11, 2012 findings identified a "little bit more mucosal thickening" as compared to the February 2012 scan. The doctor provided that thickening could occur after a viral tract infection, a recent sinus infection or due to a chronic sinus infection. When asked if an injury to the mucosa of the nasal passages

cause a susceptibility to infection, the doctor replied that he was not aware of any data to suggest that an injury to nasal mucosal lining would make a person susceptible to recurrent sinus infections. However, upon further inquiry, he added that "you can get a sinus infection following trauma." The doctor also testified that there was an outside possibility, the accident could cause Petitioner's chronic sinusitis or aggravated a pre-existing condition. The doctor further stated that a septum can contribute to chronic sinusitis. Lastly, Dr. Hulett testified that turbinate hypertrophy is an indication of inflammation and that chronic sinusitis is a known cause of inflammation and hypertrophy, also known as swelling and enlargement. It could, he agreed, cause airway obstruction.

The Arbitrator also finds that Petitioner failed to prove that her psychological conditions are causally related to her work accident on February 21, 2012. None of her claimed problems are documented anywhere in the medical records of treatment that occurred over the course of more than four years. Dr. Pyslar, the only physician who treated these conditions, offered no causation opinion one way or the other.

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:

Having found the requisite causal relationship, the Arbitrator awards the following medical expenses:

1. Rafa Adi, M.D.	$622.00
2. Mishael Shapiro, D.O.	$ 11.45
3. Illinois Department of Health and Family Services	$1,745.56

Respondent shall hold Petitioner harmless and indemnified from all liability, attorney fees, costs and expenses arising as a result of all claims for reimbursement by the Illinois Department of Health and Family Services for those related sums it paid for Petitioner's medical care. Respondent shall further authorize and pay for a hearing aid for Petitioner's left ear.

The parties stipulated that Respondent paid a total of $7,065.84 in medical bills. The Arbitrator awards a credit for any medical bills that were paid prior to this award.

With regard to Issue (K.), What temporary benefits are in dispute, the Arbitrator finds as follows:

Petitioner is claiming temporary total disability benefits for the periods of August 9, 2012 through August 19, 2012; from February 12, 2013 through February 15, 2013; and from July 13, 2013 through July 18, 2013.

The parties agree that Petitioner was temporarily and totally disabled for work for the period of August 9, 2012, through August 19, 2012. She returned to work on August 20, 2012 and continued to work until she was terminated from her employment on September 5, 2012.

On July 11, 2013, Dr. Shapiro performed a septoplasty, frontal and bilateral sinuplasty, and submucous resection and outrastructure of the inferior turbinate. Petitioner returned to the doctor on July 16, 2013 for splint removal. Dr. Shapiro noted Petitioner was doing well with no complaints. The doctor also indicated Petitioner "may return to work in 7 days after surgery…"

Based on the above, the Arbitrator finds that Petitioner was temporarily totally disabled from work for the periods of August 9, 2012, through August 19, 2012 and from July 11, 2013 through July 18, 2013, or a period of 2-5/7 weeks.

With respect to the period of February 12, 2013 through February 15, 2013, the records show she was seen in the emergency room for her C-dif condition. However, the record fails to demonstrate she was authorized off work. As such, the Arbitrator finds Petitioner failed to prove she is entitled to temporary total disability benefits for said period.

Respondent is entitled to credit for payments it made to Petitioner in the amount of $270.12.

With regard to Issue (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 incurred on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to the most current edition of the AMA'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 Section 8.1b(a) the Arbitrator notes Dr. Coe determined that Petitioner sustained an impairment equivalent to 3% loss of use of the whole body based on the diagnoses of facial laceration with scarring and nondisplaced nasal bone fracture. Dr. Coe does not evaluate the impairment caused by Petitioner's left ear hearing loss since at the time of his assessment and report of January 13, 2015 Petitioner was still under treatment for infection. Nor did he consider any impairment from the consequences of Petitioner's C-diff infection and residuals or her nasal fracture. The Arbitrator gives little weight to this assessment.

With regard to subsection (ii) of Section 8.1b(b), the Arbitrator notes Petitioner was working in a customer service capacity at the time of her injury. She was returned to work in a full duty capacity and is not currently under any physical restriction because of her work-related condition. The Arbitrator gives weight to this factor.

With regard to subsection (iii) of Section 8.1(b), the Arbitrator notes Petitioner was 60 years old on the date of arbitration. Petitioner is an individual who is in her sixth decade of life and will live with her permanent disability for a shorter period than a younger individual. As such, the Arbitrator gives little weight on this factor.

With regard to subsection (iv) of Section 8.1(b), the Arbitrator notes that no evidence was offered to show that Petitioner sustained any loss of earnings capacity due to her work-related. The Arbitrator gives no weight on this factor.

With regard to subsection (iv) of Section 8.1(b), the Arbitrator notes Petitioner's claim of left ear hearing loss is noted in the records as severe and declining, that a prosthetic device has been left in Petitioner's left ear protruding from the inner ear through to the outside, passing through her eardrum. There has been a prescription for a left ear hearing aid that was never authorized or provided. The Arbitrator gives greater weight to these finding.

Relating to Petitioner's nasal bone fracture, a statutory specific loss (with a minimum of 2 weeks required), the Arbitrator finds that Dr. Shapiro removed bone and cartilage chips during the surgery of July 15, 2013. He performed more than just a "bone setting" procedure. He performed a septoplasty, a sinuplasty of the frontal and maxillary sinuses bilaterally and performed a submucous resection and an outfracture of the inferior

turbinates. This was not done for appearance sake. It was done to clear the nasal airway obstructions. The Arbitrator awards 3% permanent partial disability under Section 8(d) 2.

Relating to Petitioner's hearing loss issue, the Arbitrator, while having heard that Petitioner claims to have no hearing in her left ear, refers to the last audiogram test result in the record, this was performed on her on January 24, 2013. It showed a 35 decibel hearing loss at 1000Hz, a 40 decibel hearing loss at 2000 Hz and a 50 decibel hearing loss at 3000Hz. This equates to a then present percentage disability to Petitioner's left ear of 27.3%.

Relating to the permanent disfigurement consequence of the injury, the Arbitrator finds Petitioner's upper lip scar is clearly visible and disfiguring. It also interferes with her normal function of her lips and mouth in that the scar creates numb area between her nose and the lip surface. This impairs her smile and interferes a bit with her talking. The Arbitrator awards 20 weeks in that the injury caused permanent and disfiguring scars to Petitioner's lip that also interferes with the normal functions of her mouth.

Relating to the C-dif consequence of a treatment component of Petitioner's chronic sinus condition (the treatment with Augmentin), the Arbitrator awards 2% permanent partial disability under Section 8(d)2 of the Act.

Based on all the above, the Arbitrator finds that sustained 27.3% loss of use of the left ear under Section 8(e), 20 weeks for disfigurement under Section 8(c) and is permanently disabled to the extent of 5% under Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jon Willoughby,
Petitioner,

vs. NO: 13 WC 01449

18IWCC0098

I-70 Truck Center,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b), having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of accident, medical expenses, prospective medical expenses, temporary total 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 June 13, 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.

18IWCC0098

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 13 2018

Joshua D. Luskin

o-01/30/18
jdl/wj
68

L. Elizabeth Coppoletti

Charles J. DeVriendt

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

WILLOUGHBY, JON
Employee/Petitioner

Case# **13WC001449**

I-70 TRUCK CENTER
Employer/Respondent

18IWCC0098

On 6/13/2016, 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 0.43% 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:

0009 ANESI OZMON RODIN NOVAK KOHEN
JENNIFER J C KELLY
161 N CLARK ST 21ST FL
CHICAGO, IL 60601

2593 GANAN & SHAPIRO PC
DRU A DENNIS
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

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)

Jon Willoughby
Employee/Petitioner

v.

I-70 Truck Center
Employer/Respondent

Case # 13 WC 01449

Consolidated cases: N/A

18IWCC0098

An *Application for Adjustment 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 **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. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What 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, **04-02-2012**, 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 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 **$34,870.68**; the average weekly wage was **$670.59**.

On the date of accident, Petitioner was **25** years of age, *single* with **1** dependent children.

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

Respondent shall be given a credit of **$8,982.81** for TTD, **$0** for TPD, **$0** for maintenance, and **$10,828.45** for medical benefits paid.

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

ORDER

Because Petitioner failed to meet his burden of establishing that he sustained an accident which arose out of and in the course of his employment with Respondent on April 2, 2012, failed to provide appropriate 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 the alleged accident, benefits are denied.

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

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

Michael K. Nowak, Arbitrator

6/7/16
Date

ICArbDec19(b)

JUN 13 2016

STATEMENT OF FACTS

Prior to April 2, 2012, Petitioner injured his back in a motorcycle accident in July of 2004. Petitioner sustained a T7-T8 compression fracture in his thoracic spine for which he underwent medical treatment with Dr. James Harms. Petitioner remained under the care of Dr. Harms from July 21, 2004 through December 1, 2004. (PX3). During that time, he was placed in a back brace and took pain medication. He did not undergo any physical therapy, and did not have injections or surgery. Petitioner was discharged from treatment by Dr. Harms on December 1, 2004 with the understanding that his back was healed and he had no further issues. Dr. Harm's office note from December 1, 2004 indicated the T7 fracture had healed. He recommended Petitioner gradually resume activity and stated "the odds are 95% if he will do a good exercise program he will live happily ever after." (PX3, p. 24). Petitioner never returned to Dr. Harms.

On November 7, 2005, Petitioner presented to the emergency room at Sarah Bush Medical Center after a truck he was working on fell and hit his leg. Petitioner testified he initially felt some pain in his back but the main priority was his leg. Petitioner testified that from November 7, 2005 through April 2, 2012, his back "felt perfectly fine." He had a normal life, even when working manual labor jobs, and he did not need to limit his daily activities or work activities in any way between 2005 and April 2, 2012. Petitioner did not seek any medical treatment in relation to his back from November 7, 2005 until 2012.

Petitioner is a mechanic who was employed with Respondent, I-70 Truck Center, on April 2, 2012. Petitioner had been working for Respondent since approximately September 2011. On April 2, 2012, Petitioner reported to work as usual and was feeling fine. He testified that during his shift he was working on a large piece of equipment with tracks on it. Petitioner spent the day putting together wheel kits that keep the track aligned and then putting them on the tractor itself. While performing this activity, he was sitting on a low creeper seat bent over with tools by his feet in front of him. Petitioner testified that he performed this task for approximately 10 hours and his body remained bent over that entire time. Petitioner testified that at the end of the day his back was sore from being "bent over like that all day." Over the next few days the pain in his mid-back worsened. Petitioner testified that he told one of the owners, Tim Thoele, that his back was hurting and sore after working on the dolly wheels. (Tr. 21). Mr. Thoele told him that was part of the job and suggested he take some ibuprofen.

Petitioner testified that he continued to perform his work duties for the Respondent and experienced continuous pain that never got better. He further testified that on May 1, 2012, while working on a truck in the parking lot, he turned to go into the building and felt an increase of back pain. Petitioner testified that he told Chris Roepke, another owner of the Respondent employer, about his pain and Mr. Roepke suggested he go home for the rest of the day.

Petitioner presented to Sarah Bush Medical Center on May 1, 2012, where he complained of significant mid-back pain and numbness in the thoracic area. He reported his thoracic pain had progressively worsened over the last couple weeks and that day he turned and felt a pinch to the upper back which exacerbated his symptoms. (PX5, p. 12). During this visit, the 2004 fracture was noted and the assessment was acute exacerbation of chronic thoracic pain. Petitioner testified that the numbness and pain had been present since the April 2012 incident. It was recommended he rest for a few days and then follow-up with an orthopedic surgeon, Dr. James McKechnie. He returned to work for the Respondent and continued to experience back pain that increased with activity.

Petitioner came under the care of Dr. McKechnie on July 6, 2012 and complained of pain in his thoracic spine "which began three months ago and it seemed to be related to activities at work. There was no specific injury. In early May he turned at work and ever since has felt a pinching sensation through the mid to low thoracic spine between his shoulder blades." (PX2, p. 9). Dr. McKechnie also recorded that Petitioner had some symptoms of pain since the accident in 2004 but these current symptoms were much more limiting for him. Per Dr. McKechnie's recommendation, Petitioner began physical therapy at Central Illinois Physical Therapy on July 9, 2012. (PX4, Tr. 32).

In the Initial Evaluation Report at Central Illinois Physical Therapy on July 9, 2012, it was noted that Petitioner suffered "a compression fracture of the spine 7-8 years ago, now having some pain between the shoulder blades, probably for four months. Two months ago it became a spasm that does not go away. Four months ago he was working on a rolling stool and had pain at the end of the day." (PX4, p. 35).

At a return visit on July 17, 2012, Dr. McKechnie took Petitioner off of work. (PX2). He continued to see Dr. McKechnie over the next few months while he continued therapy, and on October 23, 2012, Dr. McKechnie ordered a TENS unit. Petitioner testified that the therapy did not help his symptoms, but the TENS unit did provide some relief. (Tr. 33). Petitioner was discharged from therapy on October 26, 2012. (PX4, p. 25).

On November 21, 2012, Petitioner attended a Section 12 evaluation with Dr. Brett Taylor. (RX2). Prior to this examination, Petitioner was receiving TTD and medical benefits. Following the Section 12 evaluation, the Respondent advised Petitioner that they were denying his claim and would no longer pay benefits. Petitioner reported a six month history of back pain with no leg pain. Petitioner stated an incident occurred in May where he was "turning in a parking lot to go inside". Petitioner was not holding anything and did not slip, trip, or experience any untoward event other than turning to walk inside a building. After the alleged May incident, Petitioner had an onset of stabbing pain. Dr. Taylor noted that Petitioner did have a prior motorcycle accident after which he was diagnosed with a thoracic fracture. Petitioner reported he had low back pain and upper back pain since his 2004 fracture, but the current symptoms were more severe. Upon examination, Petitioner had a normal gait, and was able to heel to toe walk. On forward flexion, Petitioner could reach his hands to his toes and be extended beyond neutral. Petitioner's lateral bending was full. Petitioner's lower extremity motor function was 5/5. Petitioner also had a negative straight leg raising test.

Dr. Taylor reviewed Petitioner's thoracic films from July 19, 2004, and November 7, 2005. Dr. Taylor opined that the CT images showed two fractured vertebrae with approximately 33-35 degrees of kyphosis. The compression of the most significant of all thoracic vertebrae showed 50 percent compression of the anterior vertebral body. Dr. Taylor also reviewed Petitioner's thoracic images from June 7, 2012, which again showed persistent kyphosis in the thoracic spine at the previous fracture of approximately 35 degrees. Dr. Taylor also took his own radiographic films on November 21, 2012, which revealed thoracic kyphosis of 37 degrees at the two adjacent fractured vertebrae. There was also decreased disc height consistent with degenerative changes of the lower lumbar spine.

After reviewing multiple medical records and Petitioner's diagnostic films Dr. Taylor diagnosed Petitioner with post-traumatic thoracic kyphosis/mal-union. Petitioner did not advise Dr. Taylor of the April 2, 2012, accident where he was allegedly bent over a stool. Dr. Taylor did note an event in May, 2012, where Petitioner was turning, and walking under normal conditions when he had the onset of thoracic pain. Dr. Taylor

opined that Petitioner's thoracic spine symptoms were not a direct result of the May 1, 2012, work exposure. Dr. Taylor indicated that Petitioner's subjective complaints were consistent with post-traumatic kyphosis and deformity of the spine due to his 2004 motorcycle injury. Dr. Taylor opined that the medical treatments to date were reasonable, but their need was not directly related to his work injury. Dr. Taylor recommended no additional treatment for his thoracic spine in relation to a work accident, as Petitioner's thoracic spinal condition was due to a motor vehicle accident in 2004. Dr. Taylor opined that Petitioner's work exposure did not contribute in any way structurally to Petitioner's thoracic spine condition. Additionally, Dr. Taylor opined that any effects of Petitioner's work exposure on his thoracic spine would be no more than his activities of daily living. Dr. Taylor opined that Petitioner was at MMI for his work injury. Dr. Taylor did not recommend any limitations to Petitioner's work duties in relation to his alleged work accident.

Dr. Taylor opined Petitioner had typical residual complaints of pain which are common at the thoracic fracture site. Dr. Taylor further opined that Petitioner had a worse prognosis for his thoracic spine condition because of the multiple level compression fractures which were continuous resulting in a greater degree of angular deformity in his back. Dr. Taylor opined that Petitioner's condition was not causally connected to his work exposure of May, 2012. Dr. Taylor also opined Petitioner's work exposure of turning to walk inside the building was not an aggravating factor for his spine conditions.

At a follow-up visit with Dr. McKechnie on November 20, 2012, Petitioner reported significant relief from the TENS unit. (PX2). The next visit occurred on December 10, 2012, at which time Dr. McKechnie reviewed the IME report of Dr. Taylor. While he agreed that the forces of the current work incident were not sufficient to create a new fracture, he found they did cause him to have pain from a strain injury which has persisted because of his spinal deformity. Dr. McKechnie stated Petitioner would require additional pain management treatment and recommended Petitioner look for work with lesser physical demands. (Id).

Petitioner last saw Dr. McKechnie on January 7, 2013, at which time ongoing pain symptoms were noted and he recommended ongoing use of the TENS unit. (PX2, Tr. 35). However, Petitioner was unable to continue use of the TENS unit given the denial by workers' compensation and lack of other insurance. (Tr. 36).

Petitioner testified that he started a "haul for hire" business called Delux Transport in March of 2013 in an effort to support his family after his workers' compensation benefits were terminated. His job consists of driving pickup trucks and he does not do any loading or unloading of the freight. Before beginning this position, Petitioner passed a DOT physical test on February 25, 2013. Petitioner testified that his current job duties are in line with the restrictions set by his physicians, specifically no lifting over 50 pounds and limited bending and twisting. (Tr. 55). Petitioner testified that as of the trial date, he was working but was not earning any income from his business and does not draw a paycheck. Petitioner's tax returns for 2013 and 2014 were submitted into evidence. (PX 9).

On May 21, 2013, Petitioner came under the care of Dr. Michael Zindrick. (PX1). He provided a history of injury on April 2, 2012. The record states he experienced back pain at work on April 2, 2012 after being bent over for 10-12 hours on a stool. (Id). The Arbitrator notes that this is the first complete description of the alleged accident contained in the medical records. Petitioner advised Dr. Zindrick of the prior injury in 2004 but stated he was given a full release and was doing well until the recent issues at work. Petitioner reported ongoing mid-back pain and Dr. Zindrick ordered an MRI of the thoracic spine. (PX1). Dr. Zindrick imposed work restrictions of no lifting over 50 pounds and a need to sit, stand and walk as comfort allows. The MRI was

completed on May 24, 2013 and demonstrated chronic compression deformity of T8 without central canal or foraminal stenosis.

At the next visit on June 3, 2013, Dr. Zindrick recommended thoracic facet injections and referred Petitioner to a pain management specialist. (PX1). Petitioner came under the care of Dr. Kiran Chekka and underwent the thoracic facet injections and also continued to follow-up with Dr. Zindrick.

Petitioner was first examined by Dr. Chekka on July 3, 2013, at which time he complained of primarily mid back pain with associated numbness. (PX6). By way of history, Petitioner stated he had a motorcycle accident 10 years prior after which nearly all of his pain resolved and he had no issues with his back for 10 years. (Id, p. 4). Petitioner stated he lived a very high functioning life until suffering an injury at work in April 2012. (Id). On July 3, 2013 and August 7, 2013, Petitioner underwent T6, T7 and T8 medial branch blocks. He subsequently underwent a left T6, T7, T8 and T9 medial branch radiofrequency ablation on August 21, 2013. (Id, p. 15).

At a return visit to Dr. Zindrick on September 6, 2013, Petitioner reported 20% improvement following two facet rhizotomies. Dr. Zindrick indicated Petitioner was not a surgical candidate. (Id). Petitioner's last visit with Dr. Zindrick was on October 18, 2013, at which time he was determined to be at maximum medical improvement from an orthopedic and surgical standpoint. (Tr. 38). However, Dr. Zindrick noted Petitioner had ongoing chronic dorsal pain and recommended continued pain management with Dr. Chekka. Dr. Zindrick discharged Petitioner to return as needed. (PX1).

Petitioner continued treatment with Dr. Chekka and at his follow-up visit on October 10, 2013, He was noted to have mid back pain consistent with thoracic facet syndrome, and had approximately 25% pain reduction following the ablation.(PX4). It was noted that Petitioner could not be on significantly sedating medications due to driving for work. Dr. Chekka prescribed a new medication regimen, and performed T7-T8 thoracic epidural steroid injections on December 27, 2013, February 13, 2014 and April 27, 2014. Petitioner testified that these treatments provided only minimal relief of his symptoms. (Tr. 39). At the visit on May 1, 2014, it was noted that any improvement was incremental and Petitioner continued to experience residual symptoms that significantly limited his function and affected his quality of life. (PX4, p. 36). Dr. Chekka recommended spinal cord stimulation given the failure of other conservative measures. (PX4, Tr. 40). In the meantime, he continued to take non-narcotic medication at his request because he needed to be able to drive for work. (Tr. 40).

Petitioner last saw Dr. Chekka on January 5, 2015, at which time the doctor continued to recommend a spinal cord stimulator. As of the trial date, Petitioner testified that he had not moved forward with the stimulator because he has no way to pay for it. (Tr. 41). He testified that he would like to proceed with placement of the spinal cord stimulator if he was given the opportunity to do so. (Id).

The deposition of Dr. Chekka was taken on August 7, 2014. (PX7). Dr. Chekka initially stated that Petitioner provided a history that "he was at work working as a mechanic and hurt himself." *Id.*, at 8. He further indicated that the reported date of accident was "April of 2012. I don't have the specific date." *Id.* He was then asked to review the May 21, 2013 note of Dr. Zindrick which contained the history that Petitioner "was injured at work on April 2, 2012 while working as a mechanic....He specifically remembers on that particular day being bent over for 10 to 12 hours on a stool doing work and having increased pain."*Id.*, at 9-10.

After reviewing the MRI reports, but not the actual films, Dr. Chekka noted that Petitioner had a chronic compression deformity at T8 without central canal or foraminal stenosis, as well as T7/8 and T6/7 facet degenerative changes. Dr. Chekka testified that Petitioner's facet syndrome is similar to inflammatory arthritis. Dr. Chekka did not believe Petitioner's alleged work accident in April, 2012, caused Petitioner's vertebral compression fracture, but he felt Petitioner's pain syndrome was precipitated by his work related incident. He testified that Petitioner's ability to perform his activities of daily living and work duties were changed following the April, 2012, accident. Dr. Chekka opined Petitioner's current thoracic condition and treatment were causally related to his work accident on April 2, 2012. Dr. Chekka testified that Petitioner's thoracic compression fracture was exacerbated by his April 2, 2012, work accident.

Dr. Chekka testified that his recommendation of a spinal cord stimulator is an end-stage therapy when other measures have failed and the hope is to block the transmission of pain at the level of the spinal cord. He would first recommend a five day trial period, followed by permanent implantation of the device if the patient has a positive response. Dr. Chekka further testified that MMI would not be reached until the spinal cord stimulator had been implanted. He confirmed his agreement with Dr. Zindrick's work restrictions in the meantime.

On cross examination, Dr. Chekka admitted that Petitioner did not make him aware of an alleged accident on May 1, 2012. Dr. Chekka reviewed a medical record from Dr. Zindrick, which indicated that Petitioner "remembers a specific incident in May when he turned in the parking lot to go inside" and developed a stabbing pain. When asked whether Petitioner's current thoracic condition could be causally related to an incident in May, 2012, where Petitioner allegedly turned in a parking lot to go inside and felt a stabbing pain, Dr. Chekka opined he would have to ask Petitioner more questions to be able to causally relate his condition to that accident. Dr. Chekka testified that he would have to determine the impact of Petitioner's May 1, 2012, incident. Dr. Chekka testified that driving can be a causative factor, but he would have to know how many hours Petitioner was driving for to relate his thoracic condition to the May 1, 2012, accident.

Dr. Chekka admitted that he did not review Petitioner's initial treatment with Sarah Bush Lincoln Health Center on May 1, 2012. Dr. Chekka admitted that Petitioner's 2004 thoracic compression fracture did not heal in the proper alignment and that the deformity still existed. Additionally, Dr. Chekka admitted that he did not specify in his medical records and did not recollect Petitioner's condition and pain after the alleged April 2, 2012, accident. Dr. Chekka also admitted that it would be difficult to determine whether Petitioner's thoracic spine degeneration would be related to the April 2, 2012 incident without reviewing the serial MRIs pre and post incident. Dr. Chekka admitted he did not review any imaging studies prior to the 2012 incident and he did not review any of the previous records from Dr. McKechnie.

The deposition of Dr. Taylor, Respondent's examining physician, was taken on September 24, 2014. (RX3). Dr. Taylor testified that Petitioner provided a history of an accident that occurred in May of 2012. Dr. Taylor testified that Petitioner explained he was simply turning in the parking lot to walk inside a building. Petitioner did not state he was working under the hood of a semi-truck. Dr. Taylor admitted that Petitioner indicated his back pain began in April, but Petitioner did not describe any specific incident in April of 2012. Dr. Taylor noted that Petitioner had a previous history of a thoracic vertebral fracture in 2004 following a motorcycle accident.

After reviewing numerous medical records, Dr. Taylor performed an examination. Upon examination, Petitioner was able to heel and toe gait, forward flex with reaching his hands to his toes. Petitioner could extend beyond neutral. Petitioner's lower extremity and motor functions were 5/5 or normal with a negative straight leg raising. Petitioner's deep tendon reflexes were symmetrical and normal. Petitioner had a deformity in the thoracic spine that was tender to palpation with paravertebral muscle spasms.

Dr. Taylor reviewed Petitioner's radiologic and diagnostic studies in regard to Petitioner's thoracic spine. These studies included Petitioner's pre-existing September 19, 2004, CT scan, radiographs from September 7, 2005, thoracic images from June 7, 2012, and radiographs from November 21, 2012, the date of Dr. Taylor's independent medical examination. Dr. Taylor testified that upon his review of the diagnostic films. Petitioner had two fractured vertebrae at T7 and T8. When comparing the 2004 and 2005 films and studies with the 2012 films and studies, Dr. Taylor testified that Petitioner had the expected persistent kyphotic deformity which he described as a mal-union, clarifying that Petitioner's spine was broken and it healed in a shape that was not normal and natural, due to Petitioner's previous 2004 injury. Dr. Taylor testified that this type of thoracic spine condition creates a very high rate of spine problems and spine complaints due to the abnormal shape of the spine as a result of the thoracic fracture. Dr. Taylor testified that there were no objective changes that could be identified that occurred in April or May, 2012, as a result of Petitioner's alleged work incidents.

Dr. Taylor diagnosed Petitioner with post-traumatic thoracic kyphosis and mal-union. Dr. Taylor opined that Petitioner's event at work as described to him was not a contributor to Petitioner's thoracic spine condition and would have no more impact than his activities of daily living. Dr. Taylor testified that Petitioner's thoracic fractures created an angular deformity with compensatory hyperlodosis and that deformity is associated with long-term complaints or chronic back pain. Therefore, Petitioner's work exposure in May of 2012, was not a factor in causing Petitioner's spine pain or condition.

When asked in a hypothetical whether Petitioner being bent over a stool for ten to twelve hours would change his opinions on whether Petitioner's thoracic condition was causally related to Petitioner's employment and alleged aggravation, Dr. Taylor testified that standing or bending forward with no other traumatic exposure would not structurally damage or injure Petitioner's spine. Dr. Taylor testified that the basis of this opinion is Petitioner's diagnosis and 2004 thoracic injury met surgical criteria in 2004. Petitioner's problems will continue to have causal connection to the motorcycle accident in 2004, as Petitioner's thoracic problem is not subtle nor was it corrected in 2004. Dr. Taylor admitted that he did not question Petitioner had symptoms, but Petitioner's symptoms are attributable to the 2004 injury and lack of treatment that he had after the motorcycle accident. Dr. Taylor testified that when individuals with unstable spine fractures are treated "with no treatment" they will have pain with activities of daily living. They will have pain at rest, as their spine is abnormal and will hurt for the duration of their life.

Upon review of additional medical records from Sarah Bush Lincoln Health Center and Dr. McKechnie, Dr. Taylor admitted that the records indicated Petitioner had some symptoms of pain since 2004, but the current symptoms are much more limiting for him. Additionally, Dr. Taylor testified that the records are replete with statements regarding chronic back pain, including the initial emergency room note. Therefore, according to Dr. Taylor's review of the records, it was clear there was a history of chronic back pain. Dr. Taylor testified that there is a history of a temporal relationship between increasing back pain and activities at work.

When asked whether being bent over a stool at work for a long period of time could exacerbate Petitioner's pre-existing thoracic spine condition, Dr. Taylor testified it is possible Petitioner's activities of daily living would exacerbate his very severe thoracic spine condition and fracture. Dr. Taylor further testified that the 2004 thoracic fracture was treated in a way that was not appropriate, and therefore the resulting spinal condition resulted in chronic back pain which is documented since the 2004 injury.

On redirect examination, Dr. Taylor testified that Petitioner never gave a history of being bent over on a stool on April 2, 2012, during his independent medical examination. Petitioner only gave a history that he was turning in a parking lot to go inside a building and that was his onset of pain. Petitioner did note that in April he started to notice increased back pain. However, Petitioner did not recall a specific day, or specific event, when the pain began in April of 2012.

Dr. Taylor testified that Petitioner's work exposure did not alter the course of Petitioner's pathophysiology. Dr. Taylor testified the Petitioner's work exposure did not cause a permanent exacerbation of his pre-existing condition. Dr. Taylor admitted a physical activity can cause a temporary exacerbation of his symptoms, but those symptoms do not necessarily correlate with structural damage.

At the time of hearing, Petitioner testified that he was recently involved in two motor vehicle accidents, one in April 2015 and one in June 2015. There was no medical treatment following the second accident, but he did obtain medical care after the first accident. Petitioner testified that while his whole body, including his back, was sore after the collision, his actual injury and treatment were limited to his left shoulder. (Tr. 42-43). He did not receive any medical treatment for his back following these motor vehicle accidents.

A video was submitted into evidence showing Petitioner climbing a makeshift rock wall. He explained in his testimony that it was a celebration for the end of his daughter's Vacation Bible School and he was enjoying time with his family. As Petitioner described, the climbing was a brief moment that resulted in an increase of his back pain over the next three or four days. (Tr. 45). His current pain restricts his daily activities, although he admitted to sometimes pushing himself too hard after which he pays for it later. The Petitioner specifically stated "I'm not going to spend the rest of my life sitting in a chair at home so I don't aggravate my back, I still want to live my life as much as I can and tolerate the pain I have and just try to manage what I do." (Tr. 44)

During his testimony, Petitioner described that he still has the same level of pain today that he did when the pain began in April 2012. Petitioner reiterated during cross-examination and re-direct examination that his mid-back pain began on April 2, 2012, and that before that date he felt perfectly fine and had a normal life.

Christopher Roepke, one of the owners of I-70 Truck Center, was called by Respondent as a witness. Mr. Roepke testified on direct examination that individuals should advise him of a work accident and that the standard practice would be to send them to the secretary to fill out a First Report of Injury. Mr. Roepke denied receiving notice of Petitioner sustaining an accident on April 2, 2012. Mr. Roepke further testified that there would be no reason for a mechanic to be bent over on a creeper stool for ten consecutive hours, but he acknowledged that a job assembling wheel kits could last ten hours. Moreover, on cross-examination, he further acknowledged that a creeper stool is a regular tool found in a mechanic shop, that it is low to the ground, and that a mechanic on a creeper stool would need to bend over to grab tools.

On cross-examination, Mr. Roepke admitted an injured individual would not have to notify him and may instead notify the co-owner, Tim Thoele, of any injuries. He testified that he could tell by observing Petitioner's body movements that "he was getting slow and stuff" but denied Petitioner directly told him he hurt his back at work. Mr. Roepke indicated that there was not a process in place for reporting injuries because there never had been an injury before the one alleged by Petitioner. He also stated he personally was not familiar with a First Report of Injury and would not review an incident form. Instead, they would delegate that to the secretary.

Respondent next called Timothy Thoele, the other co-owner of I-70 Truck Center, as a witness. He testified that he is the person someone would notify in the event of a work accident and they would then try to record the incident and have paperwork filled out by a secretary. Mr. Thoele stated he was not notified by Petitioner of any injury at work. He testified that he filled out a Form 45 report once he was notified of the event of May 1, 2012. The form was completed on July 13, 2012. He acknowledged that no one spoke with the Petitioner about what information was put on the Form 45.

Mr. Thoele admitted that assembling dolly wheels would be a normal job performed by a mechanic at I-70 Truck Center and that it would be reasonable for a mechanic to be on a creeper stool while performing this task. Mr. Thoele further admitted during his testimony that he did remember Petitioner telling him his back was sore and that he may have told him to take some ibuprofen to see if it goes away. Petitioner did not, however indicate that the soreness was the result of an incident at work.

Mr. Thoele agreed that in the almost 10 years of business, they had never had a prior work accident and therefore did not have any experience implementing a process for reporting an accident. Upon further questioning, he went on to admit that "we're always getting hurt but nothing we couldn't deal with as far as filing a claim."

During his rebuttal testimony, Petitioner testified that he specifically remember telling Tim Thoele that his back hurt, but admitted he did not indicate that his back was hurting due to a work injury. Additionally, Petitioner admitted he never notified the Respondent of being bent over a creeper stool for ten hours or his work duties causing his alleged back pain. Petitioner admitted that back pain was every day stuff and normal. Petitioner admitted that the information contained on the Form 45 was accurate in relation to the alleged work accident on May 1, 2012.

CONCLUSIONS

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

Issue (D): What was the date of the accident?

Petitioner filed an Application for Adjustment of claim for an April 2, 2012, accident. However, Petitioner did not seek treatment until May 1, 2012. The initial treatment records from May 1, 2012, through July, 2012, indicate that Petitioner experienced significant back pain after a May 1, 2012, accident in which he was turning in the parking lot. The medical records do not indicate any accident occurring in April of 2012 until Petitioner first sought physical therapy on July 9, 2012. The July 9, 2012, medical record indicates that four months prior to that date, Petitioner was working on a stool and had pain at the end of the day. This was the first indication Petitioner was rolling on a stool and developed back pain while working for Respondent. However, the medical record does not state a specific accident date, despite Petitioner's testimony he

specifically remembers being injured on April 2, 2012. Additionally, the medical records do not mention a specific accident date of April 2, 2012, until May 21, 2013, when Petitioner first sought treatment with Dr. Zindrick at Hinsdale Orthopedics. Dr. Zindrick's May 21, 2013, record gives more specific facts surrounding the April 2, 2012, alleged accident of Petitioner being bent over a stool for ten to twelve hours consecutively. The arbitrator finds this significant, as no medical records entered into evidence indicate any specifics regarding the April 2, 2012, alleged accident, including facts or a specific date, for over a year of medical treatment.

Petitioner's testimony at arbitration is generally inconsistent with the medical records entered into evidence. The arbitrator notes that Petitioner's back pain was exacerbated by a specific accident on May 1, 2012, where Petitioner was turning in a parking lot. However, Petitioner did not file an Application for Adjustment of Claim for a May 1, 2012 accident. Petitioner's initial medical records indicate that the May 1, 2012 accident exacerbated Petitioner's symptoms and caused Petitioner's back pain to increase substantially. It was not until months after the alleged April 2, 2012 accident that Petitioner advised his treating physicians of the specific April 2, 2012 accident date and the specific history of being bent over on a stool for ten to twelve consecutive hours.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner failed to prove that he sustained an accident on April 2, 2012 which arose out of and in the course of his employment with Respondent.

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

Petitioner testified at trial that he specifically advised Tim Thoele of the alleged accident and subsequent mid-back pain on April 2, 2012. However, on cross-examination, Petitioner admitted that he did not advise Tim Thoele of the specific facts surrounding the April 2, 2012 accident. Instead, Petitioner advised Mr. Thoele that he had back pain, but did not relate his back pain to any work activities. Additionally, Petitioner continued to work full duty following the alleged April 2, 2012 accident and did not seek treatment until May 1, 2012, approximately one month after the alleged April 2, 2012 accident. Mr. Thoele testified that until the date of arbitration, he was unaware of Petitioner's allegations of being bent over a stool for ten consecutive hours on April 2, 2012 which allegedly caused his back pain. Mr. Thoele admitted that Petitioner complained of back pain, but testified there was no way to decipher whether Petitioner's back pain was caused by his work activities or activities outside of work.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner did not give timely notice of an alleged April 2, 2012 accident within the statutory forty-five days required under Section 6(c) of the Act.

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

Petitioner alleges a work accident occurred on April 2, 2012, wherein he suffered a thoracic spine injury. However, the Arbitrator notes that Petitioner did not seek treatment following the alleged April 2, 2012, accident until May 1, 2012. Additionally, the Arbitrator notes that Petitioner admitted at trial that following the April 2, 2012, accident he did not believe he needed treatment and, in fact, did not seek any medical treatment. It was not until May 1, 2012, after Petitioner suffered a second distinct incident when he was turning in the

parking lot to go inside Respondent's building and felt a substantial increase and exacerbation of his pain, that he sought medical treatment.

Petitioner's medical records indicate that Petitioner had a pre-existing thoracic spine fracture at T7 and T8 in 2004. When Petitioner first sought treatment with Dr. McKechnie on July 6, 2012, Dr. McKechnie noted that Petitioner has had some symptoms of pain since his 2004 motorcycle accident and thoracic spine fracture. Dr. McKechnie noted that Petitioner's pain following his alleged work accident was to the same area as his 2004 thoracic spine fractures at T7 and T8.

Dr. Chekka testified by way of evidence deposition at the request of Petitioner. Dr. Chekka based his causation opinions on Petitioner's increase in symptoms following the alleged work accident in April of 2012. However, Dr. Chekka admitted that he was not aware of the specific accident date and did not know the specific facts surrounding Petitioner's alleged April 2, 2012 accident. Dr. Chekka also admitted that he did not review any of Petitioner's previous records from Dr. McKechnie or any imaging studies prior to or subsequent to the alleged April, 2012, accident. Dr. Chekka also admitted he did not review Petitioner's initial treatment records with Sarah Bush Lincoln Health Center from May 1, 2012. Dr. Chekka was unable to provide opinions on whether Petitioner's symptoms were exacerbated by the May 1, 2012, accident of turning in the parking lot, as Dr. Chekka was unaware of Petitioner's subsequent accident.

Dr. Taylor also testified by deposition. He was not made aware of an April 2, 2012, accident where Petitioner alleges he was bending over a stool for ten to twelve consecutive hours. Petitioner only advised Dr. Taylor of an incident that occurred in May of 2012 when he was turning in the parking lot to walk inside of Respondent's building. Petitioner never advised Dr. Taylor of an alleged April 2, 2012 accident of being bent over a stool for numerous consecutive hours. Dr. Taylor opined that Petitioner's thoracic spine condition was related to his previous 2004 motorcycle accident and thoracic spine fractures at T7 and T8. Dr. Taylor reviewed all of Petitioner's previous records from Sarah Bush Lincoln Health Center, Dr. McKechnie, and Petitioner's pre-existing records from Dr. Harms in 2004 and 2005. Dr. Taylor testified that Petitioner's thoracic spine condition is one which has a very high rate of spine problems and complaints. Dr. Taylor also testified there was no objective evidence to support changes that could be identified that occurred in April or May of 2012 as a result of Petitioner's alleged work accidents. Dr. Taylor testified that Petitioner's thoracic spine condition could be exacerbated by his activities of daily living. Dr. Taylor opined that Petitioner's prognosis following his 2004 accident was incredibly poor due to the lack of surgical intervention to stabilize Petitioner's thoracic spine. Therefore, Dr. Taylor opined that Petitioner's thoracic spine fractures and back deformity would cause ongoing back complaints. Dr. Taylor testified that Petitioner's work exposure did not cause a permanent exacerbation of his pre-existing condition and Petitioner's current condition was not related to his work duties or alleged accidents in April or May, 2012.

The Arbitrator finds the testimony and opinions of Dr. Taylor more persuasive than those of Dr. Chekka in this case.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has failed to meet his burden of establishing that his current condition of ill-being is causally related to the alleged accident of April 2, 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?**
Issue (L): **What temporary benefits are in dispute?**

Based upon the Arbitrator's findings with regard to Issues C, D, E, and F, Petitioner's requests for benefits, including TTD, medical treatment, and prospective medical treatment, are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PATRICIA SANDOVAL,

Petitioner,

vs.

NO: 14 WC 24067

EL RANCHITO MARKET, INC.,

18IWCC0099

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, benefit rate, wage rate, temporary total disability and medical, 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 affirms the Arbitrator's decision as to accident, causation, medical expenses, prospective medical care, and temporary total disability. However, the Commission finds that the Petitioner's hourly rate was $8.75/hour, with an average weekly wage of $350. The only evidence offered into evidence regarding Petitioner's rate of pay was Px8-3, which showed a rate of $8.75/hour that Petitioner was paid for 22 hours worked. This was for the week following the accident. Petitioner testified that she worked an average of 40 hours per week, (T. 24) but there is no evidence other than Px8-3 that would corroborate Petitioner's testimony that it would have been at a rate of $9.75. Based on an hourly rate of $8.75, the Arbitrator's award is modified to reduce the AWW from the $390.00, as awarded by the Arbitrator, to $350.00. The award is further modified to reduce the TTD awarded from $260.00/week to $233.33/week.

All else is affirmed and adopted.

18IWCC0099

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $233.33 per week for a period of 47 5/7 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 pay to Petitioner the sum of $4,997.91 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 Petitioner be awarded prospective medical care in the form of the left shoulder arthroscopy/rotator cuff repair recommended by Dr. Sclamberg, Dr. Primus, and Respondent's shoulder examiner, Dr. Vitello.

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 $16,231.00. 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 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O: 011718
49

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

SANDOVAL, PATRICIA
Employee/Petitioner

Case# 14WC024067

EL RANCHITO MARKET INC
Employer/Respondent

18IWCC0099

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:

1072 LAW OFFICES OF JACK R EPSTEIN
4346 W 26TH ST
SUITE 2000
CHICAGO, IL 606023

0507 RUSIN & MACIOROWSKI LTD
CHARLES C NWABUEZE
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

STATE OF ILLINOIS)
) SS.
COUNTY OF CHICAGO)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

18IWCC0099

Patricia Sandoval
Employee/Petitioner

Case # 14 WC 24067

v.
El Ranchito Market, Inc.
Employer/Respondent

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 C. Mason, Arbitrator of the Commission, in the city of Chicago, on March 9, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☒ What were Petitioner's earnings?

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

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

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

K. ☒ 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 _____

18IWCC0099

FINDINGS

On the date of accident, 6-30-14, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

For the reasons stated in the attached decision, the Arbitrator finds, with respect to the lumbar spine, that the accident resulted in an aggravation of an underlying condition and brought about the need for certain conservative care. With respect to the left shoulder, the Arbitrator finds that the accident resulted in a significant rotator cuff tear and brought about the need for certain initial care, orthopedic consultations and the arthroscopy/rotator cuff repair recommended by Dr. Sclamberg, Dr. Primus and Respondent's shoulder examiner, Dr. Vitello.

In the year preceding the injury, Petitioner earned $780.00; the average weekly wage was $390.00.

On the date of accident, Petitioner was 58 years of age, married, with 0 children under 18.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $4,997.91 (bills in PX 1, 3, 4, 5 and 7), subject to the fee schedule. The Arbitrator declines to award the claimed bills from Rehab Dynamix ($19,655.00, PX 2) and Windy City Medical (6,370.00, PX 6), for the reasons set forth in the attached decision.

Respondent shall pay Petitioner temporary total disability benefits of $260.00/week from August 15, 2014 through July 14, 2015, a period of 47 5/7 weeks, as provided in Section 8(b) of the Act.

The Arbitrator awards prospective care in the form of the left shoulder arthroscopy/rotator cuff repair recommended by Dr. Sclamberg, Dr. Primus and Respondent's shoulder examiner, Dr. Vitello.

For the reasons set forth in the attached decision, the Arbitrator declines to award penalties and fees.

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

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

4/26/16
Date

ICArbDec19(b)

APR 27 2016

Patricia Sandoval v. El Ranchito Market, Inc.
14 WC 24067

18IWCC0099

Summary of Disputed Issues

Petitioner claims a work-related fall of June 30, 2014. The disputed issues include accident, causal connection, average weekly wage, medical expenses, temporary total disability, penalties/fees and prospective care, with Petitioner seeking an award of left shoulder surgery. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner testified through an interpreter.

Petitioner testified she began working at Respondent's grocery store in mid-June. T. 18. She denied having any arm or back pain before being hired. T. 55. The store manager, Ricky Perez, hired her to work in the deli section. T. 18. Her duties included waiting on deli customers, slicing meat and cheese, carrying heavy boxes of avocados and tomatoes and making guacamole. T. 18-19. She performed these duties from her first day of work forward.

Petitioner testified that Ricky Perez worked in the store only on Sundays. T. 25. Perez was the person who paid her and informed her of her schedule. He would give each worker, including her, a piece of paper showing the hours. T. 22. She does not have the paper showing her schedule for her first week of employment but recalls working 32 hours that week. T. 24-25. She was, however, able to find the paper showing her schedule for the second week, which was the last full week of June. She identified page 1 of PX 8 as that paper. T. 23-24. This page is handwritten. It shows the name "Patricia" at the top and lists the following hours: 1) L(unes), 10-5; 2)M(artes), 2-10; 3)M(iercoles), no hours; 4)J(ueves), 2-10; 5) V(iernes), 10-10; 6) S(abado), 10-5; and 7(D)omingo, 2-10.

Petitioner also looked at RX 1, a schedule that, according to Perez, showed Petitioner's and other deli workers' hours for the weeks beginning June 30th and July 7th. [With respect to the week of June 30th, RX 1 shows Petitioner was scheduled to be off work on Monday, June 30 and Tuesday, July 1, to work very limited hours each of the next three evenings and to be off work again over the weekend. RX 1 references four employees other than Petitioner, none of whom is named Yolanda.] Petitioner testified she never saw RX 1 before. T. 38. She also testified that the information in RX 1 is not accurate. RX 1 shows she was off work on Saturdays and Sundays but she "always" worked those days. RX 1 also shows she was off work on Monday, June 30th, but that is the date she fell while working. T. 39-40.

Petitioner testified Respondent assigned numerical codes to deli products and prepared foods. She had to learn those codes. At the deli, she operated a machine that had large buttons. The buttons were marked with the codes. T. 20-21.

Petitioner testified that some deli items, such as hams, were stored in a cooler that was some distance away from the deli counter. She described the cooler as larger than the arbitrator's hearing room. T. 19.

Petitioner testified she was injured while working for Respondent on June 30, 2014, a Monday. T. 34. On that day, Yolanda, one of her deli co-workers, sent her to the cooler to get a particular kind of ham. T. 26. After she entered the cooler, she walked "all the way to the end, where all of the hams are." When she turned, she encountered "a lot of water on the floor." T. 27. She slipped and fell to the floor, striking her left arm and left hip on the floor. She fell at about 1 PM. T. 27. She felt pain in her low back and left arm. She managed to get to her feet and went back to the deli. She told Yolanda, "you only sent me there to fall down." She was upset because the ham Yolanda wanted was not in the cooler. T. 28-29. She also informed Alfonso, the manager of the nearby butcher section, about her accident. Alfonso said, "don't worry about it – all of us have fallen here." T. 29. Two days later, she mentioned her fall to a female co-worker, who prepares food. The woman told her she had also fallen and was undergoing therapy. Alfonso, Poncho and two other butchers heard this and began laughing, telling Petitioner they would watch her accident on the in-store camera and get a laugh. T. 30. Petitioner testified that prior to this conversation she did not know there were cameras in the store. T. 33.

Petitioner testified she continued working on June 30, 2014, after falling. She was able to perform her assigned duties but experienced pain while doing so. T. 31. After Yolanda left, another deli employee, Marcos, arrived. She told Marcos about having fallen and he said he had also fallen at the store. She also told Marcos she had pain in her back and left arm and was unable to lift anything heavy. T. 32-33.

Petitioner testified she was scheduled to work from 10 AM to 10 PM on June 30, 2014. She took lunch at about 3 or 4 PM that day. T. 31.

Petitioner testified that, despite being in pain, she did not request medical treatment on Monday, June 30, 2014, because Patricia, the deli manager, was on vacation. T. 34. Patricia returned to work on Friday or Saturday, at which point Petitioner told her about the accident and asked whether she could go to therapy like her co-worker had. T. 35. Petitioner testified that Yolanda was present when she told Patricia this. T. 35.

Petitioner testified that, on Sunday, July 6th, while at work, she told Ricky Perez about the accident. Specifically, she told Perez she had fallen in the cooler and did not want to continue carrying heavy boxes. She asked Perez to tell the male employees to carry the boxes. Perez replied, "yes, don't pick up anything heavy." T. 41. She did not ask Perez for permission to see a doctor. T. 36-37.

Petitioner testified she continued performing her usual tasks, including moving the boxes, thereafter. On the Friday after she reported the accident to Perez, she asked Patricia if she could take the following day off so that she could see a doctor. T. 33, 37. Patricia went up

front to talk with Eric, the owner. T. 42. Petitioner testified that Eric was at the store every day. Patricia had told her that Eric owned the store. T. 43. Later that night, while closing the store at 10 PM, Eric turned out the lights, gave Petitioner some cash and told her "here, don't come back tomorrow." She asked why and Eric told her to "come see Ricky [Perez] on Sunday." She asked Eric, "are you firing me?" and he said "yes." T. 44-45.

Petitioner testified she and her daughter, Laura Lopez, went to the store on Sunday. At about 11 AM or noon, she (Petitioner) talked with Ricky Perez in the middle of the store, near some boxes. T. 45-46. No one else was present. Her daughter was in the vicinity but was distracted. T. 49. Petitioner testified she asked Perez what was going on and why was she being fired when she had been working just fine. T. 46. Perez told her she was being fired based on something that Patricia told Eric. T. 46. Perez also told her he had a check for her but she would have to sign a piece of paper in order to get the check. After she signed the piece of paper, Perez gave her a check. T. 47. Petitioner identified page 4 of PX 8 as the paper she signed, page 2 of PX 8 as the check and page 3 of PX 8 as the check stub. [The stub shows year to date earnings of $192.50 for 22 hours (at a rate of $8.75/hour) worked between July 7 and July 13, 2014.] Shortly thereafter, she found her daughter, who asked her what she had signed. Her daughter then requested, and obtained, a copy of the document she signed. T. 49. The document is a letter dated July 13, 2014 from Ricky Perez "to whom it may concern" indicating that Petitioner was employed by Respondent for two weeks and was terminated effective July 11, 2014 "due to liability issues regarding her past medical condition." PX 8, p. 4.

Petitioner testified she consulted an attorney after being fired because she did not feel Respondent had treated her properly. T. 49. The attorney [Petitioner's original counsel] sent her to "Dr. Brian" at a medical facility called "Doctores y Mas." Petitioner testified she told "Dr. Brian" what happened to her. He examined her and recommended physical therapy. T. 50-51.

Petitioner acknowledged that "Dr. Brian" was the first medical provider she saw after her claimed work accident of June 30, 2014. T. 50.

Records in PX 2 reflect Petitioner saw Dr. Brian Kuzich, a chiropractor, on July 16, 2014. Dr. Kuzich's history of the work fall is largely consistent with Petitioner's testimony. The doctor noted that Petitioner reported continuing to perform full duty after the accident until July 11, 2014, when she was fired. He indicated Petitioner had had no treatment since the accident.

Dr. Kuzich described Petitioner's past medical history as significant for a left total knee replacement in 2011 and a right total knee replacement in 2012.

Dr. Kuzich indicated that Petitioner complained of 8/10 non-radiating lower back pain, 8/10 left shoulder pain, 5/10 left elbow pain, 9/10 left hip pain and 4/10 right knee pain.

On lower back examination, Dr. Kuzich noted a reduced range of motion with lateral bending and rotation, tenderness to palpation in various areas and pain with straight leg raising, Kemp's and Yeoman's testing bilaterally.

On left shoulder examination, Dr. Kuzich noted pain and a markedly reduced range of motion and positive Neer's, Speed's and supraspinatus testing.

On left elbow examination, Dr. Kuzich noted reduced flexion and supination.

On left hip examination, Dr. Kuzich noted pain with range of motion testing and positive Patrick/Fabers testing.

On knee examination, Dr. Kuzich noted right knee pain with extension and "long scar from TKR on both knees."

Dr. Kuzich recommended therapy, including electrical stimulation, taping and manipulation, for two weeks. He directed Petitioner to remain off work during that period. PX 2.

On July 16, 2014, Petitioner underwent an initial physical therapy evaluation at Rehab Dynamix. It appears Dr. Kuzich performed this evaluation. He recorded a detailed history of the June 30, 2014 work accident, noting Petitioner continued working thereafter until her July 11, 2014 termination "even though she was having a lot of pain." PX 2.

On July 17, 2014, Petitioner filed an Application for Adjustment of Claim alleging a June 30, 2014 work accident involving her left arm, back and right knee. Arb Exh 2.

Petitioner returned to Dr. Kuzich on July 22, 2014, with the doctor noting gradual improvement. He directed Petitioner to continue therapy. PX 2.

At a subsequent visit, on July 28, 2014, Dr. Korfel, another chiropractor in the same office, noted that Petitioner was scheduled to undergo knee surgery the following day. PX 2. [Petitioner did not testify to this and there is a note reflecting she saw Dr. Kuzich on July 29, 2014, with that note containing no mention of knee surgery.]

On August 1, 2014, Dr. Kuzich noted some improvement but indicated Petitioner was "still in a lot of pain." He directed Petitioner to remain off work for four weeks. PX 2.

On August 15, 2014, Petitioner saw Dr. Mehta at the Chicago Pain and Orthopedic Institute. The doctor's note of that date sets forth a history of the work accident, termination and subsequent treatment. The doctor indicated Petitioner complained of 10/10 low back pain radiating into both legs and had "initially" and "recently" sought treatment at Cook County Hospital, where she had been started on Naprosyn. [No records from Cook County Hospital are in evidence.]

On initial examination, Dr. Mehta noted increased pain with lumbar flexion and extension, 4/5 strength in the lower extremities and paraspinal tenderness bilaterally.

Dr. Mehta recommended a lumbar spine MRI and prescribed Tramadol, Gabapentin, Terocin ointment and patches and continued therapy. He indicated that returning to work would be detrimental to Petitioner or anyone else around her. He directed Petitioner to return to him following the MRI. [There is no evidence indicating Petitioner returned to Dr. Mehta after August 15, 2014.] PX 3.

On September 2, 2014, Dr. Kuzich noted negative straight leg raising bilaterally. He recommended additional therapy and indicated that work status was "per specialist recommendation." PX 2.

At Dr. Kuzich's recommendation, Petitioner underwent MRIs of her left shoulder and lumbar spine on September 5, 2014. The left shoulder MRI showed a full-thickness tear of the supraspinatus tendon with medial tendon retraction to the level of the humeral head apex, significant diffuse underlying subscapularis tendinopathy and an apparent degenerative signal involving the anterior labrum without definite evidence for a discrete labral tear. The radiologist indicated an MR arthrogram might be of additional value. The lumbar spine MRI showed mild diffuse right convexity scoliosis, diffuse lower thoracic and lumbar spondylosis with diffuse degenerative disc disease, posterior disc bulges at T9-10, T12-L1 and from L3-L4 through L5-S1, creating various degrees of central canal, lateral recess and neural foraminal stenosis. PX 1.

On September 8, 2014, Dr. Kuzich reviewed the MRI results and recommended an orthopedic consultation. Petitioner continued seeing Dr. Kuzich for manipulations, etc. thereafter through November 4, 2014. PX 2.

On September 26, 2014, Petitioner saw Dr. Sclamberg at the Chicago Pain & Orthopedic Institute. T. 52. The doctor's history reflects that, on June 30, 2014, Petitioner fell on a wet floor while carrying avocados at work, landing on her left non-dominant shoulder. On left shoulder examination, the doctor noted tenderness over the lateral deltoid, 4-/5 strength, a positive impingement sign and positive Hawkins testing. After reviewing the MRI, the doctor diagnosed a "rotator cuff tear supraspinatus left non-dominant after falling at work as described." He causally linked the shoulder condition to the work fall. Given Petitioner's symptoms and the full-thickness nature of the tear, he recommended a left shoulder arthroscopy with subacromial decompression rotator cuff repair. He took Petitioner off work pending surgery. PX 3.

Petitioner returned to the Chicago Pain & Orthopedic Institute on October 27, 2014 and saw Dr. Saldanha. The doctor noted Petitioner was injured at a deli when she lifted a box of avocados and fell. He indicated Petitioner was seeing an orthopedic surgeon for her shoulder. He noted a complaint of mid and low back pain radiating down both legs. He indicated Petitioner had discontinued taking the prescribed Tramadol and Gabapentin due to dizziness and nausea. On examination, he noted pain throughout all facet loading maneuvers, positive straight leg raising bilaterally at 45 degrees and a normal gait. After reviewing the lumbar spine

MRI, he recommended bilateral L3-S1 transforaminal epidural steroid injections and started Petitioner on Meloxicam. He directed Petitioner to stay off work and continue therapy. PX 3.

On November 26, 2014, Petitioner saw Dr. DeBartolo at the Chicago Center for Sports Medicine and Orthopedic Surgery. The records from this facility include a history form indicating Petitioner underwent a "scope" in October 2010 and total knee replacements in April 2011 and October 2013. PX 1. Dr. DeBartolo noted complaints of left shoulder and lower back pain, as well as foot numbness, secondary to a fall at work on June 30, 2014. The doctor described Petitioner as slipping "on a wet spot on the floor and [falling] on some pallets onto the left shoulder and left hip and left side of the back." The doctor indicated that Petitioner continued to work, with that work including carrying heavy boxes, with her low back and shoulder becoming "more and more painful." The doctor described Petitioner's past medical history as unremarkable.

On left shoulder examination, Dr. DeBartolo noted reduced and painful abduction, reduced strength, particularly in the supraspinatus, and positive Hawkins, Neer's, "drop arm" and impingement testing.

On lower back examination, Dr. DeBartolo noted an antalgic gait and positive straight leg raising on the left.

Dr. DeBartolo indicated she reviewed the report and images concerning the left shoulder MRI. She diagnosed a rotator cuff tear and explained to Petitioner that a moderate to large rotator cuff tear would not heal on its own. She indicated that therapy should be "very guarded" and should not involve any abduction forces. She referred Petitioner to Dr. Primus for a surgical consultation.

With respect to the lumbar spine, Dr. DeBartolo indicated she reviewed only the MRI report. She diagnosed a strain. She prescribed Naproxen and physical therapy.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Vitello, an orthopedic surgeon, on January 12, 2015. In his report of that date, Dr. Vitello noted that Petitioner allegedly slipped and fell while walking into a freezer on June 30, 2014, injuring her left shoulder, lumbar spine, left elbow and pelvis. He also indicated that, according to Respondent's work schedule, Petitioner did not work on either June 30, 2014 or the following day and worked on various days between July 2, 2014 and her termination on July 11, 2014.

Dr. Vitello indicated he reviewed records from Drs. Kuzich, Mehta and Saldanha, along with the left shoulder MRI. Dr. Vitello did not indicate he reviewed Dr. Sclamberg's records.

Dr. Vitello indicated that Petitioner complained of left shoulder pain and weakness but described her left elbow as doing well.

On left shoulder examination, Dr. Vitello noted no signs of asymmetry or atrophy. He described Petitioner as "very guarded with any attempts of range of motion." He indicated Petitioner pulled away from him and cried out in pain with range of motion testing and was unable to tolerate any provocative maneuvers. He stated that Petitioner's subjective complaints seemed to be out of proportion to the physical examination.

Dr. Vitello described his left elbow examination as benign.

Dr. Vitello assessed Petitioner as having a left shoulder rotator cuff tear. He addressed causation as follows:

> "There is no report of any injury occurring in the medical records. It is my opinion that a rotator cuff tear sustained secondary to a fall or blunt trauma would cause considerable pain and an individual would likely not be able to continue to work with this type of injury and a full-thickness rotator cuff tear. The MRI shows signs of full-thickness rotator cuff tear. However, the date and the length of time of this tear is indeterminate and cannot be stated."

Dr. Vitello described Petitioner as having had "considerable therapy (43 visits) for the left shoulder." He indicated she had not undergone necessary treatment and had not had an orthopedic evaluation. He noted that rotator cuff tears do not respond to the type of chiropractic care Petitioner underwent at Rehab Dynamics. He stated this type of injury requires an orthopedic evaluation, formal physical therapy and a corticosteroid injection. He viewed Petitioner as "likely a candidate for left shoulder cuff repair" but again noted there was no evidence indicating Petitioner sustained an accident on June 30, 2014. He found Petitioner to be at maximum medical improvement with respect to the left elbow.

Dr. Vitello indicated that, with respect to the left shoulder, Petitioner required restrictions of no lifting over 5 pounds, no overhead use and limited pushing/pulling. RX 2.

Petitioner returned to Dr. DeBartolo on February 6, 2015. Petitioner reported no improvement of her lumbar spine complaints, despite undergoing therapy. She also complained of left shoulder pain. She reported having undergone an IME two weeks earlier.

Dr. DeBartolo again referred Petitioner to Dr. Primus for a surgical consultation with respect to the left shoulder. She also recommended four to six more weeks of physical therapy for the lower back. She released Petitioner to work with no use of the left arm. PX 1.

On February 20, 2015, Petitioner saw Dr. Primus. The doctor noted ongoing left shoulder and left-sided back complaints. He also indicated Petitioner was awaiting approval of left shoulder surgery. He released Petitioner to work with no use of the left arm. PX 1. RX 7.

Petitioner saw Dr. Primus again on April 3, 2015, with the doctor noting some lower back improvement but no shoulder improvement following a course of therapy. The doctor again discussed shoulder surgery. He released Petitioner to work with no use of the left arm. PX 1, RX 7.

At Respondent's request, Petitioner saw Dr. Bernstein, a spine surgeon, for purposes of a Section 12 examination on April 27, 2015. Dr. Bernstein recorded a history of the accident and its aftermath, noting that Petitioner reported being terminated on July 11, 2014 "because of an inability to walk normally." Dr. Bernstein indicated that Petitioner complained of non-radiating low back pain and had seen another physician who had recommended shoulder surgery.

Dr. Bernstein described Petitioner's gait as normal. On examination, he noted no tenderness along with good strength, sensation and reflexes in the lower extremities. He interpreted the September 5, 2014 lumbar spine MRI as showing degenerative changes and no evidence of traumatic injury.

Dr. Bernstein described Petitioner as "doing quite well despite her subjective complaints." He described his examination as benign. He interpreted the MRI as showing age-appropriate degenerative changes. He saw no reason why Petitioner could not resume full duty with respect to her lower back. The fact that Petitioner did not seek treatment until after being terminated prompted him to suspect she did not sustain any significant low back injury. RX 3.

On May 15, 2015, Dr. Primus noted Petitioner was still awaiting approval of shoulder surgery and requested more therapy for her lower back, which had worsened during the preceding month. The doctor prescribed therapy and directed Petitioner to return in one month. PX 1, RX 7.

On June 12, 2015, Dr. Primus again noted that Petitioner was awaiting approval of shoulder surgery. He prescribed another month of therapy for the lower back. PX 1, RX 7.

On July 14, 2015, Dr. Primus noted no left shoulder or lumbar spine improvement. He again indicated Petitioner was waiting for the left shoulder surgery to be approved. He recommended a consultation with a spine surgeon for the lower back. He released Petitioner to restricted work with no use of the left arm, no ladder usage, no bending or stooping and limited repetitive grasping and squatting/kneeling/crawling. PX 1, RX 7.

On August 14, 2015, Dr. Primus recorded the following interval history:

> "Her symptoms are worse since last visit. Patient states she has been working and has noticed an increase in pain in her shoulder and lower back. She has been working, however, her employer has not been honoring her restrictions and she has had to use the left arm for overhead activity."

Dr. Primus prescribed Tramadol and additional physical therapy. He directed Petitioner to stay "off work due to employer not honoring restrictions." PX 1, RX 7.

The Arbitrator notes that Petitioner did not testify to working in any capacity after being terminated by Respondent on July 11, 2014. In fact, Petitioner did not address her post-termination work status in any way.

On September 11, 2015, Dr. Primus noted that Petitioner was no longer attending therapy for her back due to lack of approval. He described his left shoulder and lower back examination findings as unchanged. He prescribed physical therapy for the back. He expressed concern about receiving no communication from the carrier as to whether the left shoulder surgery was being accepted or denied. He stated that any delay in care would negatively affect the outcome of the surgery. He directed Petitioner to stay off work. PX 1, RX 7.

On October 9, 2015, Dr. Primus described Petitioner's symptoms as unchanged. He indicated she was "still off duty since last visit." His left shoulder and lower back examination findings were unchanged. He prescribed physical therapy and Naproxen. for the back. He again expressed concern about receiving no communication from the carrier. He directed Petitioner to remain off work. PX 1, RX 7.

On December 4, 2015, Dr. Primus noted Petitioner was still experiencing shoulder and low back pain. His examination findings were unchanged. He indicated he was still recommending a rotator cuff repair but had received no response from the carrier. He refilled the Naproxen and directed Petitioner to continue therapy for her back. PX 1, RX 7.

At the hearing, the Arbitrator asked Petitioner's counsel to offer into evidence any petition for penalties and fees he filed on behalf of Petitioner, since no such document was in the Commission file. Petitioner's counsel offered PX 10, a group of documents filed on December 28, 2015. PX 10 includes a 19(b) Petition, along with a Notice of Motion on which various boxes are checked, including boxes for penalties and fees. PX 10 does not include a petition for penalties and fees.

Petitioner testified she wants to undergo the left shoulder surgery that Dr. Primus has recommended. T. 54. She feels pain when she lifts her arm to perform activities such as combing her hair. Her arm also hurts when she lies down. T. 54. She is also experiencing low back pain. She attributes her arm and back pain to the accident because she never experienced this pain before the accident. T. 55. She has not received any benefits since being fired. T. 56. Before she was fired, Respondent paid her in cash. It was only on the last day she went to the store that she received a paycheck. T. 56. Her medical bills have not been paid. T. 57. All of the physicians she has seen were referrals from "Dr. Brian" at Doctores y Mas. T. 57.

Under cross-examination, Petitioner acknowledged that the handwritten schedule marked as page 1 of Exhibit 8 has no dates on it. It only shows the days of the week, in Spanish,

and her scheduled hours on those days. T. 61. She knows she began working for Respondent in mid-June but she does not know the exact date she started. T. 61. The letter she signed on July 13, 2014 indicated she had worked for Respondent for two weeks. The letter is wrong. She started working for Respondent in mid-June. T. 63. She received a work schedule each Sunday but usually discarded it after looking at it. She was only able to find one of the schedules. T. 63-65. That schedule shows the hours she worked the week of June 23, 2014. T. 69. It was Yolanda who sent her to the cooler. She worked with Yolanda on more than one occasion. T. 65-66. Yolanda was her co-worker, not her supervisor. T. 75. On June 30, 2014, she worked from 10 AM to 10 PM. She closed the deli that day. Very shortly after the accident, she reported the accident to Yolanda and Alfonso. When Patricia, the deli manager, returned from her vacation, she (Petitioner) asked her for permission to see a doctor. She was supposed to bring boxes up from the basement but could not do this. It was about four days after the accident that she spoke with Patricia. T. 70-71. During that four-day period, she did not communicate with any other managers because she thought her symptoms might resolve on their own. T. 71. By the time Patricia returned from vacation, she could no longer lift heavy boxes. T. 72. Before Patricia returned, she continued lifting the boxes. She did this because she had to. T. 72-74. She first sought treatment five days after her termination. T. 72. After she was first hired, she underwent training for four or five days. During the training period, she had to learn all of the codes associated with items sold in the deli. T. 75. She provided the handwritten work schedule to her attorney about a month before the hearing. T. 77. She did not ask to take the day after the accident off. T. 78. She does not remember each shift she worked in terms of the date the shift fell on. T. 78. On Sundays, Ricky arrived with a tray of cash for everyone. T. 79-80. She did not know ahead of time that Respondent planned to pay her in cash. T. 79. She used this cash to buy food. She has no proof of how much she received in cash. She did not file for taxes. T. 80.

On redirect, Petitioner testified that, at the store, she conversed with everyone in Spanish. The handwritten schedules she received showed the days of the week in Spanish. She cannot speak or read English. T. 81.

In response to a question posed by the Arbitrator, Petitioner testified she went by the name "Patricia" at work. T. 82.

Richard Perez testified on behalf of Respondent. Perez testified he has worked as a supervisor at Respondent for four years. T. 85. He knows Petitioner. Petitioner worked part-time in the deli a few years back. His job involves making sure the store managers work with their teams. T. 85-86. He no longer prepares schedules but he performed this task when Petitioner worked for Respondent. T. 86.

Perez identified RX 1 as the work schedules for the deli employees during the weeks June 30 – July 6, 2014 and July 7, 2014 – July 15, 2014. He prepared these schedules. The schedules list five employees, including Petitioner. The four employees other than Petitioner were "Amparo," who was also known as "Patty," Racquel, Marco and Jose. T. 88-89.

Perez testified that the week of June 30, 2014 was Petitioner's first week of employment. Petitioner underwent training during that week. The training consisted of "shadowing" another deli employee. T. 89-90.

Perez testified he learned of Petitioner's claimed accident from a supervisor named Eddie. Eddie learned of the accident from "Amparo" after Petitioner was terminated. T. 90. Petitioner was terminated on July 11, 2014. T. 91. She was terminated due to overstaffing. T. 91.

Perez testified he observed Petitioner on a few occasions after June 30, 2014. He did not notice anything unusual about her. He talked with Petitioner after June 30, 2014 but she never mentioned any accident or requested any restrictions. T. 91-92. Respondent requires that any accident or other unusual event be reported to a manager who, in turn, reports this to him or the owner. Employees are informed of this requirement when they undergo training. Petitioner's manager was "Amparo," who also went by the name "Patty." This manager never told him that Petitioner was claiming an accident. T. 93.

Perez testified he is not aware of any deli employee named Yolanda. T. 95. He knows Alfonso. Alfonso manages the meat department. The meat and deli departments are separate. Alfonso never told him that Petitioner was claiming an accident. RX 1 lists all of the deli employees. T. 95-96.

Perez testified there is a distance of about 60 to 75 feet between the deli counter and the cooler. T. 96.

Perez testified he does not work only on Sundays. T. 96.

Perez testified he learned from Eddie that Amparo fired Petitioner. T. 97-98. No owner of the store told him to fire Petitioner.

Perez denied meeting Petitioner's daughter. T. 98.

Under cross-examination, Perez testified he went by the name "Ricky" at the store. T. 98. He and Respondent's attorney talked via telephone on about three occasions. He met with this attorney the morning of the hearing. State Farm never personally visited him to get information about the accident. T. 99-100.

Perez testified that, as of June and July 2014, all Respondent employees were paid by check. The bookkeeping department kept all of the payroll records and check stubs, including stubs of the checks given to Petitioner. T. 101-102. He would call payroll when he needed to add an employee. Payroll was handled by an outside vendor, Matrix Accounting. T. 103. He created the schedules set forth in RX 1 but those schedules were "not set in stone." T. 134. Employees could switch shifts, with Respondent's consent. When this happened, no one bothered to write out a revised schedule. Therefore, it is possible Petitioner worked on June

30, 2014. T. 105. Petitioner worked a total of 22 hours during the two weeks in question. Petitioner did not work for Respondent before June 30, 2014. Amparo, the deli supervisor, who was also known as Patricia, was on vacation before June 30, 2014. T. 111.

Perez testified that the deli employees operated a machine that had buttons marked with numerical codes. The codes were for different food products. T. 112-113. All of the employees in the deli speak Spanish. Most of the customers are Mexican-American. T. 114. Petitioner was responsible for bringing items to the deli from the cooler and basement. T. 115-116. There are cameras everywhere around the store. There are 64 cameras in total. One camera is in the cooler. T. 116. As of June and July 2014, Eddie was in charge of the cameras. The primary purpose of the cameras was to prevent theft but the cameras also recorded any event.

Perez testified Respondent operated four stores as of June 30, 2014. He traveled from store to store. On Sundays, he went to the store where Petitioner worked. He handed schedules out to all of the employees.

Perez acknowledged that Respondent terminated Petitioner. He drafted the letter (page 4 of PX 8) that Petitioner signed on July 13, 2014. He was present with Petitioner signed this. No one else was present. Petitioner's daughter could have been in the store but he is not sure about this. The term "liability issues," as used in the letter, refers to problems that could arise because Petitioner's disability prevented her from being able to handle the work. Petitioner was terminated due to overstaffing as well as her past disability. It was Amparo who told him about Petitioner's disability.

Perez testified that the schedule marked as page 1 of PX 8 is not in his handwriting. To the best of his knowledge, Petitioner did not work on June 30, 2014. Petitioner first mentioned the accident after she was terminated. He knew, less than a week after the termination, that Petitioner was claiming to have been hurt but he believed she was hurt inside the freezer, not inside the walk-in camera. He tried looking at the camera. He was not present when Emparo fired Petitioner. He told Petitioner she had to sign the letter in order to get the check.

On redirect, Perez testified he does not know exactly when Amparo was on vacation but he is sure she would have returned to work before the July 4th holiday. T. 137. Respondent was not able to review the video to determine whether Petitioner had an accident because Petitioner did not report the accident until after the footage was automatically deleted based on the 7-day DVR. T. 137. Eddie would have reviewed the footage had he known about the claimed accident. T. 141.

Perez testified that Respondent terminated Petitioner for three reasons: 1) Petitioner failed to disclose a medical condition on her job application; 2) the store was overstaffed; and 3) Petitioner was not physically able to perform her job. T. 138. The undisclosed medical condition was not a shoulder condition. To his knowledge, the condition "was something about [Petitioner's] knee." T. 143.

Perez testified that Petitioner worked a total of 22 hours during her two weeks of employment. T. 140. Respondent pays its employees weekly but, in Petitioner's case, it combined the hours from the two weeks in the check it gave to Petitioner. T. 141. [The Arbitrator notes that the hours for Petitioner delineated in RX 1 actually total 24, not 22.]

Under re-cross, Perez testified that all employees complete applications. Respondent retains these applications but does not have the applications completed in 2014 because it "changed [the] back-up system in the office." T. 144. He is able to remember what Petitioner wrote on her application even though she completed the application two years ago. T. 144.

Perez testified he calls in the employees' hours to an outside vendor and the vendor creates the paychecks. T. 146. The employees are not paid in cash. If Petitioner testified she received cash for the hours she worked, she is lying. T. 146. He retained the checks that are marked as page 2 of PX 8. T. 146. He did not give any other checks to Respondent's counsel. T. 147.

On further redirect, Perez testified he obtained copies of the checks from the outside vendor. He hired Petitioner. Petitioner walked in off the street and asked a cashier if Respondent was hiring. The cashier called him and he then interviewed Petitioner. T. 148-149.

Petitioner was recalled. She identified pages 5 and 6 of PX 8 as photographs she took on June 30, 2014, the day of her accident. She testified she took these photographs at work because she wanted to study some of the Mexican food codes during her lunch break. T. 152, 154. She was having some difficulty memorizing those particular codes. T. 155. She used her iPad to take the photographs. She sent the photographs to her daughter and also posted them on her Facebook page.

Under cross-examination, Petitioner testified she showed the two photographs to her attorney about two weeks before the hearing, after he told her Respondent was claiming she was not at the store on June 30, 2014. T. 156-157. She used the photographs as a study aid because, "at the store they were telling them to [her] too fast." T. 158. She is familiar with Facebook. She uses Facebook to post pictures of herself, her relatives and her friends. T. 159. She also uses it to communicate with her family in Mexico. T. 160. The two photographs still appear on her Facebook page. T. 161. One shows American meat products and the other shows Mexican food items. T. 164. The Mexican food products sold at the store changed often so she wanted to learn the codes in order to be "faster at the deli." T. 165. The Spanish phrase meaning "I remember" appears on the re-posted version of PX 8-5. T. 165-166.

On redirect, Petitioner clarified she recently brought her iPad to her attorney's office and showed her attorney the photographs. Her attorney showed her how to take a screen shot of the photographs. He daughter then E-mailed the photographs to her attorney. T. 167. The date on the photograph, "30 de junio de 2014" is written in Spanish. It means she uploaded the pictures to her Facebook page on June 30, 2014. The date of the upload never changes. She

took a third photograph, PX 8-7, while in the lunch area at work. She took this photograph because she thought the sign posted in the lunch area was funny. She uploaded this photograph to her Facebook page. T. 171-172.

Arbitrator's Credibility Assessment

At the outset, the Arbitrator clarifies that she did not rely on Petitioner's rebuttal testimony, or the iPad photographs Petitioner identified during rebuttal, in assessing Petitioner's credibility or resolving the disputed issue of accident.

Petitioner's testimony concerning the timing of her hiring and accident was detailed and credible. Respondent's witness, Ricky Perez, produced schedules (RX 1) indicating Petitioner was not slated to work on June 30, 2014, the claimed date of accident, but he acknowledged schedules at the store were "not set in stone." He agreed it was possible Petitioner worked on June 30, 2014. He denied that Petitioner worked for Respondent before that date. The Arbitrator believes that if Petitioner had fallen at work on her very first day of employment, she would recall that. The Arbitrator also finds it very unlikely Petitioner would have worked a 12-hour shift on her first day, especially given Perez's testimony that any new employee starts out by "shadowing" a more experienced employee.

Petitioner's testimony concerning the circumstances of her fall was also detailed and largely consistent with the histories in her medical records. Ricky Perez acknowledged Petitioner was tasked with retrieving items from the cooler.

Petitioner's testimony concerning her work schedule and method of payment was also detailed and believable. The Arbitrator finds credible Petitioner's assertion that Ricky Perez came to the store on Sundays and paid workers in cash out of a tray that he carried around the store. Also credible was Petitioner's testimony that she worked on Sundays and worked a 12-hour shift, closing the deli, on June 30, 2014 and on her last day of employment. Perez did not directly contradict this testimony. Petitioner's testimony as to the 12-hour shifts undermines Perez's claim that Petitioner worked a total of only 22 hours during a two-week period before being terminated. Perez's testimony that Respondent opted to pay Petitioner for the two weeks of work in a single check is inconsistent with the check, which states that it reflects earnings for <u>one</u> week, i.e., July 7 through July 13, 2014. PX 8, p. 3.

Petitioner was not credible as to all issues, however. Dr. Primus's note of August 14, 2015 reflects that Petitioner reported she was working, albeit with difficulty. Petitioner did not acknowledge returning to work after Respondent terminated her. She claimed temporary total disability benefits from July 12, 2014, the day after the termination, through the hearing of March 9, 2016. Arb Exh 1.

At the hearing, much was made about the circumstances of Petitioner's termination. Employment and ADA issues are beyond the Arbitrator's jurisdiction. The Arbitrator makes no finding as to the legitimacy of the termination but addresses the termination-related testimony.

The Arbitrator finds credible Petitioner's testimony that she reported her work fall to her immediate supervisor, Patricia, as well as Alfonso, the manager of the adjacent meat department and Ricky Perez. The Arbitrator notes, however, that Petitioner consistently linked this reporting with a request that other employees take over her some of her duties, including lifting heavy boxes and retrieving items from the basement.

Ricky Perez attributed the termination to three factors: Petitioner's alleged failure to disclose a significant disability on her employment application, overstaffing and Petitioner's inability to perform her assigned duties. Perez recalled that the undisclosed disability was knee-related. Respondent did not produce any application pursuant to Petitioner's subpoena. PX 9. Perez indicated this was due to a change in Respondent's back-up system.

Petitioner argues the termination was purely retaliatory, i.e., that Respondent fired her solely because she claimed a work accident. This is possible but there may also be some truth to Perez's assertions. Dr. Kuzich's initial note reflects Petitioner complained of right knee pain, among other problems. A history form dated November 26, 2014 reflects Petitioner underwent knee replacements in April 2011 and October 2013. Subsequent records suggest Petitioner was scheduled to undergo knee surgery on July 29, 2014, although it is unclear whether this surgery proceeded. Dr. Bernstein indicated that Petitioner told him she was terminated because she was unable to walk normally. Petitioner included "the knee" as an injured body part on her Application although, ultimately, she did not claim any knee injury.

The Arbitrator, having considered all of the foregoing, concludes that Petitioner did in fact fall as she claimed, injuring her shoulder and back, and provided timely notice of that fall but that Respondent, having learned of her bilateral knee problems during this same time period and based on her requests for assistance and therapy, seized upon the knee condition as a basis for terminating her.

Arbitrator's Conclusions of Law

Did Petitioner sustain an accident on June 30, 2014 arising out of and in the course of her employment?

The Arbitrator finds that Petitioner sustained an accident on June 30, 2014 arising out of and in the course of her employment. In so finding, the Arbitrator relies primarily on the following: 1) Petitioner's credible and detailed testimony concerning the circumstances of the accident; 2) the largely corroborating histories set forth in the treatment records; and 3) the left shoulder MRI results. Petitioner testified she slipped and fell on water in Respondent's cooler while looking for ham that she was supposed to bring back to the deli counter. There is no dispute that Petitioner's job required her to go into the cooler to retrieve items such as ham. Ricky Perez testified he believed the accident occurred in the freezer rather than the cooler but he did not take issue with Petitioner's description of her duties or the fact that there was water on the cooler floor. All of the treatment records describe Petitioner falling onto her left side after slipping on a wet floor at work. The left shoulder MRI shows a significant, retracted

rotator cuff tear. Respondent's shoulder examiner, Dr. Vitello, acknowledged this tear and did not contend it could not have resulted from a fall. Rather, he contended that the tear would have been so painful that it would have prevented Petitioner from being able to continue working. Petitioner testified she was in pain but tried to keep working; as the pain increased, she asked her superiors to arrange for others to take over some of her duties. Petitioner also testified she requested permission, via the deli manager, Patricia (a/k/a Amparo), to attend therapy, with Respondent responding to the request by firing her. The Arbitrator finds Petitioner's testimony on these points to be credible. The person who would have been in the best position to respond to this testimony was Patricia but Respondent did not call her to testify.

Did Petitioner establish a causal connection between her June 30, 2014 work accident and her claimed current conditions of ill-being?

With respect to the lumbar spine, the Arbitrator finds that the June 30, 2014 work accident aggravated an underlying degenerative condition and brought about the need for an MRI and treatment by Drs. Mehta, DeBartolo and Primus. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible denial of any pre-accident lower back problems; 2) Petitioner's credible account of the mechanism of her fall; and 3) the consistent histories and complaints recorded in the treatment records. The Arbitrator has also considered the causation-related opinions of Dr. Bernstein, Respondent's low back examiner. Dr. Bernstein did not exclude the possibility of a back injury or aggravation. Rather, he opined that the injury could not have been very significant since Petitioner did not immediately seek treatment. He indicated he relied on information provided in a cover letter. The cover letter is not in evidence. The Arbitrator acknowledges there was a delay in treatment but finds credible Petitioner's testimony that she asked her manager to send her to therapy, only to be rebuffed and terminated. The Arbitrator finds that, with respect to the lumbar spine, Petitioner established causation as to the need for a consultation, an MRI and formal therapy but failed to establish causation as to the extensive chiropractic care rendered by Dr. Kuzich. That care consisted largely of cold packs and manipulation, with Petitioner reporting little improvement along the way. Dr. Kuzich, via Rehab Dynamix, charged $128.00 at each of 44 visits (for a total of $5,632.00) for transportation. The notes are silent as to the basis for these charges and Petitioner did not testify to requiring transportation. The Arbitrator finds that Petitioner failed to establish causation as to the need for the durable equipment provided by Windy City Medical Specialists. PX 6. Petitioner did not testify to using any of this equipment, which included a $900 lumbar home exercise kit. See further below.

With respect to the left shoulder, the Arbitrator finds that the June 30, 2014 work accident resulted in the rotator cuff tear demonstrated on MRI. The Arbitrator further finds that Petitioner established causation as to the need for the consultations with Drs. DeBartolo, Sclamberg and Primus, the left shoulder MRI and the rotator cuff repair recommended by Dr. Sclamberg, Dr. Primus and Dr. Vitello, Respondent's shoulder examiner. The Arbitrator agrees with Dr. Vitello's opinion that chiropractic manipulation is an inappropriate method of dealing with a rotator cuff tear. Dr. DeBartolo echoed this opinion.

What were Petitioner's earnings? What was Petitioner's average weekly wage?

Petitioner claims she began working for Respondent in mid-June 2014. She recalled working 32 hours during her first week and 48 during her second week. She acknowledged discarding a written schedule she received for the first week. She identified page 1 of PX 8 as her schedule for the second week. She later clarified that page 1 of PX 8 showed her schedule for the week of June 23, 2014. She claimed an hourly wage of $9.75. She testified she was paid in cash (with the exception of the check she received on the day of her termination) and earned a total of $876.00 before the accident of June 30, 2014. She claims an average weekly wage of $438.00 ($876.00 divided by 2). It is not clear to the Arbitrator how she arrived at these figures since 80 (32 + 48) hours multiplied by $9.75 totals $780.00, not $876.00.

Respondent claims $187.00 for both earnings and the average weekly wage. It is not clear to the Arbitrator how Respondent arrived at $187.00 based on the dispute as to when Petitioner began working and whether she ever sustained an accident. Respondent's claim is also inconsistent with the only paycheck in evidence, i.e., page 3 of PX 8. This document reflects hours and earnings for the week July 7 through July 13, 2014, after the alleged accident. It reflects year to date earnings of $192.50, representing 22 hours multiplied by $8.75/hour. As noted earlier, it is inconsistent with the schedule Perez allegedly created. That schedule shows that Petitioner was slated to work 24, not 22, hours.

As stated above, the Arbitrator found Petitioner credible as to her work schedule and earnings. Based on Petitioner's credible testimony as to her hours, hourly rate and cash earnings before the accident, the Arbitrator finds pre-accident earnings of $780.00 and an average weekly wage of $390.00.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims she was temporarily totally disabled from July 12, 2014 (the day after her termination) through the hearing of March 9, 2015. Arb Exh 1. Respondent contends Petitioner is entitled to no temporary total disability benefits, relying primarily on its accident-related defenses.

The Arbitrator has previously found in Petitioner's favor on the issues of accident and causation. The Arbitrator finds that Petitioner was temporarily totally disabled from August 15, 2014 (the date Dr. Mehta took her off work) through July 14, 2015, the date of the last office visit before the visit at which Dr. Primus noted Petitioner was working, albeit with difficulty. The Arbitrator declines to award temporary total disability benefits after July 14, 2015, as requested by Petitioner, even though Dr. Primus took Petitioner off work again on August 14, 2015 (having restricted her to one-armed duty at previous visits) because Petitioner failed to address her post-termination work status at any point during her testimony. The Arbitrator would have to engage in speculation to find that Petitioner did not work from July 14, 2015 through the hearing.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims $31,022.91 in expenses from various medical, durable equipment and medication providers. Arb Exh 1. Based on the foregoing causation analysis, the Arbitrator awards all of the claimed expenses other than the following: 1) the Rehab Dynamix chiropractic bill of $19,655.00; and 2) the Windy City Medical Specialists bill of $6,370.00 (PX 6), which relates to durable equipment and a "lumbar home exercise kit" that Petitioner did not mention at any point during the hearing. The Arbitrator awards medical expenses in the amount of $4,997.91 [$31,022.91 minus $26,025.00 ($19,655.00 plus $6,370.00)] subject to the fee schedule.

In declining to award the Rehab Dynamix charges, the Arbitrator does not intend to imply that chiropractic care is never appropriate or beneficial. Rather, the Arbitrator views such care as inappropriate in this case, based on Petitioner's left rotator cuff tear (with Dr. Kuzich noting significant left shoulder deficits at his first evaluation). The Arbitrator also views certain of the Rehab Dynamix charges as excessive and unjustified.

Is Petitioner entitled to prospective care?

The Arbitrator has previously found in Petitioner's favor on the issues of accident and causation. The Arbitrator has also found that Petitioner specifically established causation as to the left rotator cuff tear diagnosed by both the treating physicians and Respondent's examiner, Dr. Vitello. The Arbitrator awards prospective care in the form of a left shoulder arthroscopy and rotator cuff repair.

Is Respondent liable for penalties and fees?

Petitioner seeks an award of penalties under Sections 19(k) and 19(l) as well as fees under Section 16. At the outset, the Arbitrator notes that, even with respect to the "lowest threshold" penalties, i.e., those provided in Section 19(l), a claimant must make a "written demand for payment of benefits under Section 8(a) or Section 8(b)" before the burden of proof shifts to the employer to explain the denial or delay in payment.

The Arbitrator has found Petitioner credible as to several disputed issues and has awarded benefits on her behalf. The Arbitrator declines, however, to find Respondent liable for penalties and fees. Petitioner was alone when the accident occurred, did not seek treatment until after being terminated, was apparently working during some of the claimed temporary total disability period and did not offer a petition for penalties and fees or written demand for payment of benefits into evidence. PX 10, a 19(b) petition filed on December 28, 2015, is marked so as to reflect Petitioner planned to seek penalties and fees but no penalties/fees petition is attached. The Commission main frame does not reflect that any petition for penalties and fees was ever filed. PX 10 is non-specific as to all issues other than the alleged date of accident and the identity of one medical provider. It does not reference any unpaid bills

or claimed period of disability. The Arbitrator is bound by the record the parties create. The record in this case is insufficiently developed to support an award of penalties and fees.

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

Donna Guebert,

Petitioner,

vs. NO: 15WC 000554

Gilster Mary-Lee,

Respondent.

18IWCC0100

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, 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. 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 file June 13, 2017, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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 15 2018
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MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

GUEBERT, DONNA
Employee/Petitioner

Case# **15WC000554**

GLISTER MARY-LEE
Employer/Respondent

18IWCC0100

On 6/13/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4075 FISHER KERKHOVER COFFEY ET AL
JASON E COFFEY
1300 1/2 SWANWICK ST SUITE 203
CHESTER, IL 62233

0693 FERICH MAGER RYAN
PIETER N SCHMIDT
2001 W MAIN ST SUITE 101
CARBONDALE, IL 62903

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)

DONNA GUEBERT
Employee/Petitioner

v.

GILSTER MARY-LEE
Employer/Respondent

Case # 15 WC 00554

Consolidated cases: _____

18IWCC0100

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **November 3, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0100

FINDINGS

On the date of accident, **November 12, 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 **$24,871.16**; the average weekly wage was **$536.02**.

On the date of accident, Petitioner was **54** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of **$2,551.55** for TTD, **$229.81** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$2,781.36**.

Respondent is entitled to a credit of **$62,019.16** for medical expenses paid under Section 8(j) of the Act.

ORDER

The Petitioner has failed to prove, by the preponderance of the evidence, that her cervical condition of ill being is causally connected to the November 12, 2014 accident.

No benefits are awarded.

With regard to conditions of ill-being other than the Petitioner's cervical condition, 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 8, 2017
Date

ICArbDec19(b)

JUN 13 2017

STATEMENT OF FACTS

The Petitioner alleges that she sustained injuries to her left shoulder, left knee, cervical spine, and lumbar spine when she tripped over angle iron and fell to the ground on 11/12/14. The current Section 19(b) hearing only involves disputed treatment with regard to the cervical spine. .

Petitioner testified she is a 22 year employee of the Respondent, currently serving as a QA Lab Tech, which is essentially quality control testing of the Respondent's food products, check for correct product codes, making sure packages are sealed and that there is no glue on the packaging before the products go out to the public. While working on 11/12/14, the Petitioner testified she was making her rounds on the floor and tripped when she caught her left foot on some angle iron and falling. She testified that she wasn't certain exactly how she fell. She was taken by her boss to the Chester Memorial Hospital emergency room. She then followed up with her primary-care physician, who referred her to Dr. Fissel due to an upper left arm fracture. Dr. Fissel treated the fracture conservatively, and Petitioner testified she underwent physical therapy. She testified she was then referred to both Dr. Gornet, for her back and neck, and Dr. Mall for left shoulder and left knee issues, all of which she relates to the 11/12/14 incident.

The Petitioner ultimately underwent left shoulder surgery with Dr. Mall in July 2015 while remaining under Dr. Gornet's care, as they were treating the left shoulder prior to addressing her back and neck. The Petitioner testified that Dr. Gornet is currently recommending cervical surgery, and because she continues to have neck pain, she wishes to undergo the surgery.

The Petitioner admitted to neck pain and treatment prior to the 11/12/14 work injury, and she had been under the care of a chiropractor prior to 11/12/14. She also agreed she has been diagnosed with fibromyalgia and has been treating for this for years with medication, including Naprosyn and Vicodin, prescribed by her primary-care physician. The Petitioner also admitted she underwent prior cervical MRIs in 2001 and 2011. Petitioner testified she had never been previously told she had a herniated disc in her neck, and that surgery had never previously been recommended.

On cross-examination, the Petitioner acknowledged she was in a significant motor vehicle accident in the late 1970s where she injured her pelvis and ribs, but denied injuring her neck. She agreed she complained of bilateral arm pain in 2002, and admitted she had numbness and tingling in her arms into her hands prior to November 2014. She has treated in the past with chiropractors Dr. Kennedy and Dr. Osborne.

Petitioner's prior medical history included fibromyalgia; rheumatoid arthritis; Meniere's disease; injuries to the low back, mid-back, cervical, shoulders, and knees; radiculopathy; hand and feet numbness; joint swelling/stiffness; headaches; and pain in the neck, low back, upper extremities, hip, upper leg, shoulders, and wrists. (Px5; Rx2; Rx10; Rx11; Rx12; Rx13). The medical records document complaints and treatment regarding the neck and shoulders for numerous years before the work accident of 11/12/14, as well as what appears to be fibromyalgia related pain. (Rx2, Exh. 2; Rx8; Rx10; Rx11; Rx12). A 6/9/11 note of Dr. Birner notes chronic back and neck pain.

On 9/19/01, Petitioner underwent a cervical MRI at the request of Dr. Murry based on complaints of arm pain, shoulder pain, and bilateral arm numbness. The report indicated the films were within normal limits. (Rx15). On 3/27/02 Petitioner complained to Dr. Birner of numbness and tingling with working above her head and doing

crafts. She noted she had been checked for carpal tunnel, had a neck MRI and was evaluated for thoracic outlet syndrome. (Rx8).

On 4/26/11, Petitioner saw orthopod Dr. Doll following a 12/28/10 fall. Her complaints included headaches, diffuse neck pain, and tingling across the base of the neck and upper shoulders. His review of prior medical referenced the prior cervical MRI; numbness of the upper extremities complaints to Dr. Birner on 3/27/02; upper extremity arterial studies on 4/4/02 based on the complaints of numbness; 6/8/02 cervical x-ray; 3/7/06 neck soreness; records of chiropractor Dr. Kennedy from 2009 through October 2010 referencing complaints including the neck and upper back, and including a reference to falling on ice at work. His diagnoses included a resolving cervical strain and a history of diffuse pain and fibromyalgia. (Rx12).

Petitioner began seeing Dr. Hoffmann in August 2011 for global myalgias and arthralgias. Petitioner reported a fall going to her car from work with significant low back and bilateral knee pain, and that she had not felt the same since. It noted she had a 9 year history of fibromyalgia. On 10/31/11 she noted complaints that included neck pain and global complaints. (Rx13). On 11/4/11, Petitioner underwent a cervical MRI at the request of Dr. Hoffman that showed a mild broad based disc bulge at C5/6 and a small central disc protrusion at C6/7. There was no evidence of spinal or foraminal stenosis. (Rx7). On 5/16/12, Petitioner complained of pain that was totally global; she hurt in every part of her body with the most severe areas maybe being the neck and thoracic spine regions, noting pain in the neck and across the shoulders in a shawl distribution. Dr. Hoffmann also stated that Petitioner had a broad based disc bulge at C5/6 and a central disc protrusion at C6/7. (Rx13).

On 1/24/13, Petitioner sought treatment from Osborne Family Chiropractic for injuries from a work accident on 1/14/13. The injuries involved her low back, right buttock, legs, feet, neck, and right shoulder. Petitioner continued to regularly treat with Dr. Osborne for complaints that included neck pain, bilateral shoulder pain, and upper extremity numbness. (Rx10).

Between 2/25 and 5/7/13, Petitioner saw Dr. Wayne for her low back and legs following a prior work injury. There is no reference to her neck, but the initial report did note "a long history of fibromyalgia and she has had extensive treatment for generalized somatic pain over the years." There were references to: various trigger points throughout the back and upper extremities (11/07); fibromyalgia with neck pain and upper back pain (8/09 and 9/09); diagnostic cervical and thoracic studies and EMG of the upper limbs (6/10 and 7/10). He noted "I am seeing (Petitioner) for her lower back so I will not go into any detail regarding her other body parts." (Rx11).

On 6/5/14, Dr. Osborne saw Petitioner for complaints that included neck pain and noted that she had positive maximal cervical compression and foraminal compression tests bilaterally. (Rx10). On 6/13/14, Petitioner was seen at by Dr. Birner for complaints related to a fall three weeks before the visit, which flared her fibromyalgia. She also reported her fibromyalgia was causing difficulties prior to the fall, and she had to save everything for work because even vacuuming caused her to "'get sick.'" (Rx8). On 10/27/14, Dr. Osborne noted neck pain that was moderate, frequent and about 6 out of 10, unchanged since the last visit. This note indicates 44 visits by Petitioner since 8/30/12 for a variety of ailments, including neck pain. (Rx10).

On 11/13/14, Petitioner was seen by her primary care provider, Red Bud Internal Medicine and Pediatrics (RBIMP), and reported a fall at work the day before. She reported catching her left foot on angle iron and falling face down onto the floor. She did not hit her head. Petitioner had pain in her left knee and shoulder. On exam, there was a scrape to the left patella, swelling of the patella, pain with knee flexion, slight left shoulder swelling, and significant pain with left shoulder movement. Her neck exam was unremarkable. Petitioner was

diagnosed with a humerus fracture, based on a call she received from the ER, and knee pain, and she was referred to orthopedics and held off work pending same. (Px1).

On 11/14/14, Petitioner saw Dr. Fissel at Premier Care Ortho for left shoulder pain. Petitioner reported that she slipped, fell, and landed on her left shoulder. She denied numbness, tingling, or radiation of pain. Petitioner advised that the only other pain she had involved her left knee. After reviewing the left shoulder x-ray, he diagnosed a proximal left greater tuberosity fracture and recommended an ongoing sling. He held her off work out of concern for fracture displacement (Px2).

On 11/18/14, Petitioner told Dr. Osborne that she had fallen at work and, immediately afterwards, had headaches and felt pain in her neck, left shoulder, low back, and left knee She did not remember a lot of particulars about the accident, noting she may have lost consciousness, but did remember laying on her stomach with her arms overhead. Dr. Osborne noted spasm, tenderness, loss of range of motion with pain, and trigger points. As to the neck, cervicalgia was diagnosed and she was advised to light duty, with her main problem being her left arm. Manipulation was performed along with "infratonic sound therapy" for the left shoulder. (Px7; Rx10).

On 11/21/14, Dr. Fissel's office note documented left knee and shoulder pain, he noted he was authorized to treat the left knee, and Petitioner was released to one handed duty. (Px2). An 11/24/14 note from ATI Physical Therapy states: "She continues to receive treatment from a chiropractor for her left shoulder, left knee and cervical spine", and this included manipulations. (Px3).

A 12/15/14 note from ATI indicated complaints of shoulder pain radiating up into the neck and down her arm. (Px3). On 12/19/14, Petitioner saw Dr. Fissel and reported she was improving until "they made her do too much therapy", and had increased shoulder pain. She also reported some nocturnal numbness and tingling in her fingers and finger numbness when waking up; the symptoms were mostly in her index and middle fingers. Dr. Fissel noted some carpal tunnel symptoms that were likely related to her arm position which was restricted by her shoulder, and he prescribed a wrist splint. Therapy was continued. (Px2). Petitioner was discharged from therapy at ATI on 12/24/14, and the report noted that despite excellent progress in objective range of motion, strength and function, Petitioner continued to report significant subjective disability. (Px3). Interestingly, she then began therapy again at Apex on 12/29/14, at which time she reported left lateral neck pain/upper trapezius pain radiating down the arm into the hand, and it had worsened since 'lifting boxes' in therapy. She also noted she continued to receive chiropractic treatment as the chiropractor "knows my body". (Px2).

On1/7/15, Petitioner saw Dr. Wayne at Respondent's request per Section 12. She reported falling and landing on her left side on 11/12/14. She also reported a whiplash like injury to her neck when she fell and noticed left shoulder pain, numbness to her middle three fingers, left arm weakness, left knee pain, left ankle pain, and low back pain. Sher also noted she'd been undergoing chiropractic treatment since the accident. On exam, Petitioner's cervical range of motion was within functional limits with discomfort on the left side of the neck with rotation. She was tender throughout the cervical paraspinals and the left upper medial trapezius. There was no palpable muscle spasm and the right side of the neck was non-tender. Petitioner's left third finger had diminished sensation. Dr. Wayne diagnosed a left proximal humerus fracture, a left knee sprain/contusion, a cervical sprain/strain, and a lumbar strain from the work accident. No acute findings were noted on cervical x-ray, but there was a mild loss of lordosis and mild degenerative changes in the mid to lower cervical spine. He noted a long history of treatment to multiple body parts, including the ones involved in her current complaints. He opined that her worsening neck pain was related to the 11/12/14 injury. He recommended a cervical MRI, recommending comparison to her most recent prior films, and three weeks of physical therapy. He opined that the chiropractic care was not reasonable or necessary, and that physical therapy was more appropriate. (Px5;

Rx11). Petitioner also sought treatment at RBIMP for a sore throat on 1/7/15, noted ongoing shoulder pain, and neck examination was unremarkable. (Px1).

Petitioner had multiple sessions with Dr. Osborne between 11/18/14 and 12/16/14, at which point she noted she had been "sitting in the hospital" for a week. On 12/18/14 she complained that PT made her carry more than she could handle and she had increased neck, low back, ankle and shoulder pain: "Pt is distressed and crying in my office due to the pain and stress. She is upset by the treatment she is receiving." On 1/8/15, Petitioner told Dr. Osborne that she had pain bilaterally from the base of her skull down to the shoulders and she was tight in the shoulders. Her pain was reportedly so severe it caused nausea and vomiting, which she indicated kept her from attending PT. There are references to Petitioner having feelings of anxiousness. (Px7; Rx10).

On 1/19/16, Petitioner saw Dr. Gornet, an orthopedic surgeon, for her neck and back complaints. She reported that her current level of cervical symptoms began when she fell on 11/12/14. Initially, her shoulder pain was severe, but shortly thereafter she developed increasing neck, left arm and low back pain. She complained of neck pain with headaches to the left trapezius, left shoulder and tingling in her left arm, low back pain to the left side, left buttock and hip. Dr. Gornet noted Petitioner had a longstanding monthly prescription for Hydrocodone. On exam, Petitioner had a mild amount of neck pain that was not a big issue for her. She had decreased left biceps and deltoid strength at 4/5, but Dr. Gornet noted this finding could be related to pain from her humerus fracture. Dr. Gornet ordered MRIs of the neck and back. He concluded Petitioner's symptoms were causally related to her work accident. (Px10).

On 1/19/15, Petitioner also saw Dr. Mall for her left shoulder. She reported tripping when her foot was caught on angle iron, and the next thing she knew she was face down with her arms extended. Petitioner indicated that she did not remember how she landed or how her arms landed. All she remembered was being on the ground with her arms in a Superman-type position with them forwardly elevated in front of her. Her pain ran down from her left shoulder into her fingers. Petitioner also indicated her left knee was injured during the work accident and she began having low back problems during therapy. On exam, there was some pain with cervical range of motion and some tenderness to palpation along the cervical spine. Dr. Mall diagnosed cervical spine tenderness and pain, a left knee contusion, a possible patella cartilage defect, and in the left shoulder possible SLAP and/or rotator cuff tears. He opined that Petitioner incurred injuries to her left shoulder and knee from the work accident; he further concluded the accident potentially caused a cervical spine injury, noting overlap between the shoulder and cervical spine, and that she was seeing Dr. Gornet for the neck. (Px8).

On 1/27/15, as to the cervical spine, Dr. Mall noted tenderness and limited range of motion secondary to discomfort. Petitioner also had subjective numbness that went down to her fingers. Petitioner received an injection into the AC joint and subacromial space that completely resolved her shoulder pain; she continued to have neck and bicipital tendon pain, and he recommended she continue to see Dr. Gornet for the neck. (Px8).

Petitioner continued to treat with Dr. Osborne as well, and on 2/3/15 he noted Petitioner felt some improvement in her neck following a cortisone injection into the shoulder. On 2/12/15, Dr. Osborne notes Petitioner reported she was doing well and went to PT, and "after going to work on the same day she notes that she just fell apart" with flared up neck pain. (Px7; Rx10)

On February 12, 2015, Petitioner was seen at RBIMP for sinus problems, and also noted headaches and trouble with her neck and shoulder, noting she was unsure of whether her headaches were coming from her neck or shoulder. Neck exam did not indicate any abnormalities. Her diagnoses included cervicalgia and low back pain. (Px1).

On 2/20/15, Petitioner was examined by Dr. Chabot, a orthopedic spine surgeon, pursuant to Section 12 for her neck and back. Her complaints included neck pain one time per week and left-sided lumbar pain. Her left shoulder was getting better, but was still sore. On exam, Petitioner's cervical range of motion was near normal and her Spurling's test was negative. There was mild neck tension. Dr. Chabot's diagnoses were neck, shoulder, and back contusions; fibromyalgia; chronic neck, back, and musculoskeletal complaints associated with fibromyalgia; and a non-displaced fracture of the left greater tuberosity. He noted that Petitioner's exam was devoid of significant objective findings that would suggest active radiculopathy. Petitioner did complain of intermittent left arm paresthesia, but Dr. Chabot indicated this was a nonspecific complaint and very common with fibromyalgia. He opined that the nature of Petitioner's complaints at the time of his evaluation were not dissimilar to complaints she had made in the past. He recommended physical therapy, anti-inflammatory medication, and MRIs of the cervical and thoracic spine to compare to her prior MRIs. (Rx2).

On 2/23/15, Petitioner returned to Dr. Mall and reported improvement in the left shoulder with injections, but "the neck is still a problem", and she had to stop doing some therapy exercises because of this. She was having minimal discomfort at work with her current cervical and shoulder restrictions. Dr. Mall indicated he would turn over her cervical care to Dr. Gornet. The remainder of Dr. Mall's records do not significantly reference the cervical spine. (Px9).

On 3/10/15, Petitioner told Dr. Osborne that her neck was still bothering her, mostly when sitting still and/or reading, and her low back was bothering her a little. There was some pain throughout the day at work from looking down at paperwork or mixing product. Her low back bothered her most in the morning and will loosen some throughout the day. Overall, Petitioner felt her condition had improved. (Px7; Rx10).

A 3/16/15 cervical MRI showed mild disc desiccation with a diffuse annular disc bulge at C5/6 and mild disc desiccation with a mild broad-based central disc protrusion at C6/7. There was no central canal stenosis at either level. At C5/6, the report notes there was a diffuse disc bulge and there "may be a small left foraminal disc protrusion", best seen on image #7 of the foraminal views, contributing to mild left foraminal exit stenosis. At C6/7 there was no indication of central or foraminal stenosis. (Px9).

On 3/16/15, Dr. Gornet concluded that Petitioner had central disc herniations and annular tears at both C5/6 and C6/7. He believed that the left foraminal view on the MRI showed a foraminal herniation at C5/6 and there was a subtle foraminal fragment at C6/7. An injection at C5/6 was performed on 4/4/15. (Px10).

On 3/24/15, Petitioner reported to Dr. Osborne that her neck and upper back were worse due to illness and vomiting. (Px7; Rx10).

On 3/31/15, Dr. Chabot reviewed the 2015 MRI films and compared them to the prior MRI films. He concluded the 2015 cervical MRI showed disc desiccation and degeneration at C5/6 and C6/7, some evidence of disc bulging at C5/6 and C6/7, and mild foraminal stenosis at C5/6. He did not appreciate any evidence of a focal or asymmetric disc herniation, and the 2015 report did not mention a central disc herniation at C5/6. He opined that the 2015 cervical and lumbar studies were essentially unchanged versus the prior MRIs, and there was no evidence of significant new pathology that could be directly related to the work accident. Dr. Chabot indicated that, although the 2015 report stated there may be a small foraminal disc herniation at C5/6 on the oblique images, this finding was not corroborated by the axial images. He explained that there are three separate imaging sequences: sagittal (a side view slice), axial (horizontal slice), and coronal/oblique (perpendicular slice). Pathology should be able to be seen on two separate imaging sequences; seeing a finding on one isolated slice, as described by the radiologist that read the 2015 MRI, was insufficient to diagnose a herniation. Axial images showed the left neuroforamina and revealed no evidence of a herniation there or at C6/7. Dr. Chabot also

explained that, depending on how the image is cut, there could be some degree of distortion of the anatomy. Dr. Chabot concluded that Petitioner's neck and back had returned to her baseline level of complaints prior to 11/12/14, that she was at maximum medical improvement for her work accident, and that her current condition was caused by chronic musculoskeletal complaints associated with fibromyalgia and disc degeneration. He noted Petitioner's history of chronic neck/upper extremity and back/lower extremity complaints associated with fibromyalgia and, by her own admission, her current neck complaints occurred maybe once a week and her upper extremity paresthesia was intermittent. He felt Petitioner could work full duty. (Rx2).

On 4/24/15, Dr. Osborne noted Petitioner's neck was improved with soreness but doing better as far as sharp pain, and she remained on light duty. On 5/12/15 Petitioner again reported increased neck pain with illness. At the last noted visit with Dr. Osborne on 6/8/15, Petitioner reported "much of the same in the neck and low back", noting she was scheduled for left shoulder surgery. (Px7; Rx10).

On 4/13/16, Dr. Chabot opined that any need for surgery was related to pre-exiting, chronic cervical spine conditions. Due to her history of pre-existing chronic neck pain, degeneration, fibromyalgia, and radiculopathy, Dr. Chabot indicated Petitioner will continue to have complaints regardless of what treatment regimens are undertaken and the surgery would be of no benefit. (Rx2).

On 5/4/15, Respondent referred orthopedic surgeon Dr. Rothrock for a Section 12 exam of her left shoulder and knee. She reported tripping and falling face first onto her outstretched arms; she experienced pain in her left shoulder and knee. Dr. Rothrock diagnosed a left knee contusion and a rotator cuff tear from the work accident. After reviewing an updated left shoulder MRI with contrast, on 7/8/15 Dr. Rothrock indicated it showed a rotator cuff tear and he diagnostic and therapeutic arthroscopic left shoulder surgery. He did not offer any specific opinions regarding the cervical spine. (Px6; Rx9).

On 5/18/15, Dr. Gornet authored a note to address Dr. Chabot's opinions. He maintained that there was literature that would support formainal views actually identifying pathology not seen on the axial or sagittal views. He specifically cited an article from the April edition of the Spine Journal as being the best summary. Dr. Gornet felt that pathology was clearly present in the 2015 MRI's foraminal views. He felt that Petitioner's fall that was sufficient to cause or aggravate cervical pathology. (Px10).

On 7/23/15, Petitioner underwent an arthroscopic rotator cuff repair, subacromial decompression, open AC joint resection and open biceps tenodesis with Dr. Mall. (Px8). On 8/20/15, Dr. Gornet opined that Petitioner had a disc herniation at C5/6 that was the source of her shoulder pain. On 9/10/15, Petitioner underwent an injection at C6/7. (Px10).

On 1/25/16, Petitioner saw Dr. Gornet and advised that she had recovered after her shoulder surgery and then, upon returning to full duty, her pain progressively worsened, particularly in the neck, left shoulder, and left arm with weakness and tingling. On 2/25/16, Petitioner underwent another injection at C6/7. On 4/4/16, Dr. Gornet recommended disc replacements at C5/6 and C6/7. (Px10).

Repeat cervical MRI imaging was performed on 4/4/16 at the same facility as the 3/16/15 testing. Films reportedly reflected central disc herniations at C5/6 and C6/7 with probable annular tears extending towards the left foramen but no definite nerve root impingement. There also was a small central C3/4 protrusion of uncertain clinical consequence with no nerve compression. While the report indicates the films were compared to the 3/16/15 films, it does not reference findings regarding such comparison. (Px9).

On 5/1/16, Dr. Chabot was deposed and explained that fibromyalgia is a muscloskeletal condition that is in the realm of rheumatologic disorders. It causes profoundly elevated complaints involving muscloskeletal tissues. Patients are noted to have chronic pain syndromes involving, most commonly, the neck with radiation to the shoulders, upper extremities, or back. Dr. Chabot testified that fibromyalgia could make her much more difficult to manage post-operatively and give her a very poor chance of success. Petitioner's chronic use of narcotic medication for over four years could also make her pain more difficult to manage after a surgery. Dr. Chabot also offered testimony concerning the article in the Spine Journal that was relied upon by Dr. Gornet. He testified that the article discussed a limited study that evaluated oblique magnetic resonant images for determination of cervical foraminal stenosis. The purpose of the study was to determine whether interpreters of diagnostic studies would be able to reach a more likely consensus if they included oblique images in a MRI (i.e., if they observe the same degree of neural foraminal narrowing on one set of sequence images compared to another). The article itself pointed out that the analysis performed was insufficient to justify the use of a new diagnostic technique. Rather, the study was discussing a procedure that was in its infancy and was not the gold standard. The article indicated that it was a pilot study and treatment guidelines should not be derived from it. (Rx2).

On cross-examination, Dr. Chabot admitted that there is no requirement that disc pathology be seen on two separate views in order to be confirmed a disc injury He agreed that if he was treating the Petitioner, he would probably have ordered more diagnostic testing in order to verify if there was or wasn't a disc herniation. However, he would not recommend any more testing in this case because the Petitioner did not complain of an active radiculopathy. When Petitioner's complaints of paresthesia in the left arm and pain in the left shoulder during her evaluation were noted, Dr. Chabot agreed these symptoms could be associated with an active radiculopathy (Rx. 2).

Dr. Gornet testified via deposition on 8/11/16. Dr. Gornet confirmed the first time he treated the Petitioner was 1/19/15 taking a history from Petitioner of neck pain with headaches to the left shoulder, tingling in her left arm, and some low back pain which she attributed to her 11/12/14 work injury, when she tripped and fell to the ground, fracturing her humerus. The history went on to note the Petitioner's pain in her left shoulder was so severe this was the main focus of her treatment, but shortly after she developed increasing pain in her low back as well as her neck and arm. Pysical exam noted decreased strength in the left deltoid at 4 over 5 and recommended MRI examination to fully investigate the cervical spine. Dr. Gornet testified that given the fall was significant enough to fracture her left humerus, it easily could have, at a minimum, aggravate an underlying condition in her neck as well as potentially cause even a new injury" (Px9).

Dr. Gornet's review of both the radiologist report and actual MRI films indicated the Petitioner had central herniations and annular tears at both C/6 and C6/7, as well as a foraminal stenosis due to the herniation at C5/6. Dr. Gornet testified that epidurals performed at C5/6 and C6/7 were performed to calm down the inflammation from the disc injury that's produced, "and given the fact that we had such clear evidence of pathology" at C5/6 and C6/7 which correlated with her physical exam and complaints, the injections were reasonable. Dr. Gornet identified where he saw disc injury in the actual MRI films. He challenged Dr. Chabot's opinion that there were no changes between the prior 2011 MRI and the 2015 MRI. Dr. Gornet "strongly" disagreed with Dr. Chabot, and testified that Dr. Chabot's opinion is nconsistent with current medical science Dr. Chabot's assertion that the article was not dealing with disc herniation, but with foraminal stenosis did not make sense since such stenosis can be caused by many things, including disc herniation. Thus, Dr. Gornet felt Dr. Chabot was misinterpreting the article. (Px9). Dr. Gornet reiterated that there was no evidence of disc herniation on Petitioner's prior cervical MRIs, while there was clear visual evidence of disc herniation in the cervical spine on the post-accident MRI. (Px9).

Dr. Gornet opined the Petitioner's cervical condition, as it currently stands, is causally related to her alleged work injury of 11/12/14, and is recommending a two-level disc replacement at both C5/6 and C6/7. The basis for his opinion is that the fall was significant enough to cause a fracture of her humerus, the MRI scans which show an objective change between her previous scan and her current scan, the MRI's objective pathology correlates to her subjective complaints, and she had injections performed which gave her symptomatic relief demonstrating the disc pathology seen on MRI is causing her pain. (Px9).

On cross, Dr. Gornet conceded that, in the year leading up to the work injury, Petitioner had both medical care and regular chiropractic care for complaints that included headaches and pain in her neck, shoulders, and arms. He also admitted that, before the work accident, Petitioner had symptoms that showed some signs of nerve root irritation in her upper and lower extremities. Dr. Gornet testified that he did not believe fibromyalgia truly existed and, therefore, could not comment on the symptoms associated with the condition. While he testified that his interpretation of the 2015 MRI was consistent with Petitioner's physical exam and the radiologist's reading of the films, Dr. Gornet acknowledged that the herniations could not be dated based on the MRI, but he still opined that they occurred at or near the time of the work accident. He described a protrusion as a low-level herniation and testified that protrusions and bulges were essentially the same. Dr. Gornet also recognized Petitioner's longstanding narcotics use, and testified that he would probably wean her off of all narcotic medication for approximately six weeks before performing surgery. Dr. Gornet stated that the Spine Journal study results showed that oblique views had significantly better intraobserver agreement for determining the presence of foraminal stenosis than the sagittal or axial images. He admitted that no one makes a diagnosis based on a single view. (Px10).

On 8/30/16, neurosurgeon Dr. Terry performed a utilization review at the Respondent's request and concluded the disc replacements at C5/6 and C6/7 recommended by Dr. Gornet were not medically necessary. (Rx3). Dr. Terry was subsequently deposed on 10/6/16. (Rx14). With regard to the denial of the surgical recommendation, she explained that there were mild findings at C5/6, that the C6/7 level did not have any significant pathology, that there were no significant findings particularly in the C7 distribution; and that there was no evidence of nerve root compression at C6/7. There were no exam findings for the C6/7 level and it was unclear that Petitioner was even symptomatic at that level. On cross examination, Dr. Terry testified that she would probably support a surgery at just the C5/6 level, noting she hadn't been asked to address each level individually. Based on ODG guidelines, Dr. Terry testified that epidural injections are not recommended due to the risk. Dr. Terry solely addressed the reasonableness and necessity of the treatment and did not offer testimony concerning causation. (Rx14).

On cross exam, Dr. Terry admitted she has recommended cervical epidural steroid injections on her patients she treats in spite of the ODG saying the procedure is too risky. She agreed she only reviewed the MRI report, not the films. She testified that when she is treating a patient, she reviews both the MRI films and the radiology report. She did not examine the Petitioner.

At the hearing, Petitioner testified to ongoing neck pain. She admitted that she had experienced numbness and tingling that extended down her arms to her hands prior to the accident date. Petitioner testified that, prior to the work accident, she had never been told she had a disc herniation or received a surgical recommendation involving her cervical spine.

CONCLUSIONS OF LAW

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

The Arbitrator finds that the Petitioner failed to prove that her current cervical condition of ill-being is causally related to her 11/12/14 accident.

The Arbitrator notes that the Petitioner has a longstanding history of cervical pain and symptoms going all the way back to 2001. She has sustained multiple accidents over the years. She has been diagnosed with fibromyalgia, a condition that causes widespread pain symptoms, since at least 2010, along with rheumatoid arthritis.

Petitioner reported a "whiplash" type injury at the time of the accident when she saw Dr. Wayne in January 2015. She also told him she had immediate pain into the left shoulder and some numbness in the middle three fingers and weakness in the left arm. Yet, the more contemporaneous medical records, and even some of the more recent reports, indicate the Petitioner was not sure how she fell and made no mention of a whiplash type injury. While Dr. Wayne opined there was a causal connection of the accident to a cervical strain, he also was relying on a whiplash injury, which is not supported in the initial medical histories. The initial contemporaneous records, in the Arbitrator's view, carry more weight with regard to the mechanism of injury. The fact that she may have had neck pain and symptoms with physical therapy for the shoulder does not equate to a cervical injury. She clearly had a preexisting condition in the cervical spine, as well as the longstanding history of fibromyalgia and rheumatoid arthritis.

The Arbitrator is not persuaded by the testimony of Dr. Gornet. Much of the testimony of Dr. Gornet involved whether pathologies he identified at C5/6 and C6/7 in 3/16/15 MRI films had been present in 2011 films, as well as whether the pathologies even existed. Much of the latter argument revolved around how best to accurately identify foraminal pathologies from various MRI views. This appears to be more of a red herring in the Arbitrator's view based on the evidence. The Petitioner's neck pain and treatment became significantly more consistent after 2011. The records of Dr. Osborne make it clear that subsequent to these films, and prior to the accident at issue here, the Petitioner's neck treatment increased and continued until late October 2014, just a couple of weeks prior to the accident date. On 10/27/14 Dr. Osborne noted moderate and frequent neck pain that was 6 out of 10, and unchanged since the last visit. She had undergone 44 visits with Dr. Osborne since 8/30/12. While this was for a variety of ailments, it consistently included neck pain. Her neck pain was initially documented by Dr. Gornet as being mild. As of 2/20/15, Dr. Chabot noted that Petitioner only had neck pain one time per week and intermittent left arm paresthesia. Dr. Birner noted chronic neck and back pain going back to at least 6/9/11.

Dr. Gornet's causation opinion ultimately rests on a chain of events analysis, given there is no way to date the occurrence of the herniations he notes, per his own testimony, other than the Petitioner's subjective complaints. As noted, the Arbitrator sees no significant difference between the pre and post accident neck complaints.

The fact that the Petitioner had symptoms following the accident, in and of itself, does not support a finding of causation given that there was prior treatment. While a claimant can make a valid workers' compensation claim based either on direct causation or aggravation of a preexisting condition, a review of the medical records themselves does not reflect a significant change in the Petitioner's cervical condition. While Dr. Gornet

reasonably testified that the mechanism of injury was a competent cause of a cervical herniation, the Arbitrator believes that a review of the records of Dr. Osborne reflects that the Petitioner's pre-accident and post-accident complaints were not very different at all. In fact, she appears to have treated consistently for her neck following a 12/28/10 accident. On 1/24/13, Petitioner reported neck pain to Dr. Osborne following a 1/14/13 work accident.

The Petitioner did complain of symptoms down her left arm. However, Dr. Gornet agreed that this could have been due to the left arm fracture or the left shoulder condition. The Arbitrator also notes with great interest that there are multiple references in Petitioner's prior records to radicular-type symptoms in her arms and hands, going back to at least 2001, and that the Petitioner has suffered from fibromyalgia for many years. Dr. Gornet's "belief" in this condition seems to have resulted in a lack of acknowledgement by him of Petitioner's years of widespread pain complaints, regardless of what the diagnosis may have been, and that this clearly included neck complaints that continued really through the accident date in this case per Dr. Osborne.

While the Arbitrator notes that it is possible that the Petitioner aggravated her cervical condition at the time of the 11/12/14 accident, the preponderance of the evidence does not support this finding being more probably than not. For the reasons noted above, the Arbitrator finds that the Petitioner failed to prove that her cervical condition of ill-being is causally related to the 11/12/14 accident.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

The parties stipulated on the record prior to the hearing that the Respondent had paid all alleged causally related medical expenses incurred by Petitioner through the date of hearing. Based on the Arbitrator's findings with regard to causation, medical expenses related to the Petitioner's cervical condition are denied.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings with regard to causation, prospective cervical medical benefits are 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

Roger G. Strothmann,

Petitioner,

vs.

NO: 13WC 40851
16WC 03756

City of Springfield, CWLP,

18IWCC0101

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 14, 2017, is hereby affirmed and adopted.

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

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

18IWCC0101

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 15 2018
o020618
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STROTHMANN, ROGER G
Employee/Petitioner

Case# **13WC040851**
16WC003756

CITY OF SPRINGFIELD CWLP
Employer/Respondent

18IWCC0101

On 7/14/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0352 LaMARCA LAW OFFICE PC
WILLIAM LaMARCA
1118 S 6TH ST
SPRINGFIELD, IL 62703

0332 LIVINGSTONE MUELLER ET AL
DENNIS O'BRIEN
620 E EDWARD ST
SPRINGFIELD, IL 62703

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

Roger G. Strothmann
Employee/Petitioner

v.

City of Springfield, CWLP
Employer/Respondent

Case # 13 WC 40851

Consolidated cases: 16 WC 03756

18IWCC0101

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Quincy**, on **June 8, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **October 5, 2011 & December 26, 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 these dates, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of these accidents *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident of December 26, 2015; it is not causally related to the accident of October 5, 2011.

In the year preceding the injury, Petitioner earned **$40,756.99 & $46,225.40**; the average weekly wage was **$783.89 & $888.95**.

On the date of accident, Petitioner was 55 years of age, ***single*** with **3** dependent children.

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

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

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

Respondent shall be given a credit under Section 8 (j) of the Act for medical it paid on charges causally related to the Petitioner's accidents as is explained in the Arbitrator's Conclusions of Law.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $533.37/week for 20 weeks for his December 26, 2015 accident, because the injuries sustained caused 4 % loss of use of the man as a whole as provided in Section 8(e) of the Act.

Respondent shall pay all related medical expenses as is explained in the Arbitrator's Conclusions of Law which are attached. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act

Respondent shall pay Petitioner temporary total disability benefits of $592.63/week for 3 & 1/7 weeks, commencing 12/27/15 through 01/18/16, as provided in Section 8(b) of the Act.

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

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

D. Dylan McCarty

Signature of Arbitrator

7-12-2017
Date

JUL 14 2017

Statement of Facts

Prior to any testimony, Petitioner's attorney objected to the introduction of Respondent's Exhibit 3, a decision involving the same parties, Strothmann v. City of Springfield, 13 WC 033022. Petitioner's attorney objected stating the decision involves injuries that are not relevant to Petitioner's present claim and the prejudicial affect of some of the conclusions contained in the decision far outweigh any probative value. Respondent's attorney pointed out there was some reference in the decision to a claim of memory loss and for that reason the decision has some relevancy to the current claims. The Arbitrator allowed the exhibit into evidence for the limited purpose of the issue of causation but not for the purpose of credibility.

Petitioner was called to testify. Petitioner testified he understood his testimony involved his two pending claims involving accidents he alleges he sustained on October 5, 2011 and December 26, 2015.

Petitioner was asked to describe his employment with Respondent. Petitioner testified he had worked for Respondent on two different occasions. The first time was for approximately six and one half to seven years. Petitioner testified that during that period of time he was a municipal security guard. Petitioner testified he then returned to work for Respondent as a utility security officer. His job duties in that capacity involved patrolling the lake area, city substations and other CWLP property. His responsibilities as a Security Officer involved patrolling more than one building or property. Petitioner verified he used a city truck to perform his job duties.

Petitioner testified when he arrived at work he would park his private vehicle and use a city issued vehicle. He would initially report to the main security office when he arrived at work unless he was assigned to work in dispatch. Petitioner would use a city vehicle on patrol. Petitioner testified the city vehicle was equipped with a permanently mounted radio that is connected to central dispatch. Petitioner was asked if during his shift there are any circumstances when he would not be expected to respond to a call from dispatch. Petitioner testified, "never. If you are asked to make a call or respond to something you immediately go no matter what you're doing." Petitioner gave examples of types of calls he would receive as a Security Officer from dispatch.

Petitioner's attention was directed to October 5, 2011. Petitioner testified he was on a routine patrol in the Maple Gove area. While driving in this area, two deer ran out in front of him. To avoid hitting them he veered off the road and went into a culvert. As a result, he hit his head on the door jam between the front seat and the back seat. Petitioner testified he then attempted to come back onto the road. He hit the side of the culvert and it jolted his body up, hitting his head on the roof of the vehicle. Petitioner testified the impact, "bent my neck down." Petitioner testified he was knocked unconscious as a result of hitting his head. Petitioner contacted dispatch to advise them of the accident. He then sought medical care.

Petitioner testified he recalled going to St. John's emergency room after his accident. He recalls he was having pain in his neck and was, "very fuzzy and my head was throbbing." Petitioner testified he also sought medical care from his family doctor, Dr. Western. Petitioner seemed to have had difficulty recalling whether he lost time from work after his accident of October 5, 2011. The Arbitrator notes on the Request for Hearing form there is no allegation of lost time after the October 5, 2011 accident.

Petitioner testified upon returning to work he noticed difficulty at work. In particular he noticed loss of mobility in his neck, headaches, memory loss and he began to stutter. Petitioner was asked about several emergency room visits he made subsequent to his accident. Petitioner recalled going to the emergency room on several occasions

with symptoms of dizziness, neck pain and headaches but could not recall the exact dates of the emergency room visits. The emergency room records were marked and introduced as Petitioner's Exhibit 2 and 3. Petitioner was also asked if he had been referred to Dr. Gelber, initially in August, 2012. Petitioner testified he saw Dr. Gelber by referral from Dr. Western. Petitioner also testified he continues to see Dr. Gelber every six months. Prior to his second accident, Dr. Gelber was treating his condition with different types of medication. Petitioner testified he did not recall what the medications were for but also does not recall noticing any improvement in his symptoms while taking the medications.

Petitioner was asked about treatment he received for the condition of his neck prior to his second accident. Petitioner testified he received treatment at Advanced Pain and Rehab Center. He received treatment from Dr. Venturini starting in August, 2014. Petitioner did not specifically recall whether he received treatment from anyone else, including his family doctor, Dr. Western prior to seeing Dr. Venturini in August, 2014.

Petitioner confirmed prior to seeing Dr. Venturini in August, 2014 he had not sustained any additional trauma to his head or neck subsequent to his accident in October, 2011. Petitioner was asked about the type of treatment he received from Dr. Venturini. Petitioner testified he received adjustments and other treatment modalities. He testified the treatment provided him with temporary relief. Petitioner testified he continued experiencing a loss of range of motion in his neck, headaches, dizziness and stuttering. He noticed no improvement or change in his memory or ability to focus at work.

Petitioner was asked about a reference to seeing a chiropractor in 1989. Petitioner testified he was somewhat unclear about the nature of the treatment but believed the treatment involved problems he was having with sciatic nerve pain radiating into his leg. Petitioner was also asked about treatment he received in 2010 for headaches. Petitioner testified the symptoms he had at that time were much different than the symptoms that developed after his accident. In particular, the headaches were located at the front of his face where as the headaches he developed after his accident were located on the left side of the back and top of his head. Petitioner reiterated that subsequent to his first accident and prior to his second accident he was noticing neck and head pain and lack of mobility in his neck and diminished memory.

Petitioner was asked about his second accident on December 26, 2016. Petitioner testified he was performing the same job duties he previously described on December 26, 2015 as a Utility Security Officer. He was also operating a company vehicle at the time of his second accident. Petitioner testified prior to his accident he was performing normal patrol duties. He contacted the dispatcher, Keith Marcy, advising him that he, "was going to run down the street and grab something and I'd be right back." Petitioner testified his destination at that time was the Subway sandwich shop a few blocks from the dispatch office. Petitioner was asked whether, while driving to the Subway sandwich shop he had his radio on. "Yes. We never turned them off. I mean we're not supposed to. I never turn mine off." Petitioner testified after going through the drive through he headed back to the office. Petitioner was asked if he had advised Mr. Marcy that he was taking his lunch break. Petitioner testified that he did not advise Mr. Marcy he was taking his lunch break and if he had he would have told Mr. Marcy he was, "going on my 44." Petitioner testified on his way back to the power plant while proceeding through the intersection of Stevenson Drive and West Lake, another vehicle turned in front of him causing Petitioner to strike the side of the other vehicle. Petitioner was asked if he came into contact with anything inside the cab of the truck. Petitioner testified he recalled hitting the windshield with his forehead. Petitioner recalled having his seatbelt on and that the airbags deployed. He also testified that the airbag light had been on for some time. He testified the airbag deployed but something happened and it was not inflated.

Petitioner testified after the accident he was in a state of shock. He was feeling pain in different areas of his body and trying to determine the extent of his injuries. He felt pain in his wrist, the left side of his body and was dazed and confused.

Petitioner testified that Sergeant Fuiten is the shift sergeant. Petitioner testified Mr. Fuiten drove him to the hospital. Petitioner confirmed he did not believe he lost consciousness at the time of his second accident. Petitioner testified he received treatment at the emergency room. Petitioner received a series of x-rays. While waiting for treatment, Petitioner underwent a drug screening test.

Petitioner testified he saw Dr. Sandercock, his family physician subsequent to his second accident. Petitioner testified he was sent back to Dr. Gelber and Dr. Venturini.

Petitioner was asked to examine Respondent's Exhibit 4, a log sheet of calls received on December 26, 2015. Petitioner reviewed the exhibit and testified he did not see any reference to him calling in prior to his accident. Petitioner also noticed another officer had called in that day to advise the dispatcher he was going on a 44. Petitioner testified it was his understanding on the date of his second accident when an individual is on a break or lunch that if a call came in, "You have to go on a call any time you're called regardless if you're on a break or lunch if it refers to your duties. If there would had been a substation alarm or anything I would have had to go to it."

Petitioner was asked if it was his understanding that a security guard could refuse to respond to a call while on a lunch break. Petitioner testified it was his understanding that a security guard was not allowed to refuse a call. It was also Petitioner's understanding that a security guard was expected to use the company vehicle while on lunch breaks. "That's been the practice forever." Petitioner was asked if there had been any change in that policy. Petitioner testified there was a change in the policy after his second accident. The change in policy was that if there are more than two employees on a shift, a Security Guard is supposed to take their own vehicle on lunch breaks. If there are only two people on shift. the Security Guard is supposed to take the company vehicle.

Petitioner was asked again about whether the log sheet marked as Respondent's Exhibit 1 had been rewritten. Petitioner testified based on what he was told by Mark Fuiten, one of his supervisors, the log sheet had in fact been rewritten.

Petitioner was asked about treatment he received after his accident of December 26, 2015. Petitioner testified he was taken to the emergency room by Mr. Fuiten and that Mr. Fuiten stayed at the hospital for some period of time. Petitioner recalls that at that time he was feeling, "fuzzy" and experiencing a lot of pain in his head, neck and back. Petitioner testified while at the emergency room he was given a piece of scratch paper by Mr. Fuiten and told to write some kind of short narrative of what had happened. The note was marked as Respondent's Exhibit 7. Petitioner was not certain if Respondent's Exhibit 7 is actually what he had filled out.

Petitioner was asked about a reference to the accident happening while returning from lunch. Petitioner testified he used the term lunch "vaguely" and reiterated that he really was not on a technical lunch break. He testified had he not gotten in an accident it would have taken him approximately fifteen minutes to go to the restaurant, get his sandwich and return.

Petitioner testified he continued to receive medical care from Dr. Gelber and Dr. Venturini after his second accident. He had been prescribed different medication from Dr. Gelber. Petitioner testified he continued having almost daily headaches and his memory loss has gotten worse. Petitioner confirmed he was also continuing to

have issues with equilibrium and he has had problems with balance. He also mentioned a problem with his speech and occasional stuttering.

Petitioner testified he is still experiencing problems with his neck, in particular a lack of mobility and pain that varies from day to day. Petitioner testified he also notices difficulty concentrating, both at work and at home. He has also noticed changes in his mood. In particular he has noticed his temper is shorter.

Petitioner was asked about his level of physical activity since his second accident. Petitioner testified he was advised to resume his work out activities. Petitioner confirmed he at one time was a Taekwondo instructor and he had been involved in martial arts for over thirty-five years and had been an instructor for over twenty-five years. Petitioner confirmed he at no time was a competitive fighter and at no time did he ever receive blows to his head in the course of teaching martial arts classes.

Petitioner testified he was sent for a neuropsychological evaluation by Dr. Gelber. The neuropsychological evaluation was performed by Dr. Meyer-Cox. Her report dated May 20, 2016 was marked and introduced as Petitioner's Exhibit 19. Petitioner was asked about a letter dated September 20, 2016 he sent to Dr. Meyer-Cox regarding her report and some of the background information contained in the report. Petitioner testified Dr. Meyer-Cox must have believed he was a competitive fighter and incorrectly concluded Petitioner had probably sustained multiple blows to his head while involved in competitive martial arts fighting. Dr. Meyer-Cox added an addendum to her report correcting the information in her report.

Petitioner was asked about his relationship with Joe Crifasi. Petitioner identified Mr. Crifasi as the former Deputy Chief of Security. Although they are friends, Petitioner testified they have no social relationship. Petitioner was also asked about his relationship with Rose Painter. Petitioner testified he taught Ms. Painter's teenagers martial arts for a number of years and since his divorce she has become like an aunt to his children keeping an eye on them or taking them to different functions while Petitioner is at work. Petitioner verified Ms. Painter was at the emergency room after his second accident on December 26, 2015. Petitioner's son had contacted Ms. Painter asking that she take him to the hospital to see if his father was ok.

At the conclusion of direct examination Petitioner testified, "between the two accidents, I am not the same person I used to be. There has been a great diminish of memory and then the daily pain in my neck, the headaches, the mood changes. There has been a lot of changes. They've been extensive."

On cross-examination Petitioner was asked about the exact size or depth of the culvert into which he drove. Petitioner testified he recalled that the culvert was approximately four feet deep. He also confirmed on cross-examination that his recollection was the damage to the vehicle was in the bumper area. Petitioner was also asked about his visit to St. John's ER and the types of testing that were performed. Petitioner was also asked about the passage of time between his emergency room visit on the date of accident, some follow up CT scans and his follow up visit with Dr. Western, his family physician. Petitioner confirmed during that time he continued having problems, including headaches, dizziness and some memory loss.

Petitioner was asked about specific dates on which he went to the ER with certain complaints. Petitioner was unable to recall the exact date of each visit. Petitioner also had difficulty remembering exactly what he told the ER staff at each visit. Petitioner denied having told the ER staff on August 20, 2012 he had not followed up with respect to his concussion because he was not having those symptoms. Petitioner also disputed he had advised the staff he was having no symptoms. Petitioner was asked about seeing Dr. Fowler on August 29, 2012 for an unrelated condition involving an incident in which Petitioner developed vertigo. Petitioner testified he received treatment for an inner ear problem and his symptoms associated with those problems improved.

Petitioner testified on cross-examination about a visit with Dr. Gill in August, 2012. Throughout the course of cross-examination Petitioner was questioned about specific treatment dates and what complaints he had at that time. Petitioner had difficulty remembering exact dates and what complaints he had at each visit.

Petitioner was asked on cross-examination if he had missed any time from work as a result of his first accident. Petitioner testified he had been taking time off for a divorce matter and was off a lot for that. Petitioner was asked again about an appointment with Dr. Gelber and the types of symptoms and complaints he had at that time. Again, Petitioner was unable to remember the exact date. Petitioner was also asked about an emergency room visit prior to his accident on October, 2011. Petitioner was asked about an ER visit after a chemical exposure on or about September 15, 2013 and whether at that time he had any complaints of a concussion. Petitioner was also asked about an emergency room visit on October 19, 2013 and what symptoms he was having at that time. Again, Petitioner had difficulty remembering exactly what complaints he had on each specific date he was asked about.

Petitioner was asked on cross-examination if he recalls advising the emergency room staff that his neurologist wanted him to have an MRI. Petitioner testified there had been some discussion about scheduling an MRI with Dr. Gelber. Petitioner was unable to explain why Dr. Gelber testified in his deposition that he had never ordered an MRI. Petitioner was asked about telephone conversations with Dr. Gelber's office and specific dates and what he told their office on that particular date during the conversation. Petitioner on more than one occasion made a general response that he does recall contacting Dr. Gelber's office several time with various complaints but was unable to say what date the call was made and what specific complaints he made on that day.

Petitioner was asked if he recalled seeing Dr. Venturini on October 27, 2014. Petitioner said he was unable to recall the exact dates he saw Dr. Venturini but that he had seen him over a long period of time. With regard to the passage of time between his first accident and his first visit with Dr. Venturini, Petitioner testified he, "tried to wait for a long time to see if things would change. I don't remember the exact dates of when I saw him." Petitioner was asked whether he recalled telling Dr. Venturini his symptoms were severe "50-80% of the time." Petitioner testified he did recall telling Dr. Venturini about the severity of his neck pain and his headaches. Despite the pain, Petitioner testified he continued working. Petitioner testified he also was unwilling to, "try strong opiates because I did not want to get addicted to them nor what I have been able to work under those circumstances correctly."

Petitioner was asked on cross-examination about an office visit with Dr. Ludwig on January 8, 2015. Again, Petitioner was unable to verify the exact date of the appointment. The appointment was for an unrelated condition involving Petitioner's right shoulder.

Petitioner was asked about his level of physical activity. Petitioner testified he was encouraged to maintain his level of activity to maintain and improve his physical condition. Petitioner testified the only treatment he received from Dr. Gelber was medication because it was his understanding there was no other treatment available for his post-concussion symptoms.

Petitioner was asked additional questions on cross-examination regarding his accident of December 26, 2015. Petitioner was asked what patrol he was on at that time. He was also asked about Respondent's Exhibit 4 and his testimony the time sheets had been rewritten. Petitioner testified when he returned to work for Respondent in 2009 he was never told about a memo that went out in 2008 regarding taking company vehicles to lunch. He confirmed he was only advised of this policy after his accident on December 26, 2015. Petitioner testified that

although he now takes his personal vehicle to lunch, he still has a walkie talkie he uses to keep in contact with dispatch.

> Q: You could have taken your lunch and eaten it at work, correct?
> A: That was not my lunch. It's a common practice, Mr. O'Brien, and it has been for years, that people run down the street to grab water, chew, numerous items. This has been going on for years. You keep on using the word lunch. And I use the word vaguely myself because I had gotten food, but again, people would run down the street in company vehicles for 37 years until my accident and that changed after that and that was the first time it's ever been that way, ever.

Petitioner was asked about a hand written note marked as Respondent's Exhibit 5. Petitioner believed he may have written it at the hospital or at least wrote something at the hospital. He acknowledged he used the term lunch, but, "used that term loosely because I had a food item."

Petitioner testified on cross-examination whether he received an off work slip at the emergency room at either St. John's Hospital or Memorial Medical Center. He was also questioned about whether he had to work or take sick days because he did not have an off work slip. Petitioner was asked about receiving an off work slip from Dr. Venturini and that in fact he had only received it at the request of Petitioner. "I told him the problems I had. If he gave me an off work slip then he - - he was the doctor. I don't control doctors to give me slips." Petitioner confirmed on cross-examination he is scheduled to see Dr. Gelber every six months.

Petitioner was asked on cross-examination about his visit with Dr. Meyer-Cox on May 20, 2016 and specifically a letter he wrote Dr. Meyer-Cox after reviewing her report alleging that Petitioner, "became upset." Petitioner testified he simply wanted to correct errors in the report.

Finally, Petitioner was asked about his symptom of stuttering he developed after his accident. Respondent's attorney wished to point out for the record Petitioner did not stutter during his two hours of testimony.

On redirect examination Petitioner was asked about the difficulty he was having to recall every appointment he had been asked about on cross-examination and exactly what he had said to the medical provider. Petitioner confirmed on redirect the headaches that developed after his first accident do come and go but they occur almost daily. Petitioner confirmed when he saw Dr. Ludwig for an injury he sustained to his right shoulder when practicing with his son and that it had no affect on his neck or head concussion related symptoms. Petitioner confirmed on redirect he was not aware of any policy requiring Security Guards to drive their personal vehicle to lunch.

Petitioner called Mr. Crifasi as a witness. Mr. Crifasi was asked about his employment with the City of Springfield. Mr. Crifasi testified he had retired from his position at CWLP in May, 2015. At that time his job title was Deputy Chief of Security. He had worked in that capacity since 2004. He started as a Utility Security Officer in 1981. Mr. Crifasi testified in 2011 in his capacity as Deputy Chief of Security he was involved in monitoring the activities of Security Officers. Mr. Crifasi also confirmed he was Petitioner's supervisor at that time. Mr. Crifasi was asked if he noticed any change in Petitioner's behavior subsequent to his accident in October, 2011. Mr. Crifasi testified he noticed Petitioner was less self-confident and he seemed to forget things. Mr. Crifasi testified that he retired in May 2015.

Mr. Crifasi was asked about the policy in 2011 regarding breaks and lunches for officers. Mr. Crifasi stated,

> Since I started in 1981 we were always encouraged to take the company vehicle, even on lunch, because where we work we are responsible for the lake, the patrons on the lake, you know, we'd respond to boat accidents, respond to people struggling in the water, we have emergencies at the power plant, we are responsible for securing our turbins, water towers, substations all throughout the city so we were encouraged to take the truck, that way if we got an alarm call or an emergency call we could respond because there is equipment in the truck that we need.

Mr. Crifasi was also asked if there was ever a policy requiring Security Officers to use their private cars on lunch breaks. Mr. Crifasi was shown what was marked as Petitioner's Exhibit 23, a memorandum dated January 4, 2008. Mr. Crifasi stated the policy contained in the memorandum was never enforced on the day shift. Mr. Crifasi stated he had never seen the memo before. It was Mr. Crifasi's recollection that subsequent to January, 2008 officers and sergeants continued to use their company vehicle for lunch.

Mr. Crifasi was asked if in his capacity as Deputy Chief of Security he was involved in investigating a motor vehicle accident involving one of his Security Officers. Mr. Crifasi testified he had been involved in many motor vehicle incidents and explained how he would have handled it. He was also asked if he had been working when Petitioner had his accident on December 26, 2015 he would have directed the Shift Sergeant to go to the scene of the accident and take pictures of both vehicles and would have driven to the hospital to check on Petitioner's condition.

Mr. Crifasi was shown Respondent's Exhibit 4, a dispatch log sheet. Mr. Crifasi was asked if anywhere in the log sheet it is designated that Petitioner had called dispatch to advise him he was on a lunch break. Mr. Crifasi indicated there was no indication based on the log sheet that Petitioner had called to advise dispatch he was on lunch break.

Mr. Crifasi was asked if after December 26, 2015 he noticed any changes in Petitioner's behavior. Mr. Crifasi, who had retired approximately seven months prior to Petitioner's second accident, said that they were personal friends, having gone to high school together. Mr. Crifasi stated Petitioner was quite anxious after the accident. He testified Petitioner was having a hard time understanding why he was being treated the way he was with regard to his workers' compensation claim. Mr. Crifasi was asked about his opinion as to Mr. Hubbard's relationship with Petitioner. Mr. Crifasi stated in his opinion they did not get along. On cross-examination Mr. Crifasi was asked if the hand written date on the top of the memo marked as Petitioner's Exhibit 23 was his hand writing. Mr. Crifasi stated it could be his hand writing. He further testified when he retired he went through a memo book with a marker and wrote dates of the memos on top. Mr. Crifasi stated he placed dates on all of the memos in the book but didn't necessarily read them. The purpose for placing dates on the memos was to get everything set and organized before he retired.

Mr. Crifasi was also asked on cross-examination about his relationship with Mr. Hubbard. Mr. Crifasi stated he did not necessarily get along with Mr. Hubbard on a professional level but had nothing against him on a personal level.

On redirect examination Mr. Crifasi confirmed he did not actually read the contents of the memo even though he may have placed a date on top of it to make it easier for someone to locate the memo based on its date. Mr. Crifasi also stated he did not recall any requirement that stated officers use their personal cars when going on break or lunch. Mr. Crifasi was asked, if someone was running to the store to get something and coming right back that would show up on the log sheet to your knowledge?

A: No, on day shift a guy would, say it would be early in the morning. He would say I am going to run up to McDonald's and grab some breakfast or I am going to run to Panera's and grab some breakfast and they would run there and come back. It was just considered a break. It wouldn't even be on the log sheet.

Petitioner called Rose Marie Painter to testify at arbitration. Ms. Painter testified she is a paralegal for a local law office. Ms. Painter was asked about her understanding or familiarity with Petitioner's two accidents. Petitioner testified she knew Petitioner, initially from sending her son to a martial arts class Petitioner taught. Ms. Painter's son began attending the classes in 1996 for approximately six and a half years. Ms. Painter testified she attended each class with her son. Ms. Painter was asked if she recalled during any of the classes seeing Petitioner struck in the head by any of the students or another instructor. Ms. Painter testified she never saw Petitioner struck in the head.

Ms. Painter was asked if she noticed any change in Petitioner's behavior after his October, 2011 accident. Ms. Painter testified prior to his accident she observed Petitioner to be, "extremely organized." She noticed after his accident Petitioner had difficulty remembering names which made him very frustrated. Ms. Painter also noticed he had less patience with his own children. Ms. Painter also noticed a slight difference in Petitioner's speech pattern. She also recalled Petitioner having complaints of neck symptoms.

Ms. Painter was asked if she was present at the emergency room on December 26, 2015. Ms. Painter stated she was present at the emergency room because Petitioner's son asked her to take him there. Ms. Painter testified she recalled Mr. Mark Fuiten being present at the hospital with Petitioner. Ms. Painter verified Petitioner had his uniform on when he was at the emergency room . Ms. Painter was asked if she had overheard any conversations Mr. Fuiten had had with anyone. Ms. Painter testified she overheard Mr. Fuiten talking to someone on the phone. Ms. Painter testified, "it was very, I would have to say cruel that they were making fun of him the way he was. What he said, to me, made fun of and mock of what evidently - - I don't know how this is going to play but evidently when Mr. Strothmann, Roger had said, that he was hurting here, there and whatever." Ms. Painter also testified after the second accident she noticed other changes in Petitioner's behavior. She testified he began having problems with memory. He seemed confused, especially with keeping track of doctor's appointments. She also noticed an increase in his level of frustration and his lack of patience. Ms. Painter confirmed Petitioner had asked her to assist him with day to day activities after his second accident.

On cross-examination Ms. Painter testified since Petitioner's second accident she has not noticed any improvement in his memory or headaches or the condition of his neck. On redirect Ms. Painter was asked if she believed Petitioner would currently be capable of performing the activities he had performed in the past running the taekwondo school. Ms. Painter stated there were a lot of forms involved in operating the school and she believed it would be difficult for Petitioner to remember all of the forms and movements involved in operating the school.

Respondent called Eric Hubbard to testify at arbitration. Mr. Hubbard identified himself as Chief of Security for CWLP. He had been in that capacity for almost ten years. Mr. Hubbard explained his job duties as Chief of Security involved overseeing security for the power plants, lakes and municipal buildings and generally any CWLP property. Mr. Hubbard confirmed he has been Petitioner's supervisor since 2009. With regard to Petitioner's 2011 accident Mr. Hubbard testified Petitioner advised him he had had the accident approximately a day or two later. Mr. Hubbard testified he observed the roadway where Petitioner's accident occurred. He did not believe there was much of a slope or culvert to the area where Petitioner's accident occurred. Mr. Hubbard testified after the accident he did not notice any difference in Petitioner's speaking ability.

He also did not notice anything with regard to Petitioner's memory or any conversations that would indicate difficulty with memory, either after the first accident or second accident. Mr. Hubbard testified he has not noticed Petitioner stuttering or any change in his demeanor since October, 2011. He testified it was possible Petitioner talked to him about working with restrictions. Mr. Hubbard was asked about Petitioner's Exhibit 23. Mr. Hubbard did not remember much detail about the memorandum. Mr. Hubbard did acknowledge Petitioner was not employed on the date of the memo and he was not sure the memo would have been brought to Petitioner's attention when he was hired. Mr. Hubbard was asked about Respondent's Exhibit 4, the log sheet, and whether he knew if it had been rewritten. Mr. Hubbard stated it had been rewritten.

Mr. Hubbard was also asked about the hand written accident report filled out by Petitioner. Mr. Hubbard testified on the date of accident he spoke with Mr. Fuiten and Officer Marcy. It was Mr. Hubbard's understanding the report was filled out at the Security Office after Petitioner and Mr. Fuiten had left the hospital. Mr. Hubbard also testified he believed Mr. Criafasi had some issues with the fact he had gotten a job that perhaps Mr. Crifasi had wanted.

On cross-examination Mr. Hubbard was asked about his involvement in investigating Petitioner's two accidents. Mr. Hubbard was also asked about the memo dated January 4, 2008, Petitioner's Exhibit 23. Mr. Hubbard indicated the policy contained in the memo was probably enforced in 2008 and possibly in 2011. "I think it's gotten more laxed as we've lost officers." Mr. Hubbard suggested the policy was being enforced in 2015 prior to Petitioner's accident but Petitioner was never disciplined for taking the company truck on lunch.

On redirect Mr. Hubbard testified Petitioner was probably not disciplined or reprimanded for using the truck on lunch break.

Petitioner was recalled to testify. Petitioner testified, "in 2011 my understanding was that everyone used the company vehicle whether they went down the street to get a snack, lunch, whatever. I never, ever saw anyone use their private vehicle to go to lunch, ever, on any shift." Petitioner also testified he had never seen the memo and it was never brought to his attention. Petitioner also testified he was never reprimanded for using the company vehicle over his lunch hour nor was he ever aware of anyone else being reprimanded. Petitioner confirmed after his second accident it was brought to his attention there was now a policy for people to use their private vehicle if there are more than two officers on duty. When there are two officers on duty, it was Petitioner's understanding he was supposed to use the company vehicle. Petitioner was also asked about a discrepancy in the description of the culvert where his accident occurred in October, 2011. Petitioner stated his original description of the culvert and how the accident occurred is correct.

The deposition of Dr. Paul Venturini dated July 26, 2016 was marked and introduced as Petitioner's Exhibit 20. Dr. Venturini described his training as a doctor of chiropractic medicine and the continuing education medical programs in which he has participated. Dr. Venturini confirmed he was actively treating Petitioner for complaints of headaches, neck pain and back pain. At the time of the deposition it appeared Petitioner was seeing Dr. Venturini on more of an "as needed" basis. Dr. Venturini had his initial appointment with Petitioner was August 27, 2014. At that time he came in for treatment related to his neck and headaches related to symptoms Petitioner believed were the result of a motor vehicle accident that occurred in October, 2011 at which time he veered off the side of the road to avoid hitting a deer. "He hit a culvert, whipped his neck, hitting the side against the steel door jam and then jammed top of head on roof trying to get back on road."

Dr. Venturini referred to Petitioner seeking medical treatment, initially at the emergency room. He was treating with Dr. Western and Dr. Gelber. His complaints at that time were headaches, neck pain, pain in the back of his neck, neck pain daily. Dr. Venturini also referred to other symptoms including loss of concentration, irritability

and difficulty going to sleep. Dr. Venturini stated based on his understanding on how Petitioner was injured in the car accident and the physical findings and symptoms, it was his opinion the findings were consistent with the mechanism of injury. It was Dr. Venturini's understanding from the date of accident to Petitioner's first visit with him, Petitioner had not sustained another accident and was receiving treatment from Dr. Western and Dr. Gelber. Dr. Venturini diagnosed Petitioner with cervical and thoracic somatic joint dysfunction with associated myofascitis, headaches and reduced cervical/thoracic mobility. Dr. Venturini stated he had treated other patients who sustained concussions or traumatic brain injury but his treatment focused mainly on neck pain and associated muscle or joint dysfunction. Although some of the treatment was intended to address Petitioner's headaches.

Dr. Venturini provided a summary of the treatment he provided Petitioner during the period from August 27, 2014 through April 13, 2015. Dr. Venturini testified he believed Petitioner's condition was stationary and permanent and that no further care would change his condition other than to provide treatment for flare-ups or aggravations of his condition. Dr. Venturini recommended Petitioner continue with flexibility exercises for upper body, neck, endurance and strength training.

Dr. Venturini was asked about his report dated May 13, 2015 which had been marked and introduced as Petitioner's Exhibit 13. Dr. Venturini was asked about his opinion as to whether the condition he treated Petitioner for was either caused or aggravated by his motor vehicle accident. Dr. Venturini stated he believed Petitioner injured his neck and due to the manner in which the condition healed he was left with reduced mobility and neck pain. He also noted memory loss and loss of concentration and headaches.

Dr. Venturini was then asked about a second period of time in which he provided treatment to Petitioner. The first time Dr. Venturini saw Petitioner during the second period of treatment was December 30, 2015. It was Dr. Venturini's understanding Petitioner had sustained a second motor vehicle accident while working for CWLP on December 26, 2015. It was Dr. Venturini's understanding Petitioner struck another vehicle when the vehicle turned suddenly into Petitioner's path causing Petitioner to hit the vehicle broadside. Dr. Venturini provided some description of the symptoms Petitioner described to him subsequent to his injury. Dr. Venturini was given some of the emergency room records associated with Petitioner's December 26, 2015 accident including x-ray reports and a CT scan report. Dr. Venturini testified the CT scan revealed, among other things a calcified central posterior disc protrusion which probably predated the December 26, 2015 accident but was unable to determine if it had been present prior to the October 5, 2011 accident.

Dr. Venturini summarized Petitioner's complaints at his initial evaluation on December 30, 2015. Dr. Venturini stated Petitioner's symptoms and the nature of his injuries were similar to his condition after his October, 2011 accident with the exception of additional complaints of pain in the lumbar spine. The last time Petitioner had been seen by Dr. Venturini was July 21, 2016. Dr. Venturini provided an overview of treatment he rendered to Petitioner during this period of time. Dr. Venturini believed Petitioner would be compliant with recommendations for the exercise program or exercise activities he had recommended. Although Dr. Venturini believed Petitioner plateaued at the end of treatment, he also stated, "he could continue to heal." Dr. Venturini also stated, "can he further heal the brain and concussions can take a long time to heal." Dr. Venturini also believed Petitioner's prior injury could be contributing to the length of time Petitioner remained asymptomatic including the concussion related symptoms or condition. "They know now that repeated head trauma is going to cause - - is going to cause permanent brain damage, and its compounded each time you sustain an injury to it."

Dr. Venturini was asked about a narrative report dated April 7, 2016. The report was marked and introduced as Petitioner's Exhibit 16. It was also marked as Exhibit 4 in Dr. Venturini's deposition. Dr. Venturini referred to his report in his deposition summarizing he believed Petitioner injured his neck and upper back in both

accidents as well as suffering a concussion and he confirmed Petitioner had continuing complaints of ongoing cervical/neck pain, reduced mobility, joint crepatation in the cervical spine, memory loss, concentration difficulties, sleep disturbances and headaches.

Dr. Venturini confirmed he was still seeing Petitioner on an as needed basis. Dr. Venturini was asked about his prognosis with respect to Petitioner's cervical, thoracic and lumbar spine. Dr. Venturini was unable to say exactly how long and to what degree of severity Petitioner's symptoms would be long term, but he did believe Petitioner's injuries were permanent.

On cross-examination Dr. Venturini was asked if he had reviewed x-rays taken at the emergency room and had the benefit of reviewing the emergency room records. Dr. Venturini testified he was unsure as to the exact type of treatment Petitioner received subsequent to his October, 2011 accident prior to seeing him in August, 2014. Dr. Venturini was asked on multiple occasions as to his understanding of Petitioner's condition prior to seeing him and medical records that were provided to him regarding treatment he had received prior to his initial visit. Dr. Venturini testified Petitioner rated his neck pain as an eight on a scale of ten but that he was able to function and perform his job duties.

Dr. Venturini was asked on cross-examination about whether he believed Petitioner was capable of returning to work with certain restrictions after his second accident. Dr. Venturini stated he might have been able to return to work unless he was having severe headaches. Dr. Venturini testified that on January 15, 2016 he wrote a note stating Petitioner could return to full unrestricted duty as of January 18, 2016. Dr. Venturini stated as of January 13th Petitioner still didn't feel like he was ready to return to work. Dr. Venturini also referred to office visits after Petitioner had returned to work indicating he was able to perform his job duties.

On redirect Dr. Venturini was asked to review the emergency room records dated October 5, 2011 and whether having reviewed them changed any of the opinions he had given during his deposition. Dr. Venturini stated his opinions remained the same.

Petitioner introduced the evidence deposition of Dr. David Gelber dated November 16, 2016 marked and introduced as Petitioner's Exhibit 21. Dr. Gelber provided a brief summary of his training and qualifications. His CV was introduced as Petitioner's Exhibit 1. Dr. Gelber is board certified in neurology. Dr. Gelber was asked if his practice includes head injuries and injuries resulting in post-concussive syndrome. Dr. Gelber stated he did in fact treat patients with those injuries.

Dr. Gelber testified the last time he saw Petitioner would have been November 8, 2016. Dr. Gelber stated Petitioner sees him every six months for a regular follow up appointment.

When seen on August 31, 2012, Petitioner provided Dr. Gelber with a history in which he advised Dr. Gelber in October, 2011 he was driving a truck for work and swerved off the road. He reported that at that time he hit his head on the roof and door. He went to the hospital with neck pain and dizziness and was diagnosed with a concussion and cervical spine strain. Petitioner advised Dr. Gelber that at the time of his visit he was still having problems with dizziness, short term memory loss and neck discomfort. He also complained of difficulty finding words during a conversation. Based on his examination Dr. Gelber diagnosed Petitioner with post-concussive syndrome. Dr. Gelber ordered an MRI of the cervical spine. As far as treatment he referred Petitioner to physical therapy for his neck pain. As far as the cognitive issues and short term memory, Dr. Gelber stated there was, "I don't really have any treatment for and the dizziness and I don't really have any good treatment for that. He was already seeing the ear nose and throat doctors so essentially I was kind of focusing on the neck pain at that time." With regard to Petitioner's symptom of dizziness, Dr. Gelber stated the force of an injury can cause injury

to the inner ear and then they can also have dizziness from having the brain, "rattle around." "So dizziness is a very common symptom that occurs after concussion of any type." Dr. Gelber believed based on the history provided to him, the accident could have caused or contributed to the symptoms Petitioner presented on the day he saw him.

With regard to the diagnosis of post-concussion syndrome, Dr. Gelber testified there are five major symptoms to post-concussive syndrome: headaches, neck pain, dizziness, cognitive complaints, depressed or quick temper and grumpiness. As far as the five categories of symptoms, it was Dr. Gelber's opinion Petitioner had most of the symptoms that are normally associated with post-concussive syndrome. It was Dr. Gelber's opinion any speech issues Petitioner described were more likely related to focus and concentration.

Dr. Gelber testified Petitioner had similar complaints at his office visit of July 29, 2013 with the possibility of some increase in headaches. Dr. Gelber believed Petitioner's symptoms of shakiness or shaking of the limbs may be associated with stress and anxiety. At the next office visit on January 29, 2014 Dr. Gelber testified Petitioner seemed to be doing a little better with some improvement in his headaches. Dr. Gelber testified Petitioner called his office on October 13, 2014 complaining of a flare-up of neck pain. At that time Dr. Gelber prescribed Gabapentin and referred him to physical therapy. In January, 2015 Dr. Gelber testified Petitioner had similar complaints to previous office visits. He also testified Petitioner had begun seeing a chiropractor.

Dr. Gelber was asked about seeing Petitioner after his second accident in December, 2015 sometime in January, 2016. At that time Petitioner advised Dr. Gelber he had had another motor vehicle accident on December 26, 2015 at which time he hit his head on the windshield. He went to the hospital and was advised he had another concussion with some worsening of his symptoms from the previous accident. Dr. Gelber described this incident as causing a flare-up of his symptoms. Dr. Gelber's assessment at that time was post-concussive syndrome with an exacerbation from his second accident or a flare-up of symptoms. Dr. Gelber next saw Petitioner on March 21, 2016 at which time Dr. Gelber testified Petitioner seemed to be doing a little better, still working, problems with headaches, short temper, short term memory but, "he was getting by."

Dr. Gelber was asked about an FMLA form in which he indicated due to headaches Petitioner might need some time off. At his next appointment on November 8, 2016 Dr. Gelber testified Petitioner complained of having nightmares and was concerned he may have developed post traumatic stress disorder. Dr. Gelber did not believe Petitioner was exhibiting symptoms that would be consistent with PTSD. Dr. Gelber further testified Petitioner was at maximum medical improvement with respect to his post-concussion syndrome. However, Dr. Gelber wanted to continue seeing Petitioner for,

> reassurance for him and peace of mind for him. Again, he is stressed out about all of this so I think seeing him, you know, once or twice a year to just kind of reassure him he is not any different than anybody else that has this and it's a good thing that he's working and kind of going over some of those positives is good for him."

Dr. Gelber was asked if a normal neurological exam is typical with a diagnosis of post-concussive syndrome, Dr. Gelber indicated that it was typical.

Dr. Gelber was shown what was marked as deposition Exhibit 2, a narrative report he prepared dated April 24, 2016 and marked as Petitioner's Exhibit 18 at arbitration. Dr. Gelber stated with respect to Petitioner's condition of post-concussive syndrome, it would be difficult to state whether his symptoms would either improve or get worse. Dr. Gelber stated on an average, "most of what you get back you get back in a year." Dr. Gelber stated it would be difficult to quantitate the extent to which his second accident worsened his underlying condition. Dr.

Gelber was asked if he had any reason to disbelieve Petitioner's presentation of his symptoms. Dr. Gelber stated he did not have any reason to disbelieve Petitioner's presentation stating,

> you know, this isn't a guy who quit working and is getting disability and doesn't want to go back to work. He has been working every day, and so given that, I tend to believe him even more than I believe all my other patients, and the symptoms that he describes, although I can't quantitate them, he tells he has a headache, he has a headache. I can't quantify them.

On cross-examination Dr. Gelber was asked if he had reviewed any emergency room records or other outside records. Dr. Gelber indicated he had not reviewed the CT scan report. However, he testified it wouldn't be expected to find or see abnormality, "so whether I saw it or not, that wouldn't change anything." Dr. Gelber also stated he had not seen emergency room records from St. John's Hospital dated August 20, 2012. Dr. Gelber was asked about Petitioner's complaints of dizziness at that time. He attributed the dizziness to Petitioner's concussion injury based on his understanding Petitioner's symptoms of dizziness had begun prior to August 20, 2012. Petitioner had also been treated by Dr. Fowler for symptoms of vertigo which Petitioner testified was a different condition involving different symptoms. Dr. Gelber was also asked on cross-examination about Petitioner's complaints of difficulty finding words when speaking. Dr. Gelber testified during the "very brief" exams he had with Petitioner he did not note any evidence of short term or long term memory loss but relied on Petitioner's reporting of those problems which Dr. Gelber had previously testified are common symptoms associated with post concussive syndrome.

Dr. Gelber continued to be asked repeatedly on cross-examination about normal findings during his physical exams. Again, Dr. Gelber was asked about the symptom of dizziness stating his causation opinion in that regard would depend on when Petitioner's symptoms first began.

Dr. Gelber was asked on cross-examination about Petitioner's cervical complaints. Dr. Gelber stated, "so no treatment does not mean no symptoms." Dr. Gelber's opinion in that regard was made in the context of whether Petitioner's cervical complaints were related to his accident if there were periods of time when Petitioner's neck complaints had resolved or improved. It is not uncommon for neck pain to, "come and go. So having a brief period of time when maybe he wasn't having a lot of neck discomfort, that one is a little hazier than the dizziness."

Dr. Gelber was also asked on cross-examination about Petitioner's symptoms of headaches. Dr. Gelber testified headaches can be caused by many different conditions. Dr. Gelber stated his opinion regarding a relationship between Petitioner striking his head, Petitioner's accident and his headaches is based on the history Petitioner gave that he developed headaches shortly after the accident.

Dr. Gelber was asked on cross-examination about ordering an MRI. Dr. Gelber had previously testified he recalled ordering an MRI but was not sure whether it had been performed. Petitioner had told the emergency room staff on October 19, 2013 that his neurologist wanted him to have an MRI. Dr. Gelber later noted his name was on the MRI but he could not recall whether he had ordered it.

Dr. Gelber was asked on cross-examination about Petitioner calling his office to discuss his neck pain and memory problems and a previous office visit with Dr. Western at which time Dr. Western indicated Petitioner's light headed and dizziness had resolved after Petitioner had added some complex carbohydrates to his diet. Dr. Gelber was also asked about other references where Petitioner had reported his headache symptoms were better or at times unchanged. Dr. Gelber also acknowledged Petitioner refused to take pain medication.

Dr. Gelber testified on cross-examination he had not placed any restrictions on Petitioner's work activities. Dr. Gelber was asked if he believed Petitioner when he stated he had struck his head on the windshield during his December 26, 2015 motor vehicle accident. Dr. Gelber stated he had no reason not to believe him. He pointed out Petitioner had stated the airbag exploded but did not deploy. Dr. Gelber stated he believed Petitioner's description of how the accident occurred.

Dr. Gelber testified on cross-examination with reference to his office note that he was treating Petitioner for headaches. He noted the medication Gabapentin was being prescribed not only for neck pain but also for headaches. Dr. Gelber pointed out he never prescribes narcotics and Petitioner never asked for them. Dr. Gelber was asked about not ordering testing because he felt the severity of Petitioner's symptoms didn't warrant it. Dr. Gelber did state he had ordered a neuropsychological evaluation with Dr. Meyer-Cox.

On redirect Dr. Gelber confirmed an EMG is normally not ordered to diagnose post-concussive syndrome. Dr. Gelber was asked about Petitioner's level of motivation to continue working despite his level of ongoing symptoms. Dr. Gelber stated he felt Petitioner's motivation to continue working was "a favorable thing" suggesting he did not have ulterior motives for complaining of certain symptoms subsequent to his accident while under Dr. Gelber's care. Dr. Gelber stated normal physical exams are typical with a diagnosis of a concussion. Dr. Gelber was asked on redirect if Petitioner's symptoms that he described during the course of treating him was consistent with his diagnosis of post concussive syndrome. Dr. Gelber stated, "yes."

Petitioner introduced 23 exhibits. Exhibit 23 was marked and introduced at arbitration. Petitioner, Respondent's representative and Mr. Crifasi all testified regarding the memorandum dated January 4, 2008.

Petitioner's Exhibit 1 contains medical records from Dr. Western, Petitioner's family physician for the period from July 13, 2011 through September 18, 2014. The treatment records cover treatment Petitioner received for multiple medical conditions including symptoms of dizziness, which in November 28, 2012 Dr. Western described as, "seems different from dizziness had before." Petitioner was diagnosed with viral syndrome producing mild vertigo. The medical records also include treatment for an exposure accident involving a breach in a smoke stack pipe causing respiratory symptoms.

Petitioner's Exhibit 2 contains records from St. John's emergency room dated October 5, 2011. Also included in the exhibit are CT scan reports taken of Petitioner's cervical spine and head. The history contained in the emergency room records refers to Petitioner having head and neck pain after a car accident when he tried to avoid a deer going down into a steep incline and back up onto the road.

Petitioner's Exhibit 3 consists of emergency room records dated August 20, 2012 from St. John's Hospital. The history taken from Petitioner at that time was evaluation of intermittent dizziness over the last several days, increasing in frequency but not severe. Petitioner expressed concern his dizziness may be related to a concussion he sustained a year and a half ago.

Petitioner's Exhibit 4 is comprised of office notes from Dr. Gelber for the period from August 31, 2012 through June 2, 2017. The initial office note contains a history in which Petitioner refers to his accident in 2011 when he went off the road to avoid hitting a deer hitting his head on the door. Also contained in Petitioner's Exhibit 4 is an office note dated January 12, 2016 referring to Petitioner's second motor vehicle accident on December 26, 2015. The note refers to Petitioner advising Dr. Gelber his airbag had, "exploded" and that he hit his head on the windshield and was diagnosed with another concussion and has developed worsening balance problems, short term memory and visual symptoms.

Petitioner's Exhibit 5 contains records from Cassandra Mallet, audiologist dated September 6, 2012 through January 23, 2013. The initial office note of September 6, 2012 refers to Petitioner having been diagnosed with benign paroxysmal vertigo on the left. Petitioner advised Mr. Mallet that he had not been experiencing vertigo since his appointment with Dr. Fowler. There is a reference in the records to Petitioner's accident of "last October."

Petitioner's Exhibit 6 is an ER report dated January 3, 2013. Petitioner complained at that time of left sided headaches having started the previous night at which time the severity was ten out of ten and currently two out of ten.

Petitioner's Exhibit 7 is an emergency room report dated February 3, 2013. At that time Petitioner complained of sharp left temple pain referring to an MVA in 2011. Petitioner complaining, "it just doesn't feel right."

Petitioner's Exhibit 8 is an EKG dated March 20, 2013. The study was ordered to evaluate Petitioner's cardiac condition.

Petitioner's Exhibit 9 is ER reports dated October 19 and October 20, 2013. Petitioner's complaints at that time were muscle pain and contact ions (sic). Petitioner described other symptoms that he was concerned may be, "signs of MS."

Petitioner's Exhibit 10 is an MRI of Petitioner's brain dated October 23, 2013. The MRI appears to have been ordered by Dr. Gelber. The MRI was essentially normal.

Petitioner's Exhibit 11 is a narrative report from Dr. Gelber dated June 8, 2014. Dr. Gelber's report describes Petitioner's symptoms after his first accident. The report also refers to Petitioner's second accident resulting in similar symptoms and some worsening of the symptoms. Dr. Gelber states Petitioner suffered a concussion after both accidents. He also states Petitioner's complaints that developed after his accident may be permanent.

Petitioner's Exhibit 12 contains office notes from Dr. Paul Venturini for the period from August 27, 2014 through August 30, 2016. In his office note dated August 27, 2014 the history of present illness refers to Petitioner seeking medical treatment for neck and headache related symptoms. Petitioner described his accident of 2011 when he went off the side of the road to avoid hitting a deer injuring his neck and hitting his head against the door jam and roof of the vehicle. The office notes describe the nature and severity of Petitioner's neck pain and headaches. In the final office note dated August 30, 2016 Petitioner had complaints of worsening lower mid back pain and worsening neck pain.

Petitioner's Exhibit 13 is a narrative report dated May 13, 2015 from Dr. Venturini addressed to Petitioner's attorney. The report provides a detailed description of the reported accident of October, 2011, Petitioner's subjective complaints, prior treatment information, objective findings and assessment. Dr. Venturini diagnosed Petitioner with cervical and thoracic somatic joint dysfunction with associated mild fasciitis, headaches and reduced cervical-thoracic mobility. Dr. Venturini summarized his treatment of Petitioner. Dr. Venturini described certain treatment recommendations to prevent Petitioner's neck and back condition from worsening.

Petitioner's Exhibit 14 is an emergency room report dated December 26, 2015. Petitioner's primary complaints at that time were left wrist pain, headache and neck pain. Related notes indicate, "patient was in a motor vehicle accident going approximately 35 miles an hour hit by another car going the same speed. Patient was restrained driver and had airbag deployment. No loss of consciousness. Patient ambulatory on arrival. Complained of headache, neck pain, left wrist pain." The history contained in the emergency room report states the patient

came to the emergency room for evaluation of pain in his left wrist and ankle, head pain, lower back and neck secondary to a motor vehicle crash at 7:30 this evening. Patient states he was going 30 miles per hour when a car pulled out and hit him, causing the airbags to go off. X-rays did not reveal fractures or dislocation of the left ankle or left wrist. X-rays of the lumbar spine revealed no evidence of acute fracture or traumatic mal-alignment, mal-degenerative changes and facet arthropathy at L5-S1. The thoracic spine x-ray revealed acute fracture vs. chronic degenerative change at the inferior endplate T11, superior endplate T12 and otherwise normal. A CT of the head without contrast revealed no intracranial abnormalities. A CT scan of the cervical spine revealed no evidence of acute cervical spine fracture or dislocation and chronic advanced multilevel cervical spine degenerative disc disease/spondylosis, worse at C5-6 as described. Under disposition there are references to Petitioner being unhappy with not being seen by a physician referring to the nurse practitioner as being "incompetent."

Petitioner's Exhibit 15 contains office notes from Dr. Sandercock for the period of time from December 27, 2015 through March 2, 2016. In a phone message dated December 27, 2015 there was call from Petitioner regarding his car accident the previous evening. Petitioner had advised the telenurse he had been to the emergency room. He was experiencing severe headaches and back pain. Petitioner was seen by Dr. Sandercock on December 29, 2015. At that time Petitioner provided a history of being involved in a motor vehicle accident while returning to the power plant. The history further provides that Petitioner hit his "frontal forehead" but did not lose consciousness. Petitioner advised he was still having headaches, neck pain and back pain. The assessment at that time was headache, cervicalga, back pain, mild concussion. The plan was to start the patient on Cyclobenzaprine as needed and Tramadol. Petitioner continued seeing Dr. Sandercock for general medical problems. On December 27, 2015 Dr. Sandercock took Petitioner off work until January 4, 2016. The off work slip was associated with Petitioner's complaints of headaches, neck pain, back pain and left ankle and wrist pain.

Petitioner's Exhibit 16 is a sleep study dated February 29, 2016. The assessment was sleep apnea.

Petitioner's Exhibit 17 is a narrative report dated April 7, 2016 from Dr. Paul Venturini. Dr. Venturini discussed his treatment of Petitioner following an initial visit on August 27, 2014. Dr. Venturini discussed Petitioner's diagnosis of cervical and thoracic symatic joint dysfunction with associated myofascitis, headaches and reduced cervical-thoracic mobility. In his discussion he states he believed Petitioner's condition was permanent describing the underlying condition, residual scarring, fibrosis and hypersensitivity, "from the injuries sustained on October 5, 2011." The report goes on to describe Petitioner's other symptoms including loss of cervical mobility, neck pain, crepitation, memory loss and loss of concentration, sleep disturbance and headaches.

Petitioner's Exhibit 18 is a narrative report dated April 24, 2016 from Dr. Gelber. Dr. Gelber's report was in response to a request for clarification of the treatment Dr. Gelber had provided to Petitioner for his post-concussion syndrome. Dr. Gelber states Petitioner had suffered concussions as a result of both accidents on October 5, 2011 and December 26, 2015. Dr. Gelber clarified Petitioner's complaints after the first accident of headaches, irritability and short term memory issues. After his second accident he experienced similar symptoms, "with worsening of those that he had had previously." Dr. Gelber indicated Petitioner's complaints of headaches and short term memory issues dating back to his first accident, "may be permanent."

Petitioner's Exhibit 19 is a neuropsychological evaluation conducted on June 13, 2016 at the request of Dr. Gelber. Dr. Meyer-Cox' report refers to Petitioner's accidents in 2011 and 2015. The report states Petitioner reporting almost daily headaches since his 2011 motor vehicle accident. The testing revealed a mix of borderline to mild cognitive impairments along with areas of normal range functioning. The areas of borderline to mild impairment include aspects of speed of thought processing, as well as memory functioning. Dr. Meyer-Cox discussed the possibility that the impairments could be the result of possible concussive injuries.

Dr. Meyer-Cox refers to, "repeated blows to the head secondary to sparring in martial arts over numerous years, as well as difficulties with depression and anxiety." In response to the report, Petitioner sent Dr. Meyer-Cox a letter dated September 20, 2016. The letter from Petitioner is also contained in Petitioner's Exhibit 19. In his letter Petitioner points out that at no time did he advise her he had sustained repeated blows to his head from sparring. In response to Petitioner's letter Dr. Meyer-Cox added an Addendum to her report correcting the references in her original report to Petitioner having sustained repetitive blows to the head during his martial arts career.

Respondent introduced twelve exhibits. The first exhibit consists of records from Gailey Eye Clinic for treatment rendered from October 7, 2013 through October 24, 2013. In a chart note dated October 24, 2013 Petitioner reports, among other things, short term memory loss. Petitioner advised the clinic he had undergone an MRI of the head the day before. Petitioner at that time also denied having a headache.

Respondent's Exhibit 2 contains CT and MRI test results from Central Illinois Radiological Associates dated September 15, 2013, October 23, 2013. September 13, 2013 is an x-ray of the chest. An MRI of the brain was performed on October 23, 2013.

Respondent's Exhibit 3 is a Notice of Arbitrator's Decision in the case of Roger Strothmann v. City of Springfield, CWLP, 13WC 33022. Petitioner through his attorney objected to the introduction of Respondent's Exhibit 3 on the grounds that the prejudicial value of the findings and conclusions contained in the decision outweighed any probative value. Respondent's attorney stated the decision was being offered with respect to the issue of causal connection. The Arbitrator ruled the decision would be allowed into evidence for the sole purpose of his ruling on the issue of causation. The decision involved a claim for injuries associated with an alleged accident of September 11, 2013. At the time of the alleged accident Petitioner was patrolling city property as part of his job duties as a Utility Security Guard. The claimant alleges Petitioner was exposed to debris expelled from a smoke stack. Symptoms associated with the exposure included irritation of the lungs and eyes and throat.

The Arbitrator notes none of the symptoms Petitioner alleged to be associated with his exposure claim are similar to the symptoms he alleges to be related to his current claims involving accidents in October, 2011 and December, 2015. There is a reference to memory loss but it does not appear Petitioner was associating that symptom with that claim. Respondent's attorney stated the purpose for introducing the decision was to refute Petitioner's allegations of causal connection between symptoms he alleged are associated with his current accidents. However, the decision does not address any of the symptoms Petitioner alleges are the result of his two accidents.

Respondent's Exhibit 4 is a radio station log sheet dated December 26, 2015. Respondent's Exhibit 5 is an IDOT accident report regarding Petitioner's accident of December 26, 2015. Among other things the report corroborates Petitioner's description of accident of December 26, 2015 including the fact that he was driving a CWLP owned truck. It also confirms damage to the truck as it was unable to be driven from the scene and was towed. Respondent's Exhibit 6 is a police crash report regarding Petitioner's accident of December 26, 2015. Respondent's Exhibit 7 is Petitioner's statement of December 26, 2015 describing his accident of the same date.

Respondent's Exhibit 8 is an emergency room report from Memorial Medical Center record of December 27, 2015. The report refers to patient having been seen the night prior at St. John's complaining that he did not feel he had been treated appropriately. The history also refers to Petitioner's motor vehicle accident the previous night with restraint, airbag deployment, no LOC. Complaints at that time were headaches, neck pain, left wrist

pain and complaints of feeling tired. The exam revealed normal range of motion of the cervical spine but tender posterior neck muscles and tender bilateral trapezius muscles. The head was atraumatic. The assessment was whiplash.

Respondent's Exhibit 9 is an Employee Accident Report dated December 26, 2015. The report refers to Petitioner's accident of December 26, 2015. The nature of his injuries included trauma to the head, cervical neck sprain, sprain spine, left lower back, left wrist, left ankle sprain. Respondent's Exhibit 10 is a Supervisor's Notice of Return to Work documenting Petitioner was off work from December 27, 2015 to January 4, 2016 for a total of 8 days. The Notice of Return to Work was provided by Dr. David Sandercock.

Respondent's Exhibit 11 contains an attendance monitoring summary report covering the period from July, 2010 through June, 2017. Respondent's Exhibit 12 contains Central Illinois Allergy records. The records appear to pertain to treatment Petitioner received after his alleged exposure claim dated September 11, 2013. There are references to whether Petitioner has secondary motives for his complaints regarding the exposure. There does not appear to be any treatment for conditions or symptoms Petitioner alleges are related to his accidents of October, 2011 and December, 2015 as these symptoms described in the exhibit pertain to respiratory and problems with his eyes.

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

Respondent does not dispute Petitioner's first accident of October 5, 2011or that he sustained accidental injuries that arose out of and in the course of his employment. Respondent however does dispute that Petitioner's second accident occurring on December 26, 2015 arose out of and in the course of his employment.

A significant portion of the hearing dealt with whether the Petitioner was on his lunch break when the accident occurred. Respondent argues that he was and, as such, was not in the course of his employment when he was involved in his accident. The Arbitrator does not think it matters whether the Petitioner was at lunch or not. His testimony, along with that of Mr. Crifasi, proves that he was on call while on breaks. He was in his company vehicle and was required to respond to emergency calls even while on break. As stated below, this places him within the course of his employment. Chief Hubbard did not rebut the fact that the Petitioner was on call while taking his break.

The circumstances surrounding Petitioner's accident are similar to other cases in which an individual was injured off the premises while on a break. Professor Larson points out some of the issues involved and whether an injury occurring on coffee break or rest break arises out of and in the course of an employee's employment. Some of the elements in evaluating compensability are, "whether the interval is a right fixed by the employment contract, whether it is a paid interval, whether there are restrictions on where the employee can go during the break, and whether the employee's activity during the period constitute a substantial personal deviation." Professor Larson states that it seems to boil down to,

> if the employer, in all the circumstances, including duration, shortness of the off premises distance, and limitations on off premises activity during the interval can be deemed to have retained authority over the employee, the off premises injury may be found to be within the course of employment.(Larson's Workers' Compensation; Sec. 15.54)

Petitioner had only been gone approximately 12 minutes and was 6 blocks away from the safety office when the accident occurred.

In order for an injury to be compensable under the Illinois Workers' Compensation Act it must, "arise out of" and "in the course of" the injured workers' employment. (820 ILCS 305/2) "In the course of" the employment refers to the time, place and circumstances under which the accident occurred. (Chmelik v. Vana, 201 N.E. 2d 434, 438 (1964)) If an injury, "occurs within the period of employment at a place where the employee may reasonably be in the performance of his duties, and while he is fulfilling those duties or engaged in something incidental thereto" the injury occurred in the course of the employment. (id) For an injury to "arise out of" the employment there must be a causal connection between the employment and the injury. The cause must be some risk connected with the employment

The Illinois Appellate Court in City of Springfield v. Industrial Commission, 244 Ill. App. 3d 614; 614 N.E. 2d 478; 185 Ill. Dec. 344 held that the Commission's award of benefits to a police officer who was injured in a traffic accident was not against the manifest weight of the evidence. In City of Springfield a detective had gone home for lunch and was returning to the station in an unmarked police car when his car was hit by another car. The court said since he was "on call" and had his radio on as required his employer had authority over him at the time and, he was "in the course of" his employment. The court stated the detective was "on call to the extent that he would have responded in the normal course to any request for assistance or emergency he encountered." The circumstances in the present case regarding Petitioner's accident of December 26, 2015 are very similar to the

facts in City of Springfield v. Industrial Commission. Although Petitioner is not a police officer he is required to respond to any request received on his radio, whether he is on lunch break.

Given the nature of his job as a Security Officer involving travel throughout the City in a vehicle provided by Respondent, Petitioner's accident arose out of and in the course of his employment. Going to Subway to get a sandwich is not the type of personal deviation that would have removed him from the scope of his employment. He had also advised the dispatcher where he was going and what he was doing. This was an accepted practice.

The Arbitrator concludes, Petitioner's accident of December 26, 2015 arose out of and in the course of his employment for Respondent.

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

The Arbitrator finds that no causation exists between the Petitioner's initial accident and his present condition of ill being. While the emergency room records establish that the Petitioner sustained a cervical strain and concussion on October 5, 2011, he lost no time from work nor had any other medical care which could be attributed to either condition until August 20, 2012, when he went to the emergency room complaining of dizziness which began several days prior to that visit. While the Petitioner said that he had ongoing complaints of neck pain, dizziness and headaches from the accident date forward, he was able to perform his regular job, work out three to four days a week and continue his side job teaching martial arts. Most importantly, he was seen by his family doctor Western on four occasions during the above time frame and made no mention of any of the symptoms he alleges were ongoing after his accident.

Both Dr. Venturini and Gelber testified that his symptoms were causally related to his accident but their opinions were based upon the assumption that he had ongoing symptoms from the accident date forward. His activities and lack of medical care do not support that assumption. Dr. Gelber acknowledged that if the Petitioner did not have ongoing headaches from the date of accident forward then that condition would not be causally related to his accident. (PX 21 at 42) He said the same thing with respect to dizziness and in fact wrote on his initial office note that he did not believe that the dizziness was related to his concussion. (PX 4)

The Arbitrator also questions the Petitioner's credibility in light of his insistence that he was not at lunch on December 26, 2015. The fact is that he went to Subway to get a sandwich just before 7:30 PM, about halfway through his shift. If it wasn't lunch, then what was it?

The Arbitrator does however believe that the Petitioner's current condition of ill being is causally related to his accident of December 26, 2015. The injuries, as diagnosed in the emergency room, consisted of sprains to the cervical and lumber spine along with a concussion. Dr. Gelber indicated in his report that the symptoms were similar to those he treated prior to the accident only they were worse. (PX 18) He testified however that his exam findings were no different that before the accident, characterizing it as a flare up. (PX 21 at 20) He said that he felt chiropractic care was indicated for the Petitioner's cervical complaints and that his concussion produced a mild brain injury. (Id at 23, 24) Dr. Venturini said that the Petitioner was given a full duty work release on January 18, 2016 and that his current treatment could be characterized as palliative care. (PX 20 at 8, 74) The Arbitrator will discuss the nature and extent of said injuries in the section below.

Were the medical services that were provided to Petitioner reasonable and necessary?

Petitioner marked and introduced Petitioner's Exhibit 22, which contains a group of medical bills and a summary of medical expenses. The summary reflects the total amount of expenses paid by workers' comp, the adjusted amount and any payments made by Petitioner's health insurance carrier.

The parties agreed that in the event of an award, Respondent should get credit for any and all medical bill it paid through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

The Arbitrator has reviewed the medical exhibits introduced by Petitioner and the medical bills contained in Petitioner's Exhibit 22. Having ruled that the Petitioner's current condition of ill being is not causally related to his first accident, the Arbitrator finds the Respondent responsible for only the medical care provided on October 5, 2011. Respondent is ordered to pay bills for said treatment pursuant to the fee schedule.

Respondent is also ordered to pay the outstanding charges to Dr. Venturini through the end of April 2016. It appears to the Arbitrator that treatment after April has been for palliative care after the Petitioner returned to his baseline which existed prior to the accident. The Petitioner had only seven chiropractic visits from May 1, 2016 through August 31, 2016. It appears that from the accident date in December 2015 through April 30, 2016 that the Petitioner received many treatments consistent with a traumatic aggravation of his condition.

Respondent is also ordered to pay the remaining charges in PX 22 for treatment incurred after December 26, 2015 with the exception of the neuropsych charges from Memorial Medical Center of May 20, 2016. In reviewing Dr. Meyer-Cox's office notes, the Arbitrator relies on her impression that the etiology as to the borderline to mild cognitive impairments of the Petitioner is unclear inasmuch as his description to her was that following his concussion he returned to baseline quickly. (PX 19)

What temporary benefits are in dispute?

Petitioner claimed temporary total disability benefits from December 27, 2015 through January 18, 2016 for a period of 3 and 1/7 weeks. Respondent disputed liability for temporary total disability benefits.

On December 27, 2017 Dr. Sandercock took Petitioner off work until January 4, 2016. The off work slip was associated with Petitioner's complaints of headaches, neck pain, beck pain and left ankle and wrist pain. On January 4, 2016 Dr. Venturini took Petitioner off work until January 14, 2016. On January 13, 2016 Petitioner was seen by Dr. Venturini. At that time Dr. Venturini continued Petitioner's off work status until January 18, 2016.

The Arbitrator concludes that Petitioner was temporarily totally disabled from December 27, 2015 through January 18, 2016 for a period of 3 and 1/7 weeks.

What is the nature and extent of the injury?

No permanency is awarded as a result of the Petitioner's accident of October 5, 2011. The only treatment causally related to that accident was on the date it occurred. As stated above, the Petitioner continued to work and perform his off work activities and received no medical care until over ten months later.

With respect to the December 26, 2015 accident, the Arbitrator first notes that no AMA rating was offered into evidence, so that factor is deemed waived.

The Petitioner is a security guard responsible for patrolling 62 miles of shoreline around Lake Springfield. He has to drive and respond to emergencies as they occur. Whatever symptoms of neck pain he has might be increased by such a job. This Arbitrator gives the Petitioner some weight regarding this factor.

On the date of accident he was 55 years old. This factor favors the Respondent.

There was no evidence offered to show a diminished wage capacity, so that factor also favors the Respondent.

With respect to evidence of disability corroborated by the treating records, the Arbitrator notes that Petitioner testified he continues experiencing headaches, neck pain, memory loss, irritability and at times difficulty speaking. Petitioner's witnesses, Mr. Crifasi and Ms. Painter both testified to noticing differences in Petitioner's behavior since his first accident. The differences seem to involve lack of concentration, forgetfulness, irritability and loss of self-confidence.

Both Dr. Gelber and Dr. Venturini testified Petitioner's concussion related symptoms and neck and spine symptoms are probably permanent in nature. Neither doctor testified there was any reason to disbelieve Petitioner's descriptions of his symptoms. Dr. Gelber diagnosed Petitioner with concussion syndrome. Dr. Venturini diagnosed Petitioner with cervical and thoracic somatic joint dysfunction with associated myofascitis, headaches and reduced cervical/thoracic mobility.

On the other hand, Dr. Gelber testified that on every examination, the Petitioner has exhibited intact memory function, normal concentration, normal attention span and good muscle strength. (PX 21 at 37) He described his concussion as producing a mild brain injury. (Id at 24) As noted above, the Petitioner has been seeing Dr. Venturini only once or twice a month for the past year.

The Arbitrator notes Petitioner continues to work. Dr. Gelber testified that he was very impressed with Petitioner's ability to continue working despite his condition. Petitioner testified that although he could work, he does have difficulty with focusing and concentration. Petitioner testified he continues to deal with the changes he notices in himself. In particular, memory loss, pain in his neck, headaches and mood changes.

The Arbitrator concludes Petitioner sustained permanent partial disability to the extent of 4% loss of use of the man as a whole as a result of his accident of December 26, 2015.

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

Robert Galvan,

Petitioner,

vs. NO: 15WC 24771

Madison County Government,

18IWCC0102

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 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 July 10, 2017 is hereby affirmed and adopted.

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

18IWCC0102

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 15 2018
o020618
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

GALVAN, ROBERT
Employee/Petitioner

Case# **15WC024771**

MADISON COUNTY GOVERNMENT
Employer/Respondent

18IWCC0102

On 7/10/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1580 BECKER SCHROEDER & CHAPMAN PC
TODD J SCHRODER
3673 HWY 111 PO BOX 488
GRANITE CITY, IL 62040

1001 SCHREMPF KELLY & NAPP LTD
MATTHEW W KELLY
307 HENRY ST SUITE 415
ALTON, IL 62002

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)

ROBERT GALVAN
Employee/Petitioner

v.

MADISON COUNTY GOVERNMENT
Employer/Respondent

Case # 15 WC 24771

Consolidated cases: _____

18IWCC0102

An *Application for Adjustment 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 **October 25, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was 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, **June 29, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$58,180.80**; the average weekly wage was **$1,118.86**.

On the date of accident, Petitioner was **61** 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, **$0** for maintenance, and **$N/A** for other benefits, for a total credit of **$0**.

ORDER

The Arbitrator finds that the Petitioner has shown by the preponderance of the evidence that he sustained accidental injuries arising out of and in the course of his employment on June 29, 2015.

The Arbitrator finds that the following conditions are causally related to the June 29, 2015 accident: 1) bilateral carpal tunnel, 2) right cubital tunnel, and 3) aggravation of bilateral CMC joint arthritis. The Arbitrator finds that the Petitioner has failed to prove that his left elbow/cubital tunnel condition is causally related to the June 29, 2015 accident.

Respondent shall pay reasonable and necessary medical service expenses contained in Petitioner's Exhibit 10, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall authorize the prospective treatment recommended by Dr. Beatty which includes bilateral carpal tunnel releases and right cubital tunnel release, and shall authorize the injection treatment recommended by Dr. Rotman for the bilateral CMC joints. Any recommended treatment to the left elbow is not related to the June 29, 2015 accident.

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

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

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

Signature of Arbitrator

July 5, 2017
Date

JUL 10 2017

STATEMENT OF FACTS

Petitioner worked for Respondent as a patch crew operator, and in that position he would operate a piece of equipment he called a patch machine. Essentially, this machine is used to distribute oil and rock to either fill potholes or to build up roadway shoulders. The machine itself is part of a trailer that is pulled by a dump truck.

The Petitioner's testimony was heard in conjunction with the viewing of a video (Px1) of one of Petitioner's co-workers operating the machine. The Arbitrator notes the following facts regarding the operation of the machine based on both the Petitioner's testimony and from a review of the video, which shows the building up of a road shoulder:

The engine of the machine is on the trailer, and an approximate 9' main boom extends from the machine. There are pivot points to the boom that are closer to the trailer which allow it to be maneuvered. The portion being operated by the operator, i.e. the boom arm, is made of steel and has attached to it two large hoses, one which appears to distribute the oil, and the other distributing the rocks. Toggle switches allow to the operator to change from one product to the other. Perpendicular to the boom is a crossbar with a center handle. The center handle is gripped with the right hand, while the left hand grips the end of the crossbar. While this grip takes place, the operator moves the boom to distribute the product on the shoulder. In doing so, the operator often basically shakes or rocks the boom to try to distribute the product evenly on the surface. The operator also at times has to use both hands to operate various toggles and switches on the boom, as well as a separate bar below the boom that moves the product distribution end of the boom, and which the Petitioner testified allows for crowning parts of the distributed materials. The arm motions vary and can at times appear awkward. The video does not depict vibration, but the Petitioner testified that when the engine of the machine is running, the boom becomes significantly vibratory. The Arbitrator's review of the video shows bilateral gripping, flexion and extension of the wrists/elbows/shoulders to shake the boom, and occasionally awkward positions the operator uses to operate the boom, use the switches and/or use the crowning bar. At times the job looks relatively light and not significantly physical, but often it appears significantly physical with forceful gripping. The elbows are often held in flexion at 90 degree angles while the operation is being performed.

The Petitioner agreed he operated the machine the same way the operator in the video is shown doing so. He believed that the operation of the patch machine was very difficult on his upper extremities and that, when he was operating same, he was subjected to a significant amount of vibration in his upper extremities. He also testified that when the trailer was sitting in an inclined/tilted fashion instead of flat, it made the boom harder to operate because gravity wants to pull the boom away. Petitioner estimated that he would operate this machine

for approximately 5 hours per day. He agreed that he could, and has, asked a coworker for help when he has upper extremity symptoms, but that it is his job to operate the machine.

Petitioner testified that he started to have difficulty operating the machine, particularly the switches, as he noted his fingers would lock up and his thumbs and wrists would be painful.

Records of what appear to be Petitioner's general practitioner, Dr. Simmering, reflect pre-accident date complaints of arthritis, including in his wrists and elbows. On 7/1/14 he complained of a 3-4 month history of constant and worsening bilateral thumb pain. (Rx2). 7/23/14 x-rays indicated osteoarthritis in the bilateral hands in various joints. (Px4). On 10/24/14, Petitioner was complaining of the bilateral knees. On 1/7/15, there was no discussion of arthritic complaints. Essentially, Dr. Simmering's records reflect Petitioner's various complaints/conditions and that he is in charge of medication management, advice for nutrition and weight control, and there is no significant detail regarding the thumb complaints beyond this. (Rx2).

Petitioner was seen by Dr. Beatty on 6/29/15 with complaints of weak grip bilaterally, thumb CMC pain and a history of flexor tendinitis and bilateral hand numbness. Petitioner reported being a patch crew leader for the Respondent until two weeks prior, and "his problem centers around his prior work activity." Petitioner had been referred by the Respondent to Dr. Rotman in 2010, and he performed surgery on his hand and elbow, but Petitioner reports he had persisting compressive neuropathy. Dr. Beatty noted Petitioner had a history of diabetes and hypertension, both treated without problems. He recommended x-rays and EMG/NCV testing. It appears that there was difficulty getting the EMG scheduled with insurance, and on 8/18/15, Petitioner called to cancel the EMG because he was being referred back to Dr. Rotman by Respondent. The EMG/NCV was later rescheduled. (Px3). 7/1/15 x-rays taken at Dr. Beatty's request shows mild polyarticular osteoarthritis of the bilateral 1st fingers. (Px5 & 6).

Petitioner was evaluated by Dr. Rotman at the Respondent's request on 9/14/15, and EMG/NCV testing was obtained. Petitioner underwent the EMG/NCV testing with Dr. Phillips on 9/14/15. It appears the findings were compared to 2009 findings. Dr. Phillips' impression was chronic right carpal tunnel, right ulnar motor conduction velocity across the elbow at the lower limit of normal with preservation of the ulnar sensory response. The left ulnar motor conduction across the elbow was improved but the ulnar sensory amplitude was less, there has been residual numbness in the fifth finger since his condition/surgery in 2009/ 2010. The findings were consistent with electrical residual. The study was not impressive for recurrent left carpal tunnel. Dr. Phillips noted there could be an underlying diabetic type peripheral neuropathy, but to try to determine this would require certain lower extremity electrical diagnostic studies. (Px7).

An NCV was then performed by Dr. Naseer on 11/12/15 at Dr. Beatty's request, and the report states that it showed bilateral carpal tunnel syndrome, right greater than left, and bilateral ulnar neuropathy across the elbows. (Px8). On 5/16/16, Dr. Beatty recommended a bilateral carpal tunnel releases as well as a bilateral cubital tunnel releases, including possible left ulnar nerve transposition and a bilateral thumb CMC surgery. (Px3).

Dr. Beatty testified he is a board certified plastic reconstructive and hand surgeon. (Px9). Dr. Beatty related Petitioner was a patch crew leader who had a prior surgery by Dr. Rotman for his left hand and elbow in 2010. Dr. Beatty noted Petitioner had positive findings of Tinel's signs bilaterally on the palm side of the wrist and tenderness in the area of the cubital tunnel surgical site. Dr. Beatty noted working diagnoses of bilateral carpal syndrome (CTS), right greater than left, bilateral ulnar nerve neuropathy of the elbows, i.e. cubital tunnel syndrome, and carpal metacarpal (CMC) joint osteoarthritis of the thumbs. Dr. Beatty recommended right CTS release, right cubital tunnel release and a "revisit" of the cubital tunnel area on the left, which would likely

involve returning the ulnar nerve to its original location after Dr. Rotman's prior left transposition surgery. As far as the bilateral arthritic CMC joints, Dr. Beatty recommended utilizing cortisone injections and, if that doesn't work, possible Burton procedure. The Burton procedure involves taking out the trapezium bone of the wrist, doing a tendon weave to bring the thumb metacarpal back into a better position, and using a tendon in the trapezium cavity for padding. Dr. Beatty would start with the right side surgeries first. (Px9)

Dr. Beatty reviewed the video of patch machine operation (Px1, Depx4). Based on the operator's use of the upper extremities, Dr. Beatty opined that the work activity as seen in the video could have caused and/or aggravated Petitioner's CTS and cubital tunnel. He also opined that while work activity does not cause arthritis, including in the CMC joint, the work activity can make it more pronounced and exacerbate the pain, and thus he believed the bilateral CMC joint arthritis was aggravated by the depicted work activities. Dr. Beatty explained the basis for these opinions. (Px9).

On cross examination, Dr. Beatty agreed he expressed the opinion that Petitioner's diagnoses and need for treatment were related to Petitioner's employment activities at the initial evaluation. This was prior to reviewing the video, and he agreed that this opinion at that time was solely based on the Petitioner stating he had symptoms with his work activities. The only employment information Dr. Beatty had at that time was that he was a patch crew leader operating some type of a patching machine without further specifics. (Px9).

Dr. Beatty also agreed Petitioner reported that the he had persistent difficulties with his left upper extremity despite the 2010 surgeries with Dr. Rotman. With respect to Petitioner's thumb issues, Dr. Beatty reiterated that Petitioner had significant osteoarthritis in both thumbs and that activities, employment or otherwise, do not cause osteoarthritis. (Px9).

Dr. Beatty agreed that Petitioner underwent 9/14/15 EMG/NCV testing with Dr. Phillips at the request of Dr. Rotman. Dr. Beatty testified that he took exception to Dr. Phillips addressing a possible diabetic neuropathy. He had no issue with the study itself, but concluded that an additional EMG/NCV was necessary simply because, according to Dr. Beatty, he disagreed with how it was done. This appears to the Arbitrator to reflect that Dr. Beatty did not believe that Dr. Rotman may have had the Petitioner's best interests in mind as a treating physician would. He also felt that the neurologist performing the EMG/NCV is there to perform the test and provide the results, while Dr. Phillips took a history and performed an examination. Dr. Beatty testified that the history and physical exam he obtains are the keys to the diagnoses, not the EMG/NCV. Updated additional EMG/nerve conduction studies were then completed at his request with Dr. Naseer. Dr. Beatty saw Petitioner for the last time on 11/30/15, at which time his office note reflected that Petitioner's left side was "not bothersome." Dr. Beatty testified that he didn't mean that Petitioner's left side was "not bothersome", as he wrote, but rather that it was "not as bothersome." Dr. Beatty continued to recommend six separate surgical procedures – the bilateral elbows, wrists and CMC joints. (Px9).

Board certified orthopedic and hand surgeon Dr. Rotman was a Section 12 examiner on behalf of Respondent on 9/14/15. Dr. Rotman had examined Petitioner on Respondent's behalf previously in 2009 in connection with his prior claim, and performed let ulnar nerve transposition and carpal tunnel release surgeries in 2010. At the time of Dr. Rotman's 2009 evaluation, he noted the Petitioner had substantial degenerative spurring in the left elbow related to a prior fracture. This was longstanding and a spur was digging into the ulnar nerve. However, Dr. Rotman believed at that time that the Petitioner's job duties as a patch machine operator could have aggravated that pre-existing left elbow problem due to the elbow movements, and could have contributed to the left CTS due to the gripping activities involved. The Petitioner did not have right upper extremity complaints in 2009/2010. (Rx1).

At the time of Dr. Rotman's September 2015 evaluation, Petitioner complained of shaking in his arms and fingers and bilateral thumb pain. He noted Petitioner's history of diabetes, hypertension and arthritis in multiple joints. He testified that the 2009 cubital tunnel was a bad case with nerve damage and that he would not have expected full improvement post-surgically. He testified that the tingling in the fingers could be due to diabetes. (Rx1).

He reviewed the job video submitted as Px1, and agreed Petitioner had been previously performing the same job in 2009. The EMG/NCV completed by Dr. Phillips reflected good improvement with the ulnar nerve versus 2009 testing, moderately advanced right CTS, and possible diabetic neuropathy. E noted that the numbers on the right cubital tunnel/ulnar nerve were good (Petitioner was at 50, and "anything over 48 is good"). After reviewing all of the relevant information and conducting a physical examination, Dr. Rotman concluded that Petitioner had no evidence of any type of ongoing nerve compression disorder in his left upper extremity. Dr. Rotman testified that all of the findings noted with respect to Petitioner's left elbow were related to the prior 2009 condition, with no surprise of the residual weakness and atrophy, and that there was no evidence of recurrent left carpal tunnel syndrome. He diagnosed bilateral CMC joint arthritis and mild Dupuytren's in the right ring finger, noting the latter is often associated with diabetes. He opined that Petitioner does not have left CTS or right cubital tunnel based on exam and EMG/NCV. Dr. Rotman indicated that the Petitioner did not complain of any problems with his left upper extremity at the time of his evaluation. Dr. Rotman believed that further surgery to the left elbow could lead to increased problems. Dr. Rotman testified that the right CTS condition could have been aggravated by his operation of the patch machine and warranted surgical intervention. With regard to the CMC joint conditions, Dr. Rotman testified that work activities would have to involve significant pinching activities involving force to the thumb towards the base to aggravate the CMC arthritis, and that this was not depicted in Petitioner's job duties. General gripping does not result in this type of force. He did testify that the condition itself should be treated with further injections and, if this failed, consideration of arthroplasty. (Rx1).

On cross examination, Dr. Rotman testified the gripping that he had seen in the two videos was significant enough to aggravate a CTS condition in either arm, and if Petitioner, hypothetically, had a condition of right cubital tunnel, the job activities could have caused an aggravation, as the job activities involved a lot of elbow flexion. He acknowledged that if the job duties involved forces on the tip of the thumb that transmit down to the base of the thumb, such activities could aggravate CMC arthritis. He testified that Petitioner did have a level of subluxation of the ulnar nerve at the right elbow, but it was not significant and that Petitioner did not complain of numbness on the right. He agreed that EMG/NCV testing can result in false positives and negatives. (Rx1).

Upon questioning from Respondent, Petitioner agreed he had left elbow surgery with Dr. Rotman – "I believe I broke it one time" – as well as left wrist surgery in 2010. He agrees he continued to have some problems with the left hand and elbow after the surgery. Petitioner agreed he has been diagnosed with diabetes and hypertension. Petitioner had a prior claim involving his left upper extremity in 2009, which claim resulted in authorized treatment for a diagnosis of left cubital tunnel syndrome and left carpal tunnel syndrome. Petitioner has been diagnosed with and treated for both hypertension and diabetes for a number of years. Petitioner last worked on the patch machine on June 12, 2015 and retired from his employment on September 30, 2015. Petitioner testified that his symptoms have not substantially changed since he discontinued operating the patch machine.

Petitioner testified that he last operated the patch machine on or about 6/12/15 prior to his 9/30/15 retirement. Since he has stopped using the patch machine, Petitioner testified that some of his symptoms have remained the same, but his elbows have seem to have worsened.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, and WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator notes that this claim involves multiple alleged repetitive trauma injuries to the upper extremities. In such cases, the issues of whether an accident occurred which arose out of the employment and causation are inextricably intertwined.

The Arbitrator finds that the Petitioner has fulfilled his burden of proof that he sustained accidental injuries arising out of and in the course of his employment with the Respondent on 6/29/15. The Arbitrator also finds that the Petitioner has sustained his burden of proving that the Petitioner's conditions of bilateral CTS and right cubital tunnel are causally related to the accident/work duties. Additionally, the Arbitrator finds that the bilateral CMC joint arthritis was aggravated by the work activities. The Arbitrator further finds that the Petitioner has failed to prove he has sustained an injury to the left elbow as a result of his work duties.

The Arbitrator's review of the job video shows the operator gripping the boom with both hands in two different locations. He also has to rock the boom while operating it. Petitioner testified in unrebutted fashion that the machine also has a significant amount of vibration that translates to the boom as well. While the video itself was not long, one can see how this job is quite repetitive during a day of work. Petitioner testified he would operate the machine on average, assuming that was his task for the day, for 5 hours. Given that the video shows bilateral gripping with some level of force, some level of wrist and elbow flexion and extension to shake the boom to distribute the oil and rock, significant periods of time where the elbows are held at 90 degree angles, the Arbitrator believes that the job duties could cause or contribute to the development of the bilateral upper extremity conditions he has. This is supported by the testimony and opinions of Dr. Beatty.

Dr. Beatty, following his review of the job video (Px1), opined that the Petitioner's upper extremity conditions are causally related to the work duties. The Arbitrator does note with interest the Respondent's argument that Dr. Beatty opined to causation prior to ever seeing the job video, however the testimony makes it clear that Dr. Rotman essentially agrees that the job duties could cause the compressive neuropathy conditions at the wrists and elbows, he just disagreed whether specific conditions existed or not. However, while these issues do give the Arbitrator pause, Dr. Beatty did credibly opine to causation based on the job video, and as noted above, the Arbitrator's viewing of the video comports with this. The Arbitrator believes that, based on the video and medical evidence, Dr. Beatty's opinion was persuasive given that of Dr. Rotman.

The Petitioner has been diagnosed with diabetes, arthritis and hypertension. (Px2; Rx2). In fact, the Arbitrator believes the evidence can reasonably be taken to support that at least part of the Petitioner's upper extremity conditions have diabetic involvement. However, even if diabetes and/or arthritis are causative of the Petitioner's upper extremity conditions, this does not take away from the job duties also being causative. Pursuant to Illinois law, Petitioner needs to show that the job duties are causative. He is not required to show that they are the sole or primary causative factor. The Arbitrator believes the video just as clearly shows exposure to upper extremity risk factors like gripping, flexion/extension of wrists and elbows and constant vibration.

The causal connection of the CMC joint conditions is not as strong as the other conditions based on the detailed testimony of Dr. Rotman, however the Arbitrator believes that the Petitioner's varying hand positions and hand

activities in his jobs creates a strong inference that there was at least some of the pinching activity he describes. Additionally, the thumbs are also being subjected to the vibration Petitioner described. The Arbitrator relies on Dr. Beatty on this issue.

With regard to the right CTS and cubital tunnel, the Arbitrator gives the Petitioner the benefit of the doubt that he has these conditions, and thus that they are causally related based on the testimony of both Drs. Beatty and Rotman. The EMG/NCV testing differs between that performed by Dr. Phillips and Dr. Naseer in terms of these conditions. However, the Arbitrator notes that the Petitioner did complain of numbness in both hands at his first visit with Dr. Beatty. Additionally, while Dr. Rotman opined that the right ulnar conduction was normal, he even acknowledged that it was just within the lower limit of normal.

The Arbitrator finds that the Petitioner has not sustained a worsened condition in the left elbow based on the testimony of Dr. Rotman. He testified that Petitioner's 2009/2010 left elbow condition was significant and Petitioner had sustained nerve damage at that time due to spurring digging into the ulnar nerve. He testified that updated EMG/NCV testing numbers reflected significant improvement versus pre-surgery. Petitioner also testified that he has had residual symptoms since the surgery. There just does not appear to have been any significant change in his condition based on the preponderance of the evidence, and thus no causal connection of the 6/29/15 accident to the current left elbow 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 Arbitrator finds that the Petitioner is entitled to the medical expenses contained in Petitioner's Exhibit 10. The expenses are consistent with the medical records and involve reasonable and necessary treatment. While the Arbitrator has determined that the Petitioner's left elbow condition is not causally related to his employment, the treatment to date has not been specifically directed to this condition and has involved diagnostic procedures and evaluations.

The Respondent is entitled to credit for any of the awarded expenses that were paid prior to trial, pursuant to Sections 8(a), 8(j) and 8.2 of the Act, and shall hold Petitioner harmless with regard to same.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Respondent shall authorize the prospective treatment recommended by Dr. Beatty which includes bilateral carpal tunnel releases and right cubital tunnel release. The Arbitrator further finds that Respondent shall authorize the injection treatment recommended by Dr. Rotman for the bilateral CMC joints.

The Arbitrator believes that it is premature to determine what, if any, additional prospective CMC treatments beyond injections may be reasonable and necessary, and no further award is made in this regard.

The Arbitrator finds that the proposed left elbow procedure is both not causally related and not reasonable and necessary. The testimony of Dr. Rotman, who initially operated on Petitioner's left elbow, strongly indicated that placing the ulnar nerve back in its prior location, as proposed by Dr. Beatty, is not in the Petitioner's best interests to improve his condition.

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

Isaura Martinez,

Petitioner,

vs. NO: 10 WC 30853

Staffmark,

Respondent.

18IWCC0103

DECISION AND OPINION ON REMAND

This matter comes before the Commission following the remand order of Judge Ann Collins-Dole of the Circuit Court of Cook County instructing the Commission to issue a clarification regarding Respondent's liability for the previously accrued medical bills, Respondent's liability for any prospective medical bills, and for a determination of the nature and extent of Petitioner's injuries. The Commission, after considering the issues of medical expenses and nature and extent, reverses the Decision of the Arbitrator and modifies its May 6, 2016 Decision and Opinion on Review (16 IWCC 303) for the reasons stated below.

Findings of Fact

I. Procedural History

In her December 1, 2014 decision, the Arbitrator found Petitioner's condition of ill-being is not causally related to the August 3, 2010 work incident. The Arbitrator further declared the remaining contested issues regarding outstanding medical bills and the nature and extent of Petitioner's injury moot.

Petitioner filed a Petition for Review on December 17, 2014. In a Decision and Opinion on Review dated May 6, 2016 (16 IWCC 303), the Commission reversed the Arbitration Decision as to the finding of causal relation for Petitioner's left shoulder injury. The Commission found that Petitioner's left shoulder injury is causally related to the August 3, 2010 work incident and awarded Petitioner prospective "left shoulder surgery, previously performed on April 11, 2001." (Comm'n. Dec., pg. 2). The Commission otherwise affirmed and adopted the Arbitrator's Decision. *Id.* Commissioner Lamborn dissented from the decision of the majority.

18IWCC0103

Petitioner appealed the Commission's Decision to the Circuit Court of Cook County. On June 2, 2017, Judge Collins-Dole issued an order remanding the case to the Commission. Judge Collins noted the following:

"This matter having been fully briefed and argued, the Court being fully apprised of the facts, law and premises contained herein, it is ordered as follows:

A. The May 6, 2016 Decision of the Illinois Workers' Compensation Commission, is remanded to the Commission for clarification. The Commission is instructed [to] issue a clarification of Staffmark's liability for the $98,280.61 in medical bills previously accrued by the Petitioner, for prospective medical bills, and for a determination of the nature and extent of her injuries."

II. Facts

The Commission notes that many of the facts of the case were addressed in the December 1, 2014 Arbitrator's Decision, the Commission's May 6, 2016 Decision, and the June 2, 2017 Circuit Court Order. The Commission primarily adopts the previously established findings of fact regarding Petitioner's treatment following the work accident. The Commission makes the following additional findings to address Petitioner's medical bills and the nature and extent of her injuries.

On August 3, 2010, Petitioner slipped on grease and meat on the floor when returning from a break. Petitioner testified she fell sideways onto the ground and supported herself with her left hand. Petitioner testified she hit her face, hip, and shoulder and immediately felt pain in those body parts.

Petitioner testified that she currently experiences headaches as well as left hip and shoulder pain. She testified that she has trouble turning as well as difficulty walking and cleaning her home. Petitioner testified she is unable to wear certain shoes and has had difficulty finding work within her permanent restrictions.

Petitioner claimed Respondent is liable for unpaid medical bills to Illinois Bone and Joint Institute, St. Joseph's Hospital, Injured Workers' Pharmacy, and Illinois Physician's Network—as the custodian of records and bills for United Rehab, Total Rehab, and Maximum Rehabilitation. (Arb. Ex. 1). Petitioner submitted billing statements from Illinois Bone and Joint Institute showing an outstanding balance of $14,293.00 for services rendered from 3/10/2011 – 12/14/2011. (PX 1 at 45-57). Petitioner submitted a billing statement from Injured Workers' Pharmacy showing an outstanding balance of $1,550.72 for medication dispensed from 11/18/2011 – 5/30/2012. *Id.* at 58-59. Petitioner submitted billing statements from St. Joseph Hospital alleging a total outstanding balance of $27,933.96 for services rendered from 3/17/2011 – 11/9/2011. (PX 2). Finally, Petitioner submitted billing statements from Illinois Physician's Network with a total outstanding balance of $54,502.94 for services rendered from 2/16/2011 – 12/12/2011. (PX 3).

III. Conclusions of Law

Based on the above, and pursuant to the express order of the Circuit Court, the Commission modifies its May 6, 2016 Decision. The Commission finds Respondent liable for the reasonable and related outstanding medical bills, and finds Petitioner suffered a permanent partial loss of 20% of the person-as-a-whole pursuant to §8(d)2 of the Act.

The Commission removes any reference to "prospective medical" in its May 6, 2016 Decision. Petitioner underwent left shoulder surgery on April 11, 2011; thus, any reference to prospective medical was in error.

The Commission finds that Petitioner is entitled to reasonable and necessary medical expenses relating to the work accident in the total amount of $98,280.62. The Commission finds Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $14,293.00 to Illinois Bone and Joint Institute, $1,550.72 to Injured Workers' Pharmacy, $27,933.96 to St. Joseph Hospital, and $54,502.94 to Illinois Physician's Network as provided in Sections 8(a) and 8.2 of the Act with a credit to Respondent for all amounts paid pursuant to §8(j).

The Commission further finds that as a result of the August 3, 2010 work incident, Petitioner suffered a permanent partial loss of 20% person-as-a-whole pursuant to §8(d)2 of the Act. In support of this finding, the Commission notes that Petitioner was a 53-year-old meat packer on the date of the accident. Petitioner injured her left shoulder, the left side of her face, and the lateral aspect of her left hip as a result of her fall. Doctors immediately diagnosed Petitioner with a facial contusion and a left hip contusion. Petitioner ultimately underwent left shoulder surgery to repair labrum and rotator cuff tears. Following the surgery, Dr. Newman performed four shoulder injections due to Petitioner's ongoing complaints. Furthermore, although Petitioner's facial contusion healed within a few weeks of the work accident, Petitioner's left hip injury required a significant amount of conservative treatment. Petitioner testified that her ongoing complaints limit many of her daily activities. Petitioner also has permanent restrictions due to the August 3, 2010 work accident and testified that those restrictions affect her ability to find employment.

As an aside, the Commission notes that the date of accident in the present claim (8/3/2010) predates the effective date of the amendment (9/1/2011); thus, an analysis pursuant to §8.1b is not required.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $14,293.00 to Illinois Bone and Joint Institute, $1,550.72 to Injured Workers' Pharmacy, $27,933.96 to St. Joseph Hospital, and $54,502.94 to Illinois Physician's Network, as provided in Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $220.00 per week for a period of 100 weeks, as provided in §8(d)2 of the Act, as the injuries sustained caused permanent partial disability to the extent of 20% person-as-a-whole.

18IWCC0103

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, including a credit pursuant to §8(j) for non-occupational disability benefits paid.

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 2018

o: 12/5/17
TJT/jds
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

Jeff Baker,

Petitioner,

vs.

NO: 09 WC 20490
10 WC 33530

Minova USA, Inc.,

Respondent.

18IWCC0104

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, causal connection, medical, prospective medical, penalties, fees and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 August 14, 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.

18IWCC0104

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 22 2018
o020818
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

BAKER, JEFF
Employee/Petitioner

Case# **09WC020490**

10WC033530

MINOVA USA INC
Employer/Respondent

18IWCC0104

On 8/14/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1608 MOSS & MOSS PC
DAVID M MOSS
122 WARNER CT PO BOX 655
CLINTON, IL 61727

1433 McANANY VAN CLEAVE & PHILLIPS
BRENT M NEUMEYER
505 N 7TH ST SUITE 2100
ST LOUIS, MO 63101

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JEFF BAKER
Employee/Petitioner

v.

MINOVA USA, INC.
Employer/Respondent

Case # **09** WC **20490**

Consolidated cases: **10 WC 33530**
(Previously denied and not appealed)

18IWCC0104

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Collinsville**, on **February 23, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0104

FINDINGS

On the date of accident, **April 27, 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 as it relates to his ***bilateral upper extremities and left ankle***. Petitioner *did not* sustain an accident that arose out of and in the course of employment as it relates to his ***neck/cervical spine***.

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 **$37,930.88**; the average weekly wage was **$729.44**.

On the date of accident, Petitioner was **36** 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 **$14,102.41** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$14,102.41**.

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

ORDER

As explained in the Arbitration Decision, Petitioner failed to prove by a preponderance of the evidence that his current condition of ill-being with regard to his neck and cervical spine is causally related to his accident of April 27, 2009. No benefits are awarded as respects the cervical condition.

Petitioner reached maximum medical improvement with regard to his other injuries on January 7, 2014. Respondent is not ordered to pay any TTD benefits beyond that date and shall be given a credit of $14,102.41 for TTD benefits that were overpaid from January 8, 2014, through July 28, 2014.

Respondent is not ordered to pay or provide for any medical benefits after January 7, 2014.

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

August 10, 2017
Date

ICArbDec19(b)

AUG 14 2017

STATE OF ILLINOIS)
) ss
COUNTY OF MADISON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JEFF BAKER
Employee/Petitioner

v.

Case #: **09 WC 20490 &**
10 WC 33530

MINOVA USA, INC.
Employer/Respondent

18IWCC0104

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Procedural History

On July 13, 2011, an arbitration hearing was held before a different arbitrator pursuant to Petitioner's Section 19(b) petition. With regard to case 09 WC 20490, 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 was entitled to an award of 74 3/7 weeks of temporary total disability benefits (4/30/2009-10/4/2010) at a rate of $486.29 per week under §8(b) of the Act ($36,193.87); and that Petitioner was entitled to an award of $1,444.00 for reasonable and necessary medical expenses under §8(a) of the Act. The Arbitrator found that on October 4, 2010, Dr. Ollinger opined Petitioner had reached MMI regarding the DeQuervain's syndrome and that Petitioner did not have radial tunnel, although he was still symptomatic. The Arbitrator found Petitioner failed to prove he sustained repetitive trauma injuries as a result of his work duties with Respondent on 7/14/2010 (10 WC 33530). Joint Exhibit 1 (JX1).

Petitioner appealed case 09 WC 20490 to the Commission. The Commission affirmed and adopted the decision of the Arbitrator. Petitioner appealed the case to the Circuit Court. In regard to case 10 WC 33530, the Arbitrator denied Petitioner's repetitive trauma claim from July 14, 2010, and Petitioner made no argument in opposition of said denial in its Statement on Review to the Commission or to the Circuit Court. As such, the Decision became final. JX1.

The Circuit Court's opinion was that the Commission decision affirming the Arbitrator's decision was against the manifest weight of the evidence. The Circuit Court stated the Arbitrator

found the right radial tunnel condition was causally related, but that Petitioner had reached MMI on October 4, 2010, which the Circuit Court found was inconsistent. Further, the Court stated that the MMI finding was contrary to the manifest weight of the totality of the continued medical testimony, including the treating doctors, Dr. Morgan and Dr. Young, and the examining doctor, Dr. Ollinger, who even though he opined MMI had been reached, was still recommending additional diagnostic testing. The Circuit Court further stated the manifest weight of the evidence demonstrated Petitioner's condition of ill-being had not stabilized. The Circuit Court further found the decision denying further prescribed medical treatment by the treating doctors for the condition was in error. The Circuit Court reversed the findings of the Commission which affirmed the determination of MMI on October 4, 2010, and denial of further medical treatment as recommended by the treating doctors. The case was remanded to the Commission with directions to reinstate TTD benefits and authorize further medical treatment as recommended by Dr. Morgan and Dr. Young. JX1.

In its Decision and Order On Remand From the Circuit Court, the Commission stated it found "no basis in the record, given the 18 month initial period with no radial tunnel symptoms, no evidence of a direct trauma to the elbow or of repetitive trauma to have caused the condition (as the treating doctors indicated) and evidence indicating Petitioner had reached MMI as to the DeQuervain's syndrome by October 4, 2010, to alter its Decision." Nevertheless, the Commission noted that pursuant to the order of the Circuit Court, the Commission reversed its prior decision to find an ongoing causal connection to Petitioner's current condition of ill-being in its Order of September 23, 2014. The Commission noted that with the Circuit Court's finding that Petitioner had not yet reached MMI, the Commission modified its prior decision and ordered Respondent to pay TTD benefits from October 4, 2010, through the date of the hearing, July 13, 2011, in addition to the TTD benefits originally awarded. The Commission further ordered Respondent to authorize and pay for the prospective medical care per Dr. Morgan and Dr. Young, per the order of the Circuit Court finding Petitioner had not yet reached MMI. The Commission affirmed and adopted the decision denying penalties and attorney fees, and modified in part and vacated in part its prior decision. JX1.

Issues in Dispute

A subsequent 19(b) hearing was held on February 23, 2017, at which time Petitioner asked for a finding of causal connection between the work injury of April 27, 2009, (09 WC 20490) and a recently diagnosed cervical condition. In addition, Petitioner asked for reinstatement of TTD, payment of unpaid medical bills, prospective medical treatment, and penalties. The parties agreed that, given the procedural history of the cases noted above, the current issues are dealing with case **09 WC 20490 only**. At the hearing on February 23, 2017, Petitioner voluntarily dismissed cases 16 WC 20789 and 16 WC 20683, which had previously been filed.

Background

On the date of the accident, April 27, 2009, Petitioner was 36 years old, married, and had one dependent child. He had worked for Respondent for six years and his job was to make plates for coal mines. He was ascending two to three steps to a platform, which had been moved away

from a machine. A grease mat covered an opening which was created when the platform was moved from the machine. Petitioner fell forward with his hands and arms outstretched and struck the machine. He fell through the opening and struck his elbow on the back of the press. He also struck his left ankle on a piece of angle iron. JX1.

Petitioner was first seen at Marion Memorial Hospital and was subsequently referred to Southern Orthopedic Center. He first saw Dr. Morgan on April 30, 2009, and was initially diagnosed with an acute fracture of the left ankle. By May 7, 2009, Dr. Morgan ordered physical therapy for both wrists. He treated Petitioner with conservative care for both the ankle and the left and right wrist complaints, consisting of therapy, injections, and a release from work. By July 16, 2009, Dr. Morgan noted Petitioner's ankle was no longer problematic. JX1. The Arbitrator notes that Petitioner testified at the current hearing that he had no problems with his left ankle.

On July 16, 2009, Dr. Morgan proposed surgical release of the first dorsal interosseous compartment of Petitioner's left and right wrists. Dr. Ollinger performed a Section 12 examination on August 26, 2009, and confirmed Petitioner's diagnosis of bilateral DeQuervain's syndrome. Petitioner treated with additional injections but ultimately, on December 9, 2009, had surgery to his right wrist, which consisted of a right first dorsal interosseous decompression (DeQuervain's release). On January 14, 2010, Dr. Morgan released Petitioner to return to work light duty. Dr. Morgan's records document that Petitioner called his office on January 22, 2010, upset that he was released to return to work, and stated that he had pain in his foot and could not stand on his foot to return to work. However, the previous report referring to Petitioner's foot was from July 16, 2009, at which time it was noted to be healing nicely. JX1.

On February 24, 2010 Dr. Morgan performed a surgical release of the first dorsal interosseous compartment of the left wrist (DeQuervain's release). On March 4, 2010, Petitioner followed up with Dr. Morgan and reported he was still having some throbbing pain in his hands, right more than left. An EMG/NCV was performed on May 4, 2010, which was noted to be normal. Dr. Glennon, a board certified physician in electrodiagnostic medicine and a board certified physician in physical medicine and rehabilitation noted this was "a NORMAL electrodiagnostic study. There is NO evidence of median neuropathy at the wrist (carpal tunnel syndrome), ulnar neuropathy at the elbow, or cervical radiculopathy in the nerves/muscles that were tested of either upper limb." (JX1; emphasis in original). Petitioner continued to follow up with Dr. Morgan and continued to complain of symptoms in his right and left wrists. He described the pain as radiating from the dorsal aspect of his wrist up to his elbow. JX1, PX2.

On July 14, 2010, Petitioner was evaluated by Dr. Jason Browdy, Respondent's Section 12 examiner. Dr. Browdy diagnosed bilateral wrist pain, left knee pain, and left ankle pain. He noted that he did not see any need for further treatment or work restrictions with regard to the left ankle, and did not believe Petitioner sustained any structural damage. With regard to the wrists, he opined that the history and exam were not consistent with carpal tunnel syndrome, and that the "only feasible diagnostic possibility" was intersection syndrome. He further noted that intersection syndrome was an overuse syndrome that would not result from a fall such as the one Petitioner sustained on April 27, 2009. JX1.

On August 10, 2010, Dr. Morgan ordered a Functional Capacity Evaluation, which was completed on September 17, 2010. It was reported that overall test findings, in combination with clinical observations, indicated that Petitioner was not able to perform tests required of him or for him to return to work. It was further reported that the validity of the test was questionable, because of the reliability of pain and "questionable levels of physical effort". JX1, PX2.

Dr. Ollinger re-examined Petitioner on October 5, 2010. He testified that his examination that day elicited nonselective responses, and he considered the examination to be nondiagnostic. He disagreed with Dr. Browdy's assessment of intersection syndrome, and testified that Petitioner's history and examination did not support such a diagnosis. He opined that Petitioner was at MMI. JX1.

On December 21, 2010, Petitioner returned to Dr. Morgan, who noted that Petitioner was "having pain really more up in his forearm arm now". He believed Petitioner may have radial tunnel syndrome and referred him to Dr. Steven Young at Southern Orthopedic Center. At his deposition, Dr. Morgan testified that Petitioner did not have pain in his forearms until this appointment in December 2010. JX1, PX2.

Dr. Young examined Petitioner on January 13, 2011, and opined that he had radial tunnel syndrome. At his deposition, Dr. Young testified that Petitioner's injury "may have contributed somewhat, although I would say that typically this particular syndrome is more due to a repetitive-type injury or repetitive-type work." JX1, PX2.

Dr. Ollinger was asked to opine on the diagnosis of bilateral radial tunnel syndrome. He opined that he could not make a diagnosis within a reasonable degree of medical certainty to explain Petitioner's symptoms. He had no opinion regarding Petitioner's functional capacity evaluation, but testified that if he got an FCE he would use it. JX1, RX2.

Based on Dr. Ollinger's reports and testimony, Respondent terminated Petitioner's TTD and medical benefits, and the first Section 19(b) hearing ensued. The Arbitrator notes that at the prior trial, Petitioner denied any problems with his neck. JX1.

Current Findings

Petitioner testified on his own behalf at trial. He testified that he fell through a grease mat, striking his right elbow on the back of the press, and striking his left ankle on a piece of iron. He testified he fell through the mat with his left leg, struck his right elbow, and never struck his head, nor did anything fall on top of his head. Petitioner testified that he currently has numbness, tingling, and stabbing from his fingers to his elbows in both arms. He testified that he could not recall if he had any treatment from July 2011 through January 2013, but that on January 31, 2013 he went back to Dr. Young. Dr. Young noted at that time that Petitioner had failed conservative management and that he had "obvious bilateral radial tunnel syndrome." He recommended a radial tunnel decompression. PX2. Petitioner testified that before the surgery he was diagnosed with MRSA, which was unrelated to this injury and which delayed his surgery.

On May 15, 2013, Dr. Young performed a right radial tunnel decompression. Petitioner thereafter underwent physical therapy, but complained that therapy was causing pain, so it was discontinued on August 19, 2013. On August 22, 2013, Dr. Young noted Petitioner continued to complain of right elbow and proximal forearm pain over the radial head, and that he had been slow to progress in therapy. He recommended a conditioning program and a TENS unit. Consideration was given at that time to treatment of the left arm, but Dr. Young noted he would not be able to do anything to the left arm until the right arm had fully recovered. PX2.

Petitioner returned to Dr. Young on August 26, 2013. Dr. Young noted Petitioner was doing well with regard to the radial tunnel decompression, and further noted there were no signs of pain over the first compartment where Petitioner had had a previous DeQuervain's release. He placed a hold on work conditioning and recommended repeat nerve conduction studies. The nerve conduction study was completed on September 24, 2013, which was negative. Petitioner returned to Dr. Young on September 26, 2013, who advised that the study was negative. He noted there was some mild decreased velocity at the elbow of the left ulnar nerve, which was not consistent with Petitioner's symptoms. Dr. Young advised he did not believe Petitioner had nerve compression. At that point, Dr. Young decided to not perform surgery on Petitioner's left arm, and instead referred him to pain management. PX2.

On October 16, 2013, Petitioner began treating with Dr. Paul Juergens at Southern Illinois Pain Management, upon referral from Dr. Young. As part of the physical examination, Dr. Juergens noted that Petitioner had normal range of motion of the cervical spine. He also reviewed the recent EMG/NCS and noted it showed no evidence of cervical radiculopathy, nor did the prior EMG/NCS of May 4, 2010. Dr. Juergens noted he was puzzled as to the reason for the numbness and tingling in Petitioner's hands, and prescribed medication. PX3.

Petitioner returned to Dr. Young on October 31, 2013. Dr. Young noted, "I certainly do feel that he has radial tunnel syndrome and a release may offer some benefit so we are going to go ahead and recommend that." Petitioner remained under work restrictions. PX2.

On December 10, 2013, Petitioner returned to Dr. Juergens, who again noted that there was no evidence of cervical radiculopathy in the upper extremities. He diagnosed a lesion of the radial nerve and other mononeuritis of the upper limb, and he ordered an injection. PX3.

On January 7, 2014, Petitioner was evaluated by Dr. David Brown of The Orthopedic Center of St. Louis, Respondent's Section 12 examiner. Dr. Brown testified that on physical examination, Petitioner had diffuse tenderness over the left forearm that was not localized to the radial tunnel or to any specific anatomic region. Dr. Brown did not find that Petitioner's subjective complaints and physical findings were explained by a diagnosis of radial tunnel syndrome. He testified that he could not confirm a diagnosis, and that his impression was diffuse nonspecific left upper extremity pain. He did not recommend any additional treatment. RX4.

Petitioner followed up with Dr. Juergens on February 25, 2014, at which time he again had full range of motion of the cervical spine and a normal neurological examination with regard to the cervical spine. Dr. Juergens believed his pain to be originating from a mixture of lateral epicondylitis and irritation of the radial nerve. He noted that, despite the normal nerve

conduction study, Petitioner was exquisitely tender over the radial tunnel as well as the epicondyles. He recommended a steroid injection, which was administered on March 12, 2014. The Arbitrator notes this was the final treatment record from Dr. Juergens, and Petitioner testified he did not return after that. PX3.

On June 10, 2014, Dr. Young wrote a letter to Petitioner's attorney. In the letter he reiterated his position that he believed the activities that Petitioner performed at work could have been contributing factors to the need for radial tunnel decompression. He stated, "I certainly do not believe that the fall that he had would have caused bilateral radial tunnel syndrome." RX2. On the basis of that report, Respondent terminated Petitioner's temporary total disability benefits on July 28, 2014. No further medical treatment was authorized by Respondent.

Dr. Young was called to testify by Respondent on January 13, 2015. He testified that he performed a right radial tunnel decompression "under worker's compensation" on May 15, 2013. He ordered a repeat nerve conduction study, which was completed on September 24, 2013, and which was negative. Dr. Young testified that not only did the study not show any evidence of neuropathy in the upper extremities, but it also did not show any *cervical* radiculopathy. He testified that "the numbers on his nerve study were too good to really reveal a false negative", and explained that "without question it was a negative nerve study". He testified that on September 26, 2013, he referred Petitioner for pain management, but admitted that he did not have a diagnosis for Petitioner and that Petitioner was noted to have inconsistent complaints. He further testified that the referral to pain management was not for radial tunnel syndrome. He confirmed that he had not seen Petitioner since October 31, 2013. RX3.

At the deposition, Dr. Young reviewed the pain management records and testified that he disagreed with Dr. Juergen's statement that Petitioner's pain was originating from a mixture of epicondylitis and radial nerve entrapment. He explained further that he did not identify any substantial pain over Petitioner's lateral epicondyle and, as of his last visit, the pain over his radial tunnel had substantially improved. RX3.

Dr. Young testified that he did not believe Petitoner's fall at work in April 2009 caused his left or right radial tunnel syndrome. He did not believe, as of June 10, 2014, that Petitioner's condition was work related. This was memorialized in the letter he sent to Petitoner's attorney on June 10, 2014, wherein he states, "However, at this point, it would be difficult to say that it is a work related situation. I certainly do not believe that the fall that he had would have caused bilateral radial tunnel syndrome." Dr. Young testified that it would be an unusual spot to sustain trauma, and "I don't think it would happen. And for it to happen bilaterally would just be a mechanism or way of falling that I don't see happening." Dr. Young testified that he believed Petitioner was at maximum medical improvement. RX3.

On February 17, 2015, Petitioner again presented to Dr. Brown at Respondent's request. Dr. Brown testified by way of deposition on May 18, 2015. He testified that Petitioner's examination on February 17, 2015, again showed nonspecific findings, and explained that he had diffuse tenderness to palpation. He noted that the pain in Petitioner's forearm was not noted in the medical records until much later in time, and that his initial complaints were only wrist pain and ankle pain. Dr. Brown also noted there was not a mechanism of injury from the fall that he

believed would have caused radial tunnel syndrome. He testified that in any event, radial tunnel would not be related to Petitioner's work activities because he would have expected the symptoms to improve once the work activities had stopped. As such, Petitoner's history in the case was not consistent with a repetitively induced radial tunnel syndrome. He pointed out that, per the medical records in this case, the symptoms in Petitioner's forearm were not noted until almost a year and a half after the injury. He did not believe that Petitioner was in need of any additional treatment, and believed he should resume normal activities at home and at work. He testified that if Petitioner was his patient, he would not recommend any additional treatment or testing, and that the best thing for Petitioner would be to resume normal activities. Dr. Brown testified that there was no pathology or anatomical reason why Petitioner needed to be limited from activities or restricted from working. RX4.

On September 5, 2015, Petitioner was evaluated by Dr. Patrick Stewart of Southern Illinois Hand Center, at the request of his attorney. Dr. Stewart is a Board Certified Hand Surgeon and he testified by way of deposition on February 23, 2016. (Petitioner testified at trial that he was present at this deposition, as well as the depositions of the other doctors in this case.) Dr. Stewart reviewed medical records provided by Petitioner's attorney and examined Petitioner on September 5, 2015. He testified that he agreed with Dr. Young that Petitioner's bilateral radial tunnel syndrome was not work related, because of the long period of time between the initial onset and the work injury. He opined that Petitioner did not even have radial tunnel syndrome, and based his opinion on the mechanism of the injury, his review of the medical records, and Petitioner's failure to have resolution of his symptoms with the surgery. RX6.

Dr. Stewart testified that as part of his evaluation, he performed Semmes-Weinstein testing, which is an effective test for neuropathies. He testified that the testing revealed an odd result for Petitioner, which he described as a mosaic pattern. He explained that Petitioner had different responses to the types of lines being used to test his neuropathies, and he had no explanation for Petitoner's varied responses to this testing. He did not believe there was any possible explanation for the results of this Semmes-Weinstein test that would be related to Petitioner's work injury. Dr. Stewart testified that Petitioner gave varied responses on physical examination and testing that did not make anatomic sense, and he believed Petitioner was demonstrating symptom magnification. RX6.

Dr. Stewart testified that he also administered grip strength testing. He testified that he reviewed the prior FCE, which was questionable for effort, and spoke to Petitioner about this. He told him to "give it all you've got when they test you". His office performed JAMAR five-position testing, which is a calibrated grip strength test, and despite his discussion with Petitioner to "give it all" he's got, Petitioner did not demonstrate a bell-shaped curve, which indicated symptom magnification. Dr. Stewart explained that they also did a rapid exchange test, which is purely intended to catch someone who is trying to give an altered maximum effort. The device is moved back and forth in his hand very quickly, and the patient has to grab it very quickly. He explained that it is much harder to give a defined amount of force when the patient has to grab the device quickly. Dr. Stewart testified that with the rapid exchange, Petitioner did 110 pounds, yet when asked to give his strongest effort on the other testing, he did only 55 pounds. He testified that he told Petitioner to give it his best effort and discussed with him the questioning of his maximum volitional effort on the prior FCE report. He testified that despite his discussion

with Petitioner prior to testing, the results nevertheless called into question the effort that Petitioner gave, and thus Dr. Stewart believed Petitioner was demonstrating symptom magnification. Dr. Stewart did note that Petitioner's neck was stiff, and he testified that any evaluation of his neck or cervical spine would in no way be related to his work injury. RX6.

On May 11, 2016, at the request of Petitioner's counsel, Petitioner was seen by an occupational medicine doctor, Dr. David Fletcher, in Champaign, Illinois. Petitioner testified at trial that he traveled 2 hours and 40 minutes each way for this evaluation. Dr. Fletcher testified by way of deposition on August 26, 2016. He testified that Petitioner had an EMG around the time he examined him, by Terrence Glennon, and that study was unremarkable. He ordered a cervical MRI, which he believed showed a C5-C6 disc herniation. However, he noted that it was "not the best quality exam" and so he recommended another MRI of the cervical spine. He also suggested an updated FCE, which Petitioner underwent at Dr. Fletcher's facility on May 18, 2016. Dr. Fletcher opined that it was a valid performance that demonstrated Petitioner did not meet the critical job demands for his prior position as a plate press operator. PX4.

Dr. Fletcher testified that Petitioner returned on June 1, 2016. He reviewed his updated MRI, and wanted him to have an orthopedic spine surgical consultation with Dr. Michael Chioffe, who is affiliated with Dr. Fletcher's office. Dr. Fletcher testified that he believed Petitioner could benefit from an anterior cervical fusion at C5-6. He testified that he believed Petitioner's case had been mismanaged, that the cervical spine had been overlooked, and that because Petitioner had never had these subjective complaints prior to the April 2009 accident, he believed there was a causal relationship between the diagnosis he made in 2016 and Petitioner's work injury in 2009. Dr. Fletcher testified that he believed Petitioner had "some axial injury" to his cervical spine in his accident in 2009. The Arbitrator notes that Dr. Fletcher recommended the cervical fusion surgery prior to Petitioner being seen by surgeon Dr. Chioffe, and further notes that Dr. Fletcher is not an orthopedic surgeon. PX4.

Dr. Fletcher testified that on the MRI there was a combination of soft and hard tissues, in that Petitioner had some osteophytes and bone spurs which were probably long-standing and existed before the 2009 injury. He testified that he believed the pre-existing bone spurs and osteophytes combined with an axial load injury to cause some soft tissue disc protrusion, which put pressure on the C6 nerve and caused pain and weakness. He testified that Dr. Chioffe recommended surgery. PX4.

Petitioner's counsel chose not to depose Dr. Chioffe, and did not present any reports authored by Dr. Chioffe that speak to medical causation. Respondent's Exhibit 7, however, contains Dr. Chioffe's records. The Arbitrator notes that the only indication in those records of a causation opinion from Dr. Chioffe is an interoffice email, wherein Dr. Chioffe indicates that this is "not work comp," and that he believed it was appropriate for Petitioner to proceed with surgery under his own insurance. RX7.

On June 11, 2016, Petitioner returned to Dr. Fletcher, who again recommended surgery. Dr. Fletcher's reports document that his condition was made worse by repetitive use of the hand and using hand tools and grasping, and he testified he would assume he's using these tools at home. He testified that Petitioner did not have significant loss of range of motion of the cervical

spine. Dr. Fletcher admitted that a diagnosis of C6 radiculopathy secondary to C5-6 disc pathology is one that can occur without trauma, and further admitted that Petitioner had degenerative changes and disc bulging at other levels of the cervical spine as well. He testified that the disc bulge at C4-5 and the posterolateral spurs were not caused by Petitioner's injury in April 2009, but he believed that the C5-6 disc protrusion *was* related to the April 2009 work injury, based on an axial loading type of injury when Petitioner fell off the platform. However, Dr. Fletcher conceded that a disc protrusion could occur without trauma, that all of the findings at C5-6 could occur as a result of the natural aging process without trauma, and that while he believed the disc protrusion was from an axial load injury in April 2009, it was also possible that it was degenerative and long-standing. PX4.

Dr. Fletcher agreed that the findings on Petitioner's MRI of May 24, 2016, were not uncommon for someone Petitioner's age and weight, and that about 50% of the population would have similar anatomical findings. He agreed that his findings at C6-7 were primarily on the left side, despite Petitioner's complaints being worse on the right side. He testified that Dr. Chioffe obtained a cervical spine x-ray that was entirely normal. He testified that Dr. Chioffe's reports document that his review of the MRI was that it revealed moderate, broad based posterior disc osteophyte complex causing mild to moderate neural foraminal impingement; and Dr. Fletcher admitted that the disc osteophyte complex was degenerative and likely preexisted the alleged work injury in April 2009. PX4.

Despite Dr. Fletcher's testimony that the FCE he obtained at his facility was valid, he admitted on cross-examination that his own FCE failed to show a normal bell-shaped curve during static grip testing, which he conceded would be a failure of a validity criterion. Additionally, as with Dr. Stewart's testing, Petitioner's rapid exchange grip strength values were in excess of his static grip strength values. PX4.

Respondent's Exhibit 7 contains the records from Dr. Chioffe. The Arbitrator notes there was no causation opinion on behalf of Petitioner contained in those records. However, on July 20, 2017, Dr. Chioffe responded to an email dated July 19, 2016 from medical assistant Azucena Vargas. Ms. Vargas explained to Dr. Chioffe that she called Petitioner to discuss scheduling his cervical fusion, and that Dr. Chioffe's office was under the impression this was going to be performed under his private insurance. Dr. Chioffe responded, "That is fine. I do not believe this is a work comp issue, I discussed with him personal insurance. His injury was many years ago." RX7. Petitioner also testified at trial that Dr. Chioffe wanted to perform his surgery through his wife's insurance. Dr. Chioffe was not deposed in this case, nor did Petitioner present a causation opinion from him.

On December 1, 2016, Petitioner was examined by Dr. Thomas Lee for a Section 12 examination at the request of Respondent. Dr. Lee testified by way of deposition on January 12, 2017. He is a Board Certified Orthopedic Surgeon who specializes in spine surgery and is a founding member of the St. Louis Spine Society. He testified he performs approximately 200 spine surgeries a year and about half of these surgeries, or 100 surgeries a year, are on the cervical spine. Dr. Lee testified that Petitioner told him there was nothing that alleviated his symptoms, which suggested to Dr. Lee that there was not a mechanical cause of his symptoms and which caused concern for him as a surgeon that "it's not something mechanical that has a

surgical repair." Dr. Lee reviewed Petitioner's records and recent MRI scan, and performed a physical examination. He asked Petitioner if he injured his neck in the fall, and Petitioner said he had never known of any neck problems. RX5.

Dr. Lee testified that one of the more striking things from Petitioner's records was that he had an examination on October 16, 2013, by Dr. Paul Juergens, and that his cervical range of motion, including extension, was normal and without pain at that time. Dr. Lee testified that Dr. Juergens' examination also showed a symmetric bilateral upper extremity reflex examination. He testified that this was very different than what Dr. Chioffe, Dr. Fletcher, and Dr. Lee himself found on physical examination three years later in 2016. He explained that Dr. Chioffe had seen and noted pain with range of motion, and pain with the type of motion that was *not* producing pain back in 2013. He testified the same was true in his examination of Petitioner as well, but was absent from Dr. Juergens's examination back in 2013. RX5.

Dr. Lee testified that he diagnosed Petitioner with cervical spondylosis without myelopathy at C5-6. He explained that cervical spondylosis means there are pieces of and around the disc at C5-6 that have developed an increased bulk to them and are putting pressure on the nerves, and pushing backward towards the nerves. He explained that it there is pressure against the spinal cord. He explained that spondylosis is also known as arthritis, and can occur with or without trauma, and can be a part of the normal aging process. RX5.

Dr. Lee testified that he considered "very carefully" Petitioner's case, with the "idea in mind that 'could something have been missed along the way.'" He testified that in his area of expertise, treatment of the spine, there is overlap between nerve symptoms and symptoms in the arms themselves that he has to take into account with every patient he sees. He looked "very carefully, extensively, to try to prove that was the case here". He testified, "Initially going into this, that's what I assumed probably had happened, but I came to the opposite conclusion when I looked at the evidence that was there over time that showed the normal reflexes, the normal range of motion without pain as late as four years after the injury, then a similar exam a year after that, and then these more recent findings which seems to be quite different and inconsistent between my exam and the other examiner within the last six months." RX5.

Dr. Lee testified that the work injury did not cause Petitioner's condition or symptoms. He was asked what he believed did cause Petitioner's cervical spine condition, and he explained that the more likely cause was just the degenerative change that all of our spines are undergoing over time. He explained that in this case, Petitioner's symptoms surfaced in a way that relates to the cervical spine years after the injury. Dr. Lee testified that around 2015, Petitioner started running and "trying to get healthy," and began noticing headaches in the back of his head. He explained that these symptoms can sometimes be associated with "cervical spondylosis, degenerative changes of wear and tear over time, just the process of aging, and so I think it's just the process of time and aging and gravity on our spines and the normal process of wear and tear of our tissues". RX5.

Dr. Lee noted that he reviewed over 5 inches of records from Petitioner's primary care doctor alone, as well as the records for treatment he has had for the alleged work injury. He noted that Petitioner was followed extensively, often several times per month, for a long list of

medical complaints and orthopedic complaints, and even complaints pertaining to the lumbar spine and leg, but there were *no references* to complaints that may relate to his cervical spine until 6 years after the alleged injury. RX5.

Further, Dr. Lee noted that Petitioner also showed normal cervical range of motion, as documented on October 16, 2013, including cervical extension, and had more than one evaluation showing normal upper extremity reflexes between the time of the work injury up to and including June 2016. He noted that Petitioner now presented with a pattern of not only cervical tenderness and markedly reduced cervical extension, but also asymmetrically diminished upper extremity reflexes, which indicates a more recent evolving pattern of neurologic involvement. Dr. Lee concluded that it was highly unlikely that a disguised or missed cervical disc pathology diagnosis from 2009 would include the above normal findings specific to the cervical spine for all those years, and then in 2016 that Petitioner would, as a result of the remote work injury, develop new mechanical and neurologic findings. Dr. Lee believed this strongly suggested a more recent onset of his cervical spine condition, and the far more likely causative factor was the diffuse degenerative process which resulted in the changes seen on his MRI. Dr. Lee concluded that Petitioner required no treatment for his cervical spine based on the work injury, was at MMI for his cervical spine as far as the work injury was concerned, and sustained no permanent partial disability nor did he require any restrictions pertaining to his cervical spine due to the work injury. RX5.

Despite Dr. Fletcher's opinion that Petitioner's complaints have been consistent, Dr. Morgan, Dr. Brown, and Dr. Lee all noted that Petitioner's symptoms have *not* been consistent. Dr. Lee noted that Petitioner initially had symptoms in the hand, of pain with stretching tendons, but by December 2010, he was having pain up the forearm. Dr. Lee reviewed the actual film of the May 24, 2016, MRI. He testified that if Petitioner had injured his neck in 2009, he would expect a more chronic picture by that time; since it was seven or eight years from the time of the injury until the 2016 MRI. He testified that the MRI had a more recent appearance to the herniation component, and that the MRI findings fit the time frame of a more recent onset of the disc problem having occurred within the last couple of years, as opposed to back in 2009. RX5.

Petitioner testified at trial that he never reported any neck pain to any doctors he treated with throughout this case. He testified that at the emergency room after this accident in 2009, he reported his right elbow was "fine." He testified that it was not until some time after the surgery on his right wrist on December 9, 2009, that he felt pain going up his arm. Dr. Morgan, who treated Petitioner early on in this case, testified that Petitioner did not have complaints of pain in his forearms until December 2010. Dr. Morgan admitted that the location of the pain expanded. He testified that Petitioner's pain had changed over the course of his treatment, moving from the wrist to the distal aspect of the forearm, and more proximal as time went on. JX1.

At trial, Petitioner testified that on October 1, 2010, he was assaulted by six men. The records of West Frankfort Family Practice were admitted into evidence at trial, and document his treatment for this assault. The records show that Petitioner was kicked in the head during the assault, and the doctor noted he was "beaten badly." Petitioner testified that he was knocked down, and "six guys beat me up." The records document he treated at the emergency room, where a CT scan and an X-ray of his neck were obtained. By October 4, 2010, Petitioner still

had two black eyes from the assault, and his doctor noted he still had a lot of swelling on his head and face. Petitioner followed up again with the doctor on October 7, 2010, because of the bruising over his eyes that was still present from the assault. RX8.

Petitioner testified that on June 10, 2015 he fell through a glass window, and lacerated his left arm. Petitioner testified he fell down steps and went into a window. (*See also* RX8.)

Petitioner's primary care records document that he had been running since November 2012 (RX8), and at trial Petitioner testified that he probably began running before then. The records document that in February 2016, he reported to his primary care doctor that he was running five miles per day and had been doing so for several months. Petitioner testified at trial that, in fact, he was probably running more than what his primary care physician records indicated. Petitioner was complaining of headaches and leg pain at that time. RX8.

Petitioner's primary care records also document that in addition to running several miles every day, he was also lifting weights as well. The records document that he was exercising two times a day, running and weight lifting. Petitioner disputed that he would exercise twice a day by running several miles and then weightlifting. However, the medical records document this on more than one occasion. Petitioner admitted that his wife believed he sometimes overdid it with regard to exercise, and that at times he exercised to the point of having leg pain. This is also documented in the records from his primary care physician. RX8.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After review of the evidence and due deliberations, the Arbitrator finds on the issues presented at trial as follows:

In support of the Arbitrator's decision relating to issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

A claimant has the burden of proving by a preponderance of the credible evidence all elements of the claim, including that any alleged state of ill-being was caused by a workplace accident. *Parro v. Industrial Commission*, 260 Ill.App.3d 551, 553 (1st Dist. 1994). The burden of proof is on the Petitioner to establish all elements of his right to compensation particularly that the injury complained of arose out of and in the course of employment. *Hannibal, Inc. v. Industrial Commission*, 38 Ill.2d 473, 475 (1967).

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that his current condition with regard to his cervical spine is causally related to his accident of April 27, 2009. In so concluding, the Arbitrator finds significant the extensive gap of time between Petitoner's accident and his recent cervical findings.

There is no dispute that Petitioner sustained traumatic injuries to his left ankle and bilateral wrists. Respondent provided appropriate TTD and medical benefits associated with

those injuries. Petitioner underwent bilateral DeQuervain's releases performed by Dr. Morgan. Following surgery, he underwent EMG/NCS's on May 4, 2010, and again on October 5, 2010, both of which were negative. On March 4, 2010, Petitioner specifically denied any pain in the elbow area, and complained of pain in the right hand. On August 10, 2010, he underwent an FCE, the validity of which was questionable because of the reliability of pain and his questionable levels of effort. On October 1, 2010, Petitioner was "beaten badly" by six men and sustained injuries to his head that necessitated multiple medical visits, as well as a CT scan and cervical x-rays. On December 21, 2010, Dr. Morgan noted Petitioner was "having pain really more up his forearm now".

Dr. Young took over Petitioner's treatment, diagnosed radial tunnel syndrome, and performed a right radial tunnel decompression on May 15, 2013. On September 24, 2013, new nerve conduction studies were again negative. Dr. Young decided not to do surgery on Petitioner's left arm, and instead referred him to pain management. Dr. Juergens, the pain specialist, noted on October 31, 2013, that Petitioner had a *normal range of motion of the cervical spine.*

Dr. Brown examined Petitioner on January 7, 2014, and placed him at MMI. He did not recommend any additional treatment, and noted his impression was diffuse nonspecific left upper extremity pain.

Petitioner followed up with Dr. Juergens in March 2014, and this bill was paid by Respondent in good faith. However, when Dr. Young, Petitioner's treating physician, authored a letter to Petitioner's attorney on June 10, 2014, advising that he did not believe Petitioner's complaints were work related, Respondent terminated all benefits.

Petitioner did not seek any additional medical treatment for quite some time thereafter. Dr. Brown examined Petitioner again on February 17, 2015, and again concluded that Petitioner was not in need of any additional treatment, and believed he should resume normal activities both at home and at work. Dr. Brown testified that Petitioner's current symptoms were not work related, and pointed out that his symptoms in his forearm were not noted until almost a year and a half after the injury.

Between March 2014 and September 2015, a period of one year and six months, Petitioner did not seek any medical treatment. He then went to Dr. Patrick Stewart in September 2015, at the request of his attorney. Dr. Stewart, Petitioner's own medical expert, testified that he did not believe his condition was work related. He opined that Petitoner's performance on his physical examination did not make anatomic sense, and he believed that Petitioner was exhibiting symptom magnification. Dr. Stewart testified that Petitioner appeared to have stiffness in his neck at that time, but testified that any evaluation or treatment of his neck would not be related to his work accident in 2009. It is quite telling that this opinion was rendered by Petitioner's own medical expert.

On May 11, 2016, two years after his last medical treatment, Petitioner traveled nearly three hours to Dr. Fletcher in Champaign for an evaluation of his cervical spine at the request of his attorney. Dr. Fletcher referred Petitioner to Dr. Chioffe, an orthopedic surgeon. It is quite

telling that Dr. Chioffe was not deposed by Petitioner, nor did Petitioner present a causation opinion from Dr. Chioffe as to whether or not his need for cervical surgery was related to the work accident. The only indication in the record as to Dr. Chioffe's opinion on causation is contained in an interoffice email sent by Dr. Chioffe, wherein he stated, "I do not believe this is a work comp issue, I discussed with him personal insurance. His injury was many years ago." The Arbitrator finds this to be compelling.

Dr. Lee, a Board Certified Orthopedic Surgeon who specializes in spine surgery, examined Petitioner in December 2016. He noted that Petitioner had full range of motion when examined by Dr. Juergens back in October 2013. He credibly testified that he very carefully evaluated Petitioner's case, with the idea in mind that something could have been missed along the way in his treatment. In fact, Dr. Lee testified, "Initially going into this, that's what I assumed probably had happened, but I came to the opposite conclusion when I looked at the evidence that was there over time that showed the normal reflexes, the normal range of motion without pain as late as four years after the injury, then a similar exam a year after that, and then these more recent findings which seems to be quite different and inconsistent between my exam and the other examiner within the last six months."

Dr. Lee correctly pointed out that Petitioner's primary care records indicated that around 2015 he was working out and running several miles a day, and began noticing headaches in the back of his head. The records document that Petitioner was exercising twice a day, running several miles and then lifting weights. Petitioner admitted at trial that he was probably running more than the five miles per day documented in his primary care records. Dr. Lee credibly concluded that it was highly unlikely that a disguised or "missed" cervical disc pathology diagnosis from a 2009 accident would include normal findings specific to the cervical spine for all those years, until 2016, when he developed new mechanical and neurological findings. In addition, Petitioner's nerve conduction study on September 13, 2013, demonstrated *no evidence* of cervical radiculopathy, and Dr. Juergens noted on December 13, 2013, that there was *no evidence* of cervical radiculopathy.

It is unclear from the record whether Dr. Fletcher reviewed the records from Petitioner's primary care physician. In any event, his testimony that Petitioner's cervical spine condition has been present since the 2009 accident is simply not supported by the medical records in this case, or by common sense. Dr. Fletcher's position that multiple board certified surgeons and physicians who examined Petitioner over the years simply misdiagnosed his condition defies logic and is not supported by the records.

The opinion of Dr. Lee in this case is much more credible than that of Dr. Fletcher for several reasons.

(1) Dr. Lee's credentials as a Board Certified Orthopedic Surgeon specializing in spine surgery make him imminently more qualified to give such an opinion over Dr. Fletcher, who is an occupational medicine physician.

(2) Dr. Lee reviewed Petitioner's primary care records, which document headaches that occurred in 2015 after starting a strenuous exercise regimen. Dr. Fletcher's opinion does not address the effect of this exercise regimen, and it is unclear whether he even considered Petitioner's primary care records.

(3) Dr. Fletcher's opinion ignores the fact that Petitioner had a *normal cervical examination* back in 2013. It was not until 2016, ***seven years*** after the initial injury, that any doctor opined that Petitioner had a cervical spine condition. Notably, this was after Petitioner had been beaten badly in an altercation with six men who kicked his head, necessitating diagnostic studies for the cervical spine, and after he had begun a strenuous exercise program that resulted in headaches and leg pain.

(4) Dr. Fletcher referred Petitioner to an orthopedic spine surgeon, Dr. Chioffe, whose causation opinion was never obtained by Petitioner or offered into evidence. In fact, the email from Dr. Chioffe would seem to show that his opinion was that Petitioner's cervical condition was *not* related to his work accident.

(5) Dr. Fletcher ignores the indisputable evidence in this case that it was not until a year and a half after the accident that Petitioner had complaints in his forearms, a symptom that Dr. Fletcher attributed to the cervical condition. Dr. Fletcher testified that Petitioner's complaints had been consistent all along, but this assertion is simply not supported by the medical records or testimony of Petitioner's own treating physicians. This accident occurred in April 2009, and it was not until the end of 2010 that Petitioner complained of pain into the forearms. His own chosen treating physician, Dr. Morgan, testified to this fact previously. This indisputable fact was also noted by Dr. Lee, Dr. Brown, and Dr. Stewart, but was ignored by Dr. Fletcher.

The overwhelming weight of the credible evidence is that Petitioner's cervical spine condition is in no way related to his work injury of April 27, 2009. Based upon the foregoing and the record in its entirety, the Arbitrator finds that Petitioner failed to meet his burden of proof in establishing that his current condition of ill-being with regard to his cervical spine is causally related to his work accident of April 27, 2009.

The Arbitrator further finds that Petitioner reached maximum medical improvement with regard to his other injuries on January 7, 2014, that being the date of Dr. Brown's evaluation.

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

In light of the Arbitrator's findings above with respect to issue (F), the Arbitrator finds that medical services rendered through January 7, 2014, were reasonable and necessary in Petitioner's care and treatment relative to his accident of April 27, 2009. The Arbitrator further finds that Respondent is not responsible for payment of any medical bills after January 7, 2014, that being the date Petitioner reached maximum medical improvement for his related injuries.

In support of the Arbitrator's decision relating to issue (K), Petitioner's entitlement to prospective medical care, the Arbitrator finds the following:

In light of the Arbitrator's findings above with respect to issue (F), the Arbitrator finds that Petitioner is not entitled to ongoing medical care, including the cervical surgery recommended by Dr. Fletcher and Dr. Chioffe.

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 Arbitrator's findings above with respect to issue (F), the Arbitrator finds that Petitioner is not entitled to temporary total disability benefits after January 7, 2014, that being the date he reached maximum medical improvement for his related injuries. The parties agreed that Respondent continued to pay Petitioner TTD benefits through July 28, 2014, at which time benefits were terminated. In light of the Arbitrator's findings, Respondent is entitled to a credit for the overpayment of TTD benefits paid from January 8, 2014, through July 28, 2014, a period of 29 weeks, totaling $14,102.41.

In support of the Arbitrator's decision relating to issue (M), whether penalties or fees should be imposed upon Respondent, the Arbitrator finds the following:

Petitioner has requested penalties under Sections 19(k), 19(l) and 16 of the Act. Section 19(k) of the Act allows for an award of an additional 50% of the amount payable at the time of the award if there has been an unreasonable or vexatious delay in payment. 820 ILCS 305/19(k). Section 19(l) allows for an award of penalties of $30.00 a day, up to $10,000, for an unreasonable delay in payment of weekly compensation benefits. 820 ILCS 305/19(l). Section 16 of the Act allows for an award of attorney fees for an unreasonable and vexatious delay in payment of compensation benefits "within the purview of the provisions of paragraph (k) of Section 19 of the Act." 820 ILCS 305/16.

The Arbitrator finds that Respondent's conduct in not paying benefits was neither unreasonable nor vexatious under the circumstances so as to warrant the imposition of additional compensation. Respondent relied not only upon its own Section 12 examiners, but also upon Petitoner's own medical experts.

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

Michael Warren,
Petitioner,
vs. NO: 12 WC 32094

GErresheimer Glass
Respondent.

18IWCC0105

DECISION AND OPINION ON REVIEW

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

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

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

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

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 22 2018
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DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WARREN, MICHAEL
Employee/Petitioner

Case# **12WC032094**

GERRESHEIMER GLASS INC
Employer/Respondent

18IWCC0105

On 4/25/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

0507 RUSIN & MACIOROWSKI LTD
MICHAEL P RUSIN
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

STATE OF ILLINOIS)
) SS
COUNTY OF)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Michael Warren
Employee/Petitioner

Case # 12 WC 32094

v.
Gerresheimer Glass, Inc.
Employer/Respondent

Consolidated cases:

18IWCC0105

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

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☐ What temporary benefits are in dispute?

☐ TPD ☐ Maintenance ☐ TTD

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

M. ☐ Should penalties or fees be imposed upon Respondent?

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

On 8-25-12, 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 not* sustain an accident that arose out of and in the course of employment.

In the year preceding the injury, Petitioner earned $N/A; the average weekly wage was $N/A.

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 $2,430.00 under Section 8(j) of the Act.

ORDER

PETITIONER FAILED TO PROVE A COMPENSABLE CLAIM UNDER THE ILLINOIS WORKERS' COMPENSATION 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 of at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 24, 2017
Date

APR 25 2017

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 the following facts:

Petitioner is employed as an apprentice maintenance electrician. He alleges an accident date of August 25, 2012. On that date, Petitioner alleges he was exposed to dust while working for about four hours. Petitioner alleges exposure to chemicals, compounds or dust at work caused a pulmonary condition. The Arbitrator heard the testimony of Petitioner and reviewed the records and documents submitted into evidence. The Arbitrator does not find Petitioner's testimony credible.

Petitioner did not identify chemicals, compounds or the nature of the dust he was allegedly exposed to on August 25, 2012. He did not report the exposure to management that date. He did not note any unusual dust or exposure in company maintenance logs. Petitioner acknowledged company procedures are strict in that they require immediate reporting and documenting of work related accidents. Petitioner had two prior claims during the course of his employment with Respondent. He claimed prior accidents January 2, 2010 and July 18, 2010. Petitioner reported both prior accidents on the date they occurred and accident reports were completed the same day (RX 1 and RX 2). With respect to the accident claim in question, Petitioner did not promptly report an accident on the date it allegedly occurred. He did not report this incident until six days later on August 31, 2012 at which time he completed a report (RX 3).

Petitioner did not report an accident to management on August 25, 2012 and did not seek treatment with a company clinic thereafter. August 25, 2012 was a Saturday. Petitioner testified he became ill on Sunday, August 26, 2012. He testified he had difficulty breathing. He did not report a work related condition to Respondent management Monday, August 27, 2012 and did

not seek treatment at any company clinic. He acknowledged he was aware of the company clinic associated with St. James Hospital. On August 27, 2012, Petitioner testified he sought treatment on his own at a Prompt Care facility. He did not offer any records or bills of this facility into evidence. On August 29, 2012, Petitioner sought treatment with Dr. Burda'a group, his primary care provider. Dr. Burda's records reflect that Petitioner had been diagnosed with asthma years prior to the August 25, 2012 alleged accident date. Petitioner had been diagnosed with asthma dating back to at least 2003 and had been on medication for the condition since that time. Petitioner was a long time heavy smoker. He acknowledged that he began smoking at age 8 and has apparently smoked continuously since that time. At the time of trial, Petitioner testified he was smoking up to 13 cigarettes a day. The records of Dr. Burda and Pulmonary Consultants document that diagnostic testing showed Petitioner had changes consistent with centrilobular emphysema dating back to at least 2006. Contrary to Petitioner's testimony, the emphysematous changes were seen in both lungs.

Prior to the August 25, 2012 alleged accident date, Petitioner had seen Dr. Burda's associate, nurse practitioner Ruth Valentin, less than three months prior on June 1, 2012. At that time, Petitioner reported to Ms. Valentin that he was still smoking one pack of cigarettes per day. He acknowledged smoking more than 30 years and refused to quit. He reported symptoms of shortness of breath. A diagnosis of asthma and hypertension was noted. An examination showed evidence of wheezing, which was present in both lung fields. Petitioner was noted to actively be taking medications for asthma and hypertension.

Petitioner again saw Ms. Valentin on August 29, 2012. Petitioner testified he gave medical personnel this date a history of the alleged accident of August 25, 2012. He did not. Contrary to

Petitioner's testimony, Petitioner reported the onset of acute asthmatic symptoms three days earlier. He reported the symptoms were exacerbated by smoking. He did not report any incident or exposure at work on August 25, 2012. Petitioner was given an injection. He was prescribed a different asthma medication and an antibiotic.

Petitioner was subsequently seen by Ms. Valentin on August 31, 2012. Petitioner gave a different history this date than was provided on the August 29, 2012 visit. He reported exposure to chemicals at work triggered his asthma. Petitioner was again examined and prescribed medications.

Petitioner had follow up visits with Dr. Burda's group sporadically through October 30, 2012 for various medical problems which included his asthma condition. As of October 30, 2012, Petitioner reportedly quit smoking and requested to return to work the following week.

Petitioner testified he returned to work November 5, 2012 and has taken leave sporadically due to pulmonary problems. Generally, Petitioner testified he worked until 2015 when he stopped working due to alleged back problems.

At the request of Respondent, Petitioner was examined by Dr. Terrence Moisan, a pulmonologist, on April 9, 2013. Dr. Moisan examined Petitioner that date, and reviewed pertinent medical records and material safety data sheets. Dr. Moisan states that based on Petitioner's medical records, his asthma condition was an active one dating back to 2003. The doctor noted that as of June 2012, Petitioner was experiencing shortness of breath and using Combivent due to wheezing. Petitioner had longstanding bronchospastic tendencies due to his asthmatic condition. Dr. Moisan states that given Petitioner's smoking history and pulmonary function level, he has mixed disease with a significant chronic obstructive pulmonary disease

component which is related to smoking. Dr. Moisan states that had Petitioner been exposed to a high level of irritant, his asthmatic symptoms would have been immediately worsened and not gradually come on over a couple of days. Additionally, the doctor notes Petitioner's medical history is not consistent and it was cigarette smoking that triggered a worsening of his condition. The doctor did not find any conclusive evidence Petitioner's condition was causally related to any work exposure.

CONCLUSIONS OF LAW

The Arbitrator finds Petitioner failed to prove he sustained accidental injuries which arose out of and in the course of his employment on August 25, 2012 and failed to prove his asthmatic condition and need for treatment commencing August 29, 2012 is causally related to any work accident or work exposure. Petitioner has a long history of treatment for asthma. He is a long time heavy smoker with signs of emphysema which predate this accident. He did not initially document any work related incident or exposure to Respondent management or in company maintenance records. When Petitioner first sought documented medical treatment August 29, 2012, he did not relate his increased asthma complaints to any work exposure in recent days. He related his increased symptoms to smoking. By Petitioner's own admission, he has been a smoker since age 8 and was still actively smoking at the time of trial. Petitioner did not offer any evidence of medical opinion to support his contention that his asthma condition or complaints and need for medical treatment commencing in August 2012 was causally related to any work related incident or exposure. The Arbitrator finds the opinions of Dr. Moisan persuasive and credible that Petitioner's condition and need for treatment commencing August 29, 2012 is not related to a work accident or exposure of that date. The claim for compensation is denied.

Having found Petitioner failed to prove he sustained accidental injuries which arose out of and in the course of his employment and failed to prove his condition of ill being as causally related to a work accident or exposure, all other issues are rendered moot.

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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

Anthony Lamoureux,
Petitioner,

vs.

NO: 14 WC 17547

Washington Group-Alberici ,
Respondent.

18IWCC0106

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, causal connection, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 11, 2017, is hereby affirmed and adopted.

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

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

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

DATED: FEB 22 2018
o020818
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LAMOUREUX, ANTHONY
Employee/Petitioner

Case# **14WC017547**

WASHINGTON GROUP-ALBERICI
Employer/Respondent

18IWCC0106

On 7/11/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5396 JOHNSON SCHNEIDER & FERRELL
MATTHEW B FERRELL
212 N MAIN ST
CAPE GIRARDEAU, MO 63701

2904 HENNESSY & ROACH PC
MICHAEL J HOLT
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

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

Anthony Lamoureux
Employee/Petitioner

v.

Washington Group-Alberici
Employer/Respondent

Case # 14 WC 17547

Consolidated cases: N/A

18IWCC0106

An *Application for Adjustment 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 **May 11, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0106

FINDINGS

On **11/14/2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$80,704.00**; the average weekly wage was **$1,552.00**.

On the date of accident, Petitioner was **43** years of age, ***married*** with **4** dependent children.

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

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

ORDER

Petitioner sustained an accident on November 14, 2013; however, he failed to prove that his current condition of ill-being is causally related to the accident. 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.

Signature of Arbitrator

July 6, 2017
Date

JUL 11 2017

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner alleges he sustained an injury to his right wrist, hand and arm on November 14, 2013 while working for Respondent. Accident, notice and causal connection are the primary issues in dispute.

The Arbitrator finds:

Petitioner's medical records with Missouri Plastic & Hand Surgery go back to 2010. Contained within the records are office notes regarding billing issues, a workers' compensation claim, and reference to a right wrist injury. These notes cover July 20, 2010 through November 15, 2011. On April 12, 2012 charges for $2300.00 were sent out for collection. There is reference to workers' compensation coverage for a January 13, 2009 left hand/wrist injury and reference to "unknown" workers' compensation for a right hand injury. (PX D)

On September 13, 2013 Petitioner called Dr. Tobin's office at the Missouri Plastic & Hand Surgery and left a message that he had had his elbow drained at the ER numerous times and was now ready for surgery. (PX D)

According to the records of Missouri Plastic & Hand Surgery, Petitioner came into the office on October 24, 2013 to talk about the earlier referenced collection balance and was told forms had been submitted to Blue Cross for payment but denied as they stemmed from a work-related injury. The doctor's office had then sent the claim to CCMSI and it was denied as not being part of Petitioner's 2009 work injury. Petitioner was advised he would need to contact Blue Cross Blue Shield and let it know the services he had received (and which were being billed) were not for the workers' compensation injury. Petitioner was also advised to contact the credit bureau. (PX D)

Petitioner had an appointment with Dr. Tobin's office scheduled but, according to an October 24, 2013 office note, Petitioner had failed to pay an outstanding bill incurred prior thereto. Petitioner exhibited anger towards the staff and refused to accept responsibility for the debt. He demanded to be seen by Dr. Tobin; however, his appointment was cancelled. The note states that Petitioner had been informed on September 13, 2013 that his bill needed to be resolved before the office visit. (PX D)

Petitioner, accompanied by his wife, presented to St. Francis Medical Center on November 14, 2013 at 5:30 p.m. regarding right hand pain and swelling. Petitioner reported "squeezed vise grips this am and pain to right hand since." The chief complaint was "hand injury, hand swelling, hand pain, hand complications and tenderness." The mechanism of injury was reported as "squeezed vice grip and he immediately felt pain in 2nd and 3rd metacarpal." The HPI indicates the onset was "this am" and that the "injury occurred at work." He denied any numbness, tingling or pain with finger movement. Swelling was visible across the dorsum of his hand. X-rays of Petitioner's hands showed degenerative changes without evidence of an acute fracture or dislocation. He was given medications, discharged and instructed to follow up with Dr. Tobin the next day. (PX B)

Petitioner did not appear for a scheduled November 15, 2013 appointment with Dr. Tobin. (PX D)

Petitioner was laid off from Respondent on December 2, 2013. (RX 9)

Petitioner next presented to the office of Dr. Gregory Tobin at Missouri Plastic and Hand Surgery on December 3, 2013 regarding his right hand pain. Petitioner reported he was working at the Olmstead Dam and while applying a vice grip with "all the power he could muster," he locked the wrench down and experienced substantial pain. Petitioner was seen in the emergency room and referred to Dr. Tobin. "For a variety of reasons, he has not shown up until now." Petitioner reported that his hand hurt and he didn't know why. He complained of intermittent swelling where the dorsum of his hand would get much larger than it was presently. On examination Petitioner had dorsal swelling and range of motion of the fingers was intact, both passively and actively, as was distal sensation and circulation. Petitioner reported substantial pain with pressure on the dorsum of his wrist roughly at the junction of the 3rd and 4th dorsal compartments. When making a clenched fist, Petitioner would notice significant pain. He was also tender along the MCP joint of the thumb, particularly on the ulnar side. Based upon the x-rays it appeared Petitioner had a stener lesion avulsion type fracture on the ulnar aspect of the proximal phalanx of the thumb at the MCP joint. A questionable scaphoid fracture was also noted. Dr. Tobin ordered an MR arthrogram. Petitioner was to return after the first of the year because he didn't want to do anything until he had insurance. (PX D)

Petitioner called Dr. Tobin's office on December 9, 2013 requesting more pain medications. He wished to have the strength increased from "5/325" to "10/325" so that he could cut them in half and make them last longer. Petitioner reported not having any insurance at this time. A prescription was called in. (PX D)

On December 16, 2013 Petitioner telephoned Dr. Tobin's office requesting more pain medication because he was going to be leaving town until "about the 5th." (PX D)

Petitioner called Dr. Tobin's office again on December 20, 2013 requesting additional pain medication and a script was called in. (PX D)

Petitioner returned to see Dr. Tobin on January 7, 2014. He reported ongoing pain when grasping things and tying rebar. On exam, the doctor did not see any swelling but Petitioner was tender over the dorsal wrist in the area of the junction of the third and fourth dorsal compartments. The base of Petitioner's thumb was also tender as was the anatomical snuff box. Petitioner's x-rays showed a questionable signet ring sign and scapholunate widening on the clenched view. Petitioner was asked about any injuries he could recall and he denied any. Dr. Tobin wrote, "I think he may have a serious wrist problem here." An MR arthrogram was to be performed. (PX D)

Petitioner underwent an MR arthrogram on January 7, 2014. According to the radiology note, Petitioner had right wrist pain and had injured himself two months earlier. A broken thumb and prior right carpal tunnel surgery were noted. The radiologist's impression was that of dorsal intercalated segment instability with scapholunate dissociation. A full-thickness tear of the scapholunate ligament was also noted along with suubluxed articulation of the scaphoid and trapezoid. Extensor carpi ulnaris tendinosis/tenosynovitis and mild ulnar sided superficial soft tissue edema/swelling were also noted. A 6 mm. corticated dystrophic ossification wit adjacent 2 mm. filling defect on the dorsal side of the wrist was present. They were felt to possibly lie loose within the joint and might be sequelae of an old fracture and/or soft tissue/ligamentous injury. (PX D; PX F)

Petitioner telephoned Dr. Tobin's office on January 20, 2014 reporting that he had "bumped" his hand and needed stronger pain medication. A script was called in. (PX D)

Petitioner followed up with Dr. Tobin on January 21, 2014. Dr. Tobin advised Petitioner that his MRI arthrogram showed a scapholunate dissociation and his x-rays showed a stener lesion from a gamekeeper's thumb. Petitioner wished to get both fixed. Dr. Tobin recommended a fusion of Petitioner's wrist and they

discussed a STT arthrodesis but Petitioner turned it down given his experience. It was then suggested that they repair the ulnar collateral ligament to the MCP joint of the thumb, but "given that this looks like this is old" they would probably need to reconstruct it using a Palmaris graft. Petitioner wished to proceed. (PX D)

On January 22, 2014 Dr. Tobin signed off on a "Patient Status Report" form. The form notes Petitioner's injury is "non-work-related." Petitioner was allowed to return to work on January 21, 2014 with left hand work only. (PX D)

Petitioner again called Dr. Tobin's office on February 20, 2014 requesting more pain medication. A script was called in. Thereafter, the pharmacist's office called the Doctor's office stating that Petitioner had multiple prescriptions from multiple doctors, including a script from Dr. Walker dated 2/5/14 for Norco. Dr. Tobin was notified and rescinded the script. It was also noted that Dr. Walker had prescribed Norco on 1/7/14 and that the doctor (Walker) had required that Petitioner sign a controlled substance agreement at that time. (PX D)

On March 4, 2014 Petitioner called Dr. Tobin's office and stated that he no longer needed the "Patient Status Report" filled out because he was unable to work. (PX D)

On March 13, 2014 Dr. Tobin's office called Petitioner advising him that Stephanie Baker from the Ironworker's Benefits Office had called the doctor asking about an "estimated return to work." Petitioner advised that he had spoken with her. (PX D)

Petitioner presented to St. Francis Medical Center on March 21, 2014 for a cast to be applied to his right hand due to right wrist pain. Petitioner had been seeing Dr. Tobin and was set up for surgery for a scapholunate ligament disruption and gamekeepers thumb but then something got in the way and Dr. Tobin wouldn't due the surgery. Petitioner was seeking a referral to another doctor and a splint as his current symptoms were reportedly severe. Petitioner was referred to Dr. Richard Tipton and given a splint. (PX B)

Petitioner presented to the office of Dr. Rickey Lents on March 24, 2014. Petitioner completed a "Patient History Form". He indicated he was right hand dominant and was having a problem with right wrist and thumb pain. He gave an onset date of two months earlier (11/25/13) when he squeezed a pair of vice grips. He denied that it was a work-related injury or that he was filing a workers' compensation claim. Petitioner reported being referred by St. Francis ER. He also stated that he hadn't worked in five weeks. (RX 11)

When seen by Dr. Lents on the 24th, Petitioner reported right wrist pain that had begun two to three months earlier. Petitioner reported having been seen and noted to have a scapholunate diastasis as confirmed by an MR arthrogram. Petitioner was reporting increasing pain and difficulty using his wrist and he also reported injuring his right thumb at that time. Dr. Lents also reviewed Petitioner's right hand x-rays. He noted his diagnosis as scapholunate dissociation of the right wrist with dorsal intercalated segment instability and right gamekeeper's thumb. Dr. Lents recommended a promixal row carpectomy and a pinning of the gamekeeper's thumb. (PX H)

Petitioner underwent surgery on April 4, 2014. Dr. Lents performed a right proximal row carpectomy and right percutaneous pinning of a gamekeeper's fracture. (PX H)

As of April 4, 2014 Petitioner's wounds looked very good but Petitioner was complaining of pain. He was given Norco for pain. (PX H)

Petitioner returned to St. Francis Medical Center on April 8, 2014 regarding a possible infection after surgery. An altered mental state was also noted as Petitioner was very confused. His right hand was visibly red and swollen and very painful. Dr. Lents was contacted Petitioner was seen by Infectious Disease and Internal Medicine. Dr. Rogers was consulted while Petitioner was there and, according to his note, Petitioner had been seen in Dr. Lents' office for increasing pain in his right hand. Petitioner was unable to give many details regarding the surgery but "apparently had some sort of fracture last week after getting his hand stuck in some kind of big wrench used for iron working and developed a significant infection." Petitioner had been on disability for the last two weeks due to his current injury. He improved rapidly with medication and was discharged with a prescription. He was to call Dr. Lents in the morning. (PX B)

Dr. Lents examined Petitioner on April 9th in follow up from the ER visit. Petitioner's hand was swollen but Petitioner had no fever. He was to be admitted to the hospital and started on antibiotics. Dr. Lents wanted him seen by infectious diseases. If no better on the 10th the doctor would consider an incision and drainage of the wound. (PX H)

On April 10, 2014 Dr. Lents removed the pins and applied an external fixator and drains. Petitioner was kept overnight at St. Francis and discharged on April 11, 2014. (PX B; PX H)

Petitioner's hand was noted to look much better by April 14, 2014 and the swelling was coming down nicely. As of the 21st, Petitioner's hand was looking "very very good." His Norco 10/325 was refilled and he was to cut them in half and return in two weeks. (PX H)

Petitioner continued to follow up with Dr. Lents post-operatively with no problems being noted until May 29th when Petitioner reported he had been playing with is children and his thumb was hyperextended and he had some pain at the base of his thumb. Otherwise, he had been having very little pain and his wrist had excellent range of motion and was "better than expected." On exam, Petitioner's thumb was table. Some tenderness was noted at the CMC joint and the doctor suspected a sprain of the joint. He was given a refill of Norco 5/325 for pain. (PX H)

Petitioner signed his Application for Adjustment of Claim herein on May 14, 2014 alleging an accident date of November 20, 2013. (RX 5)

When re-examined by Dr. Lents on June 19, 2014 Petitioner was still complaining about his thumb CMC joint and he was tender to palpation in that area. He was given an injection into the CMC joint. The fracture about the thumb had healed in good position and his right wrist x-ray showed a well-placed proximal row carpectomy. Petitioner had Ultracet at home for pain. Petitioner was to return in four to five weeks. (PX H)

Petitioner did not follow up with Dr. Lents.

Deposition of Dr. Ralls

The deposition of Garoll Ralls was taken on August 3, 2016. (RX 9) Mr. Ralls is employed by Respondent. Mr. Ralls testified that Respondent is working on the Olmsted Dam Project located on the Ohio River. In January of 2017 they will have been on the project six years. Mr. Ralls is an ironworker out of Local 782 in Paducah, Kentucky. At the time of his deposition he was working as the general foreman on the project, a position he has held for almost two years. Before that he was a foreman on the project. (RX 9, pp. 1-8)

Mr. Ralls testified that ironworkers on the Olmsted Dam Project perform the rebar work. Mr. Ralls recalled knowing Petitioner as he was an ironworker on the project. According to Mr. Ralls Petitioner was working in the casting yard doing rebar work in November of 2013. He did not know Petitioner before he appeared on the job nor has he had any contact with him since he left the project. Mr. Ralls testified that he was foreman when Petitioner worked there and the general foremen was Bill Jeffords and Chick Lyons although he thought Mr. Lyons might have been the superintendent by that time. (RX 9, pp. 8 – 11)

Mr. Ralls testified that before the ironworkers would physically begin working they would attend a "stretch and flex" every morning as part of a safety huddle. After the "stretch and flex" the workers would go to the "taco stand" and fill out a safe card which was a card stating what the worker would be doing that day, what the hazards were, and how to avoid the hazards. In addition to these daily safety meetings, workers were also supposed to sign and initial the safety card right after lunch. Mr. Ralls also testified that if anyone got hurt during the day he was supposed to document it on the timecard and report it to the general foreman. If necessary, the injured worker would be rushed to safety. He further testified that once that was done the general foreman would make sure the accident got reported up the chain of command or, as he explained "That's usually what happens." (RX 9, p. 14)

Mr. Ralls further testified that the project us under the auspices of the U.S. Army Corp of Engineers and the Corp was very concerned with safety. As foreman or general foreman, Mr. Ralls might be asked by the safety department to fill out some paperwork in conjunction with an accident. According to Mr. Ralls, in November of 2013 the workers were trained about the importance of reporting a work accident, including how to indicate an accident on one's timecard. (RX 9, pp. 14 – 16)

Mr. Ralls testified that the timecards, once completed by the worker, are forwarded in the chain of command so that the foreman, general foreman or superintendent countersign/sign off on the timecard. Mr. Ralls was provided with a copy of Petitioner's timecards to review. They were dated from November 11, 2013 through December 2, 2013. Mr. Ralls reviewed Petitioner's timecard for November 20, 2013 and could not find any indication of an accident having occurred that day. Mr. Ralls further testified that between November 11, 2013 and December 2, 2013 Petitioner never went to him and reported hurting himself. He also testified that if Petitioner had come to him and reported an injury to his hands or wrists he would have reported it to safety. (RX 9, pp. 16 – 24)

Mr. Ralls agreed that Petitioner's job required him to use his hands. When asked if he ever remembered seeing Petitioner having difficulty doing his job during the time he worked there, Mr. Ralls replied, "No. I know- can I – I just want to spit this out." (RX 9, p. 24) He was not allowed to do so. Mr. Ralls acknowledged that there was a medical first aid facility at the Project site. (RX 9, p. 25)

Mr. Ralls was asked when he first learned that Petitioner had injured himself and he replied it was about a couple of weeks after Petitioner had left the job and he heard he was claiming to have hurt himself. He was shown a letter dated May 14, 2014 from Petitioner's attorney and asked if that was when he first learned about the accident and he replied "Yes." (RX 9, p. 26) Mr. Ralls denied being asked by anyone if he knew anything about an injury. (RX 9, p. 28)

Mr. Ralls was given the opportunity to follow up on the information he had tried to convey earlier in the deposition. He testified that Petitioner had said something about his hands being broke before with plates and screws in them. He mentioned having a broken hand. Mr. Ralls recalled that Petitioner didn't say anything about anything on the job but one of his hands was messed up. (RX 9, p. 28)

On cross-examination Mr. Ralls reiterated that either Chick Lyons or Bill Jeffords were the general foreman at the time of the alleged injury. He further testified that the "safe card" is different than the time card. There is nothing on the "safe card" where an employee would indicate if he had been injured that day. There is, however, a spot on the time card for reporting an injury. Mr. Ralls testified that the procedure for reporting injuries is the same regardless of how minor or major the accident might be. Mr. Ralls further testified on cross-examination as to the information contained on the time cards (RX 9, pp. 35 – 38) If an employee were hurt in the afternoon after lunch he would get the timecard back and fill it in to reflect the accident. (RX 9, pp. 38 – 45)

Mr. Ralls further testified that he was aware of Petitioner's prior injury because Petitioner told everyone about it; however, he never noticed Petitioner having any limitation in his ability to use either of his wrists. (RX 9, pp. 45-47)

Mr. Ralls also testified that if Petitioner was last on the job on December 2, 2013 it was about a couple of weeks thereafter that he heard about the accident. He couldn't remember if he heard it at one of the meetings but he did hear about it. (RX 9, pp. 47- 51)

On redirect examination Mr. Ralls agreed that Petitioner's time card showed he was doing rebar work on November 20, 2013. (RX 9, p. 52) On further cross-examination Mr. Ralls testified that Petitioner did not work on November 12th or 13th, 2013 but he did not know why. (RX 9, pp. 57-58)

Deposition of Clarence Lyons

The deposition of Clarence Lyons was taken on August 3, 2016. (RX 10) Mr. Lyons did not recall ever being made aware of Petitioner's injury prior to his lay off. He testified he first learned of the injury when Petitioner called him and reported he broke his hand squeezing a pair of wicker bills at the dam. He could not recall when that conversation occurred, but believed it was 4-6 weeks after the accident.

Mr. Lyons testified that he knows Petitioner personally and has worked with him on other projects. They work out of the same local in Paducah. Mr. Lyons corroborated generally the testimony of Mr. Rawls regarding the safety practices and procedures in place at Olmsted Dam, including reporting work accidents; training; and completing time cards.

Mr. Lyons testified that Petitioner never reported to him that he injured himself during the November-December period that Petitioner actually worked on the Olmsted Dam project. His time cards did not reflect an injury either. Mr. Lyons knew that Petitioner had hurt one of his hands prior to his work at Olmsted. Despite this earlier injury, Petitioner was able to complete his job duties. He and Petitioner never ate lunch together on a regular basis. Petitioner never showed him his hand to show him it was swollen.

Mr. Lyons also testified that Petitioner called him about 4-6 weeks after the accident and told him over the cell phone that he thought he "re-broke" his hand while working on the Olmsted Dam project. Petitioner told him he was squeezing a pair of wicker bills, which are like a vice grip. This was the first time he learned that Petitioner was claiming a work injury. Mr. Lyons passed along this information to Mr. Bragg and to Doug Callor.

Deposition of Glen Bragg

The deposition of Glen Bragg was taken on August 3, 2016. (RX 8) Mr. Bragg testified regarding the time card procedures and that the Petitioner never indicated on any of his time cards that he was injured. He also testified that Petitioner's work injury came to his attention for the first time when he was told about it by Clarence Lyons. Mr. Bragg could not recall when Clarence Lyons reported the injury to him. Mr. Bragg described the various safety procedures in place at Olmsted, and this included an initial all-day orientation. Also, there were daily meetings before the work begins. The workers all sign off on a job site analysis.

Regarding work accidents, the policy was that all work accidents were to be reported, first to the foreman, and then ultimately to Glenn Bragg. Even small injuries were to be reported. Mr. Bragg described the job site as extremely safe, not just lip service is paid to job safety. He was adamant how safety conscious everyone was at the Olmsted Dam project, including having popsicles to eat when it is hot outside.

Mr. Bragg testified that the workers completed daily time cards during the work day, including Petitioner. These would be signed off by supervisors and turned into payroll. The workers are instructed to indicate whether they are hurt on the job or not. If an injury occurs after the time card is completed, it can be pulled and corrected. Mr. Bragg would sign off on every time card. Petitioner's time cards do not reflect that he suffered an injury during his tenure at Olmsted Dam. No one in the iron worker's chain of command ever reported that Petitioner injured his hand, and Petitioner was able to complete all his usual work duties. Had a work injury been reported, paper work is completed and investigation occurs. A safety stand down might occur also. Mr. Bragg further testified that it was not until after Petitioner was laid off that it came to his attention that Petitioner was claiming a work injury. He heard about it from "Chick" Lyons. He is not sure when exactly he first heard about the claimed work injury.

Deposition of Dr. Lents

The deposition of Dr. Lents was taken on February 13, 2017. (PX L) Dr. Lents is a board certified orthopedic surgeon. He began treatment of Petitioner's right wrist in March of 2014. Dr. Lents was generally aware of Petitioner's presentation to the St. Francis Emergency Room and follow up with Dr. Tobin. He diagnosed Petitioner with a game keeper's thumb and scaphoid lunate disassociation, both of which he felt were consistent with Petitioner's history of squeezing with force a large vice grip.

Dr. Lents performed a proximal row carpectomy and repaired the fracture at the base of the thumb. The wound became infected so a second surgery occurred to clean out the infection and an external fixator was installed. Once the infection cleared up, Petitioner had normal progress and last saw Dr. Lents in July 2014. Petitioner had pretty good range of motion at that time, he could return as needed.

Dr. Lents, on cross-examination, identified a patient questionnaire which Petitioner completed. Petitioner indicated his condition was not work-related. Petitioner completed this form on March 24, 2014. Dr. Lents testified that he never understood the right wrist condition to be work-related. If he had known it to be such, he would have indicated it as being work-related in his treatment notes. If it is work-related, he is much more specific in his notes to document the history for later purposes, including deposition. Petitioner's chart was never marked as work-related during the entire course of treatment. Dr. Lents' office assisted Petitioner with completing a short-term disability application and it was again not reported as a work-related condition. Dr. Lents did not personally know if Petitioner was hurt at

home or at work. The history of Petitioner squeezing a vice grip device, such as a wicker bill, could produce his injury, as Petitioner represented in his short-term disability application.

The Arbitration Hearing

Petitioner's case proceeded to arbitration on May 11, 2017. Prior to the presentation of evidence, Petitioner moved, without objection, to amend his Application for Adjustment of Claim to reflect a date of accident of November 14, 2013. Petitioner's request to amend was granted and the parties submitted a Request for Hearing identifying the issues in dispute as accident, notice, medical causation, temporary total disability, medical bills and nature and extent of injury. Petitioner, his wife, and Respondent's representative at trial, Doug Callor, testified at the hearing.

Petitioner testified he was employed by Respondent as an iron worker working on the construction of a lock and dam at Olmsted when he suffered an injury on November 14, 2013. Petitioner testified that he was working with another iron worker in an attempt to clamp an 80lb. steel angle on top of the structure so that it could be welded into place. As the other iron worker held the steel angle in place the Petitioner attempted to lock a pair of spring loaded c-nose vice grips known as wicker bills into place. While attempting to squeeze handles of the wicker bills the Petitioner testified he felt a pop in his wrist with an immediate onset of pain and swelling. The incident occurred just as Petitioner was scheduled for a morning break, so he quit attempting to lock the wicker bills down and took his morning break. Petitioner finished out the work day and testified that after completing his shift he called his wife and asked her to meet him at St. Francis Hospital to have his hand evaluated.

Petitioner testified that after being discharged from the hospital he was to see Dr. Tobin the next day. However, he could not miss work the following morning, so he called and had the appointment rescheduled to December 3, 2013.

Petitioner's time sheets were admitted into evidence as Respondent's Exhibit 4 and show that Petitioner's last day on the project was December 2nd at which time Petitioner testified he was laid off from the job. On December 3, 2013 Petitioner saw Dr. Tobin for an evaluation of his right hand. Petitioner was shown the reported history and he confirmed that was indeed what he had reported to Dr. Tobin at the time of his initial evaluation.

Petitioner testified that after his appointment with Dr. Tobin on December 3rd he called his foreman, Clarence "Chick" Lyons, and reported his wrist injury and informed him he would not be available to be called back to work.

Petitioner was then referred to Dr. Lents on March 24, 2014.

Petitioner testified that he was struggling financially in early 2014 because he could not work and workers' compensation had denied his claim. He testified that at one point he actually lost his home. Petitioner testified he went to his union for financial aid and completed a disability application with the union. In the application form Petitioner admitted he reported that the accident happened while "squeezing a pair of wicker bills while building a deck" because he was in dire need of some financial relief. Petitioner explained that he was told by the union that he could not receive accident and sickness benefits if he was injured at work and that is why reported it happened at home. Petitioner denied injuring his hand at home.

Petitioner testified that he was granted short term disability; however, Petitioner eventually paid back the funds once it was clarified that his injury was work-related. Both the disability application and the letter confirming repayment of the disability benefits were admitted into evidence.

After being laid off around December 3, 2013, Petitioner went to work for KCI Construction. Petitioner worked for other contractors also until he had his surgery. After he was released back to work following his right wrist surgery, Petitioner returned to work as an iron worker. He worked for various contractors. Petitioner recently retired from iron working. He has had other health problems, including two ankle surgeries in 2012 and a double-staged low back surgery during the summer of 2016. Petitioner was also considering a left knee replacement but chose against it.

Petitioner agreed he completed a patient questionnaire for Dr. Lents that indicated his condition was not work-related. (RX. 11.) However, on redirect, Petitioner claimed that Dr. Lents knew how he had injured his right wrist. Also, the form indicated an injury date of November 25, 2013 and that it occurred while squeezing vice grips, details that Petitioner believed were consistent with his testimony.

Petitioner has taken a loan out against his worker's compensation case. He could not recall how much he took out but he still owes a balance.

On cross-examination Petitioner confirmed that he signed time cards each day and that there were no indications of an injury noted on the time cards. Petitioner also agreed that he had been through safety training and that he never sought treatment on the worksite. Petitioner explained that he was afraid to report a work injury unless he knew it was serious because he was afraid of being laid off and had seen other iron workers laid off after reporting injuries. Finally, Petitioner admitted that when he completed the intake form at Dr. Lents' office he did not check the box indicating the injury was work-related.

Petitioner testified that he has had to retire from iron working due to this injury and other unrelated injuries. Petitioner is naturally right-hand dominant, but testified that he has now been forced to rely primarily on his left hand. Petitioner has very little range of motion in his wrist. He described his range of motion being virtually non-existent with the exception of the ability to bend his wrist slightly downward. He doesn't have constant pain, although he does have pain when he uses his right hand. He reported a loss of grip strength and testified that he now chooses to carry items with his left hand. Finally, he testified that the loss of functionality of his right wrist has made it difficult to do any iron working job unless he is in a supervisory position.

Petitioner's wife was also called as a witness at trial. Mrs. Lamoureux testified that she first became aware of Petitioner's injury when she met him at St. Francis Hospital after work on November 14. She testified he went straight to the ER after work and that she had never witnessed Petitioner hurt his wrist at home. She further testified that Petitioner never worked on their deck or used a pair of wicker bills at their home.

Respondent concluded its case by calling the safety director, Doug Callor. Mr. Callor testified regarding the safety protocols at the Olmstead project and that he was not aware of Petitioner's injury until the Application for Adjustment of Claim was filed. On cross-examination Mr. Callor confirmed that the employee's duty is to report the injury to his foreman and the foreman then has the responsibility to report the injury up the chain of command.

The Arbitrator concludes:

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

Petitioner sustained an accident on November 14, 2013 that arose out of and in the course of his employment with Respondent. Petitioner was on the clock when the injury occurred and engaged in normal job duties. In finding in favor of Petitioner, the Arbitrator has considered the credibility of all the witnesses, especially Petitioner, the histories as found in the medical records, the timing of events, and company documents. While it is clear that Petitioner did not mention an accident on his time card and may not have followed company procedures for reporting an accident on the job, that does not mean he did not have an accident on November 14, 2013.

The Arbitrator finds the history provided by Petitioner at the emergency room on November 14, 2013 highly significant. Petitioner reported to the emergency room directly after his shift on November 14, 2013 where the triage notes confirm the Petitioner was injured that morning while squeezing vice grips at work. The Arbitrator gives substantial weight to these records as they were created immediately after the shift in which Plaintiff testified he was injured. Petitioner also reported the exact same mechanism of injury to Dr. Tobin three weeks later and Dr. Tobin's records directly reference the injury occurring at the Olmstead damn. These records are completely consistent with Petitioner's testimony as to how the injury occurred. It is also noted that Petitioner described the events leading up to the injury in substantial detail.

The Arbitrator found Petitioner's testimony as to why he did not want to report an accident and why he later misrepresented the cause of his injury on the accident and sickness benefits application and the patient questionnaire form for Dr. Lents very credible. Petitioner had not worked for Respondent very long before he was injured. Petitioner had significant financial issues and did not want to lose his job. Furthermore, while Respondent disputed notice (presumably based upon the lack of accident being disclosed in time cards and per safety protocol) some of Respondent's representatives, like Clarence Lyons, acknowledged that timely notice as required under the Workers' Compensation Act was provided. That notice of the accident was given bolsters Petitioner's credibility as to an accident having occurred. Furthermore, Petitioner's wife, Nena Lamoureux, provided credible testimony that Petitioner did not injure himself at home.

Clarence Lyon's testimony further supports a finding of accident as Petitioner reported to him that the injury occurred while using wicker bills at the dam 4-6 weeks earlier. There was no reference to the injury occurring anywhere other than at Olmstead Dam until months after the injury and at a time when Petitioner was experiencing severe financial hardship. Even then, Petitioner returned all of the funds he received from the accident and sickness policy on account of the injury being work-related.

The Arbitrator has also considered the fact that Petitioner originally claimed an accident date of November 20, 2013 and that he did not amend the Application until the day of arbitration. However, Petitioner did not amend his description of the accident with the description referencing the squeezing of c-clamps, which are also known as vice grips or wicker bills.

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

As to the issue of notice, the Arbitrator finds that Petitioner gave notice to his foreman, Clarence Lyons, within 45 days of the injury. Petitioner testified he called Clarence Lyons directly after his appointment with the hand specialist, Dr. Tobin, on December 3, 2013. Clarence Lyons confirmed that Petitioner reported the injury

to him about that time. No other witnesses or testimony was offered to rebut the testimony of the Petitioner and Mr. Lyons. That Mr. Callor, Respondent's safety manager, denied knowing anything about an alleged accident until Petitioner's attorney sent a letter and a copy of the Application for Adjustment of Claim to Respondent does not negate that timely notice was provided to Mr. Lyons, the person to whom Petitioner was to provide notice.

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

Petitioner failed to prove that his current condition of ill-being in his right hand is causally related to his accident of November 14, 2013. In so concluding the Arbitrator relies upon Dr. Tobin's office notes pre-dating the accident (PX D), Petitioner's failure to testify to a lack of prior right wrist/hand problems or injuries, and Mr. Lyons' testimony, to wit, that Petitioner called him and told him he had "re broke" his wrist/hand. (RX 10, pp. 27-28). Furthermore, the Arbitrator did not find Dr. Lents testimony persuasive.

The first three pages of PX D mention a left hand injury going back to January 13, 2009, a "notice of patient surgery for right wrist" on July 20, 2010, and then reference (on page 3 of PX D) to "unknown workers' compensation for right hand." Other than stating he had some billing issues with Dr. Tobin's office regarding his left hand injury, Petitioner provided no other testimony clarifying these notes, especially with regard to whether there was a prior right wrist injury of some sort. Petitioner also never testified to having no prior right hand/wrist injuries, problems, complaints or issues.

When Petitioner was seen at the ER on November 14, 2013 his right hand was swollen and he complained of pain in the area of the second and third digits. X-rays indicated degenerative changes. Petitioner was to see Dr. Tobin the next day but he didn't do so. Instead, he continued working for Respondent and waited until the day after he was laid off to present to Dr. Tobin. Petitioner's symptoms at that time were different than the ones he presented with in the emergency room. Dr. Tobin's office note references x-rays being taken and his office billed for them but an x-ray report isn't a part of the record. Dr. Tobin went on to order an MR arthrogram. As part of that procedure, an injection was given. The history portion of the report states that Petitioner has "chronic right wrist pain. Recent injury." Petitioner had also previously undergone right carpal tunnel surgery. Petitioner's arthrogram of the same day referenced not only an injury not only two months earlier but also a broken thumb. The findings discuss a possible old fracture. Dr. Tobin diagnosed Petitioner with a scapholunate ligament disruption and game-keeper's thumb. He noted that the ulnar collateral ligament to the MCP joint of the thumb looked "old." He never rendered a causation opinion in this case. Petitioner did not depose him.

Dr. Lents' deposition testimony was unpersuasive. His office notes (PX H) contain no mention or details of an accident occurring on November 14, 2013. While Dr. Lents rendered a causation opinion on Petitioner's behalf, via a deposition, he based it on the history provided to the emergency room on November 14, 2013 and presented to him on the day of the deposition. Dr. Lents was not familiar with Petitioner's prior treatment with Dr. Tobin. He did not review and compare the ER x-ray of 2013 with the one taken on December 3, 2013 by Dr. Tobin. Dr. Lents never testified within a reasonable degree of medical certainty that the condition in Petitioner's right wrist was caused by the work accident. At most, he testified it "probably could" (PX L, pp. 14, 18). Dr. Lents further acknowledged that he wasn't aware that Petitioner's injury was work-related and that Petitioner's complaints when presenting to the ER centered around the area of his knuckles while his presenting complaints to him were in the wrist. (PX L, P. 30)

While witnesses may have testified that they didn't recall Petitioner had any problems working with his right hand prior to the accident herein, Petitioner himself alluded to the fact that employees, such as himself,

didn't report every ache or pain or problem to the employer and he, himself, was glad to be working as he had financial stressors and concerns. Of great significance is the fact that Mr. Lyons' testimony that Petitioner told him he "re broke" his right hand went unrebutted and, additionally, Petitioner did not seek any treatment after November 14, 2013 until December 3, 2013 after being laid off.

There is simply too much missing information to find in favor of Petitioner herein. He didn't address any prior problems (or lack thereof), he didn't fully explain his prior problems with Dr. Tobin's office, he didn't follow up with Dr. Tobin in a timely fashion, and he failed to discuss the accident with Dr. Lents while treating with him. Petitioner failed to meet his burden of proof on causation and his claim is denied.

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?

Consistent with her causation determination, this issue is moot.

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

Consistent with her causation determination, this issue is moot.

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

Consistent with her causation determination, this issue is moot.

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

****

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Mullins,
Petitioner,

vs.

NO: 17 WC 01133

Wal-Mart Stores Inc.,
Respondent.

18IWCC0107

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 9, 2017, is hereby affirmed and adopted.

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

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

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

DATED: FEB 22 2018
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DLG/mw
045

David L. Gore

Stephen Mathis

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MULLINS, MICHAEL
Employee/Petitioner

Case# **17WC001133**

WAL-MART STORES INC
Employer/Respondent

18IWCC0107

On 8/9/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1937 TUGGLE SCHIRO LICHTENBERGER
NICHOLAS M SCHIRO
510 N VERMILION ST
DANVILLE, IL 61832

5074 QUINTAIROS PRIETO WOOD & BOYER
CAROL CESARETTI
233 S WACKER DR 70TH FL
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Michael Mullins
Employee/Petitioner

v.

Wal-Mart Stores, Inc.
Employer/Respondent

Case # ~~17~~ WC 001133

18IWCC0107

An *Application for Adjustment 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 **Chicago**, Illinois on **05/01/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0107

FINDINGS

On the date of accident, 12/17/16, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned $22,022.00 ; the average weekly wage was $423.50.

On the date of accident, Petitioner was 56 years of age, *married* with 0 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 $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $3,571.43 for other benefits under Section 8(j), for a total credit of $3,571.43.

Respondent is entitled to an additional credit of $17,977.78 under Section 8(j) of the Act for medical.

ORDER

Because Petitioner failed to meet his burden of proof as to accident and causal connection, 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.

Edward Lee

Signature of Arbitrator

8/3/17

Date

ICArbDec19(b)

AUG 9 - 2017

FINDINGS OF FACT

18IWCC0107

Petitioner, Michael A. Mullins, testified that he was an employee of Wal-Mart Stores, Inc. on December 17, 2016. (T. 9; T. 31). He had worked for Wal-Mart Stores, Inc. as a third-shift maintenance worker since June of 2009 (T. 9; T. 31). Petitioner testified that his shift was from 10:00 p.m. to 6:00 a.m. (T. 11).

Petitioner testified that he fell by his truck the morning of December 17, 2016 (T. 12). He further testified that he clocked out early to go home and salt the driveway before his wife left for work that morning rather than finishing his regular shift. (T. 21). Petitioner testified that he clocked out of work at approximately 4:40 a.m. (T 13). On cross examination, Petitioner testified that after he clocked out, he went to the front of the store and started his car (T.44). Once he saw his car start, he came back into the store to do some personal shopping (T. 38; T. 44). Petitioner testified that he shopped around the store for ice melt, ham, and beans (T. 44). Petitioner further testified that after he checked out at the register, he went back to his car and loaded his personal groceries into his car (T.44). Petitioner testified that he believed he fell when he tried to get back into his car (T.44). Upon questioning by the Arbitrator as to the conditions of the parking lot, Petitioner testified that the lot was covered in ice (T. 18). Upon further prompting by his attorney, Petitioner testified that the parking lot was slick with ice (T. 18).

Petitioner testified that the parking lot outside of Wal-Mart is one big parking lot (T. 34). There is a gas station to the west of the store (T. 34). Petitioner further testified that Wal-Mart Associates were instructed to park on the east side of the parking lot or they would be "written up" (T. 8-9). Petitioner admitted on cross-examination that there were no signs nor was the east side of the lot roped off to prohibit customers from parking in the east side of the lot (T. 32-33). Petitioner further admitted that customers could park on the east side of the lot (T. 32-33). Petitioner admitted on cross-examination that "any member of the public at all could park" on the east side of the parking lot and any other part of the Wal-Mart parking lot. (T.32-33). Petitioner further testified that he did not have to park in the same spot every time he went to work and this was because a customer might be in his spot (T. 36). Petitioner testified that both employees and patrons walked across the same path to get to the front of the store (T. 36).

After he fell, Petitioner testified that he was in so much pain that he went straight to the Presence Hospital (T. 16; T.19). He stated that he did not go home (T. 20). Petitioner testified he is right hand dominant. (T. 28). Petitioner testified that when he arrived at the hospital, he was treated by the triage nurses (T.20). He stated that he told them he was walking to his truck and he had fallen on ice (T.21). Petitioner testified that he eventually spoke with a doctor (T. 21). Petitioner testified that he did not tell the doctor that he injured his shoulder while salting the driveway. (T. 21; Petitioner's Ex. 1; Respondent's Ex. 1). The Emergency Room doctor relocated his shoulder (T. 23). He further testified that there was no talk of surgery after this visit. (T. 43). He testified that his shoulder was no longer dislocated after the doctor relocated it (T. 42). He testified the doctor then put him in a "total shoulder immobilizer" and advised him to

follow up with his orthopedic doctor (T. 23-24). Petitioner testified and the records reflect that surgery was never considered at this visit (T. 43; Petitioner's Exhibit 1; Respondent's Exhibit 1).

Petitioner testified that he went back to the Emergency Room on December 21, 2016 because he dislocated his shoulder again while sleeping in the recliner. (T. 25). He testified that he was wearing his immobilizer and had not removed it since December 17, 2016 (T. 25). He stated that he just woke up "in intense pain." (T.25). The records submitted at trial reflect that Petitioner did not see his doctor on any of the four days between his initial December 17, 2016 visit and his subsequent December 21, 2016 visit (Respondent's Exhibit 1; Respondent's Exhibit 6).

Petitioner testified that on December 21, 2016, the doctor put his shoulder back in place and he was again advised to follow up with his orthopedic doctor (T25-26). Petitioner testified that he saw Dr. Packard on December 21, 2017, who referred him to Dr. Robert Gurtler of Carle Orthopedics because he was retiring. (T. 26). The records submitted at trial reflect that Petitioner did not see Dr. Gurtler until January 19, 2017. (Respondent's Ex. 6).

Petitioner testified that he never injured his shoulder prior to his alleged December 17, 2016 accident. (T. 42). He further testified that he had never had any treatment done to his right shoulder prior to his alleged December 17, 2016 accident. (T. 17).

When Petitioner presented to Dr. Gurtler on January 19, 2017, he examined Petitioner's right shoulder. Respondent's Ex. 6). Upon examination of Petitioner's right shoulder, Dr. Gurtler reported "certainly we can see the old surgery he had" (Respondent's Ex. 6).

Dr. Gurtler suggested that Petitioner have an MRI done to determine whether Petitioner tore his rotator cuff when he dislocated his shoulder on December 21, 2017 (Respondent's Ex. 7). Mr. Mullins did not have his MRI done until January 30, 2017 (Petitioner's Ex. 7). Petitioner testified Dr. Gurtler performed surgery on his right shoulder on March 3, 2017. (T. 27). Dr. Gurtler reported that massive rotator cuff tears are very common in individuals of Petitioner's age. (Respondent's Ex. 7)

Petitioner testified that he did not return to work after his alleged accident. (T. 28). He further testified that he has not been to work since his surgery. (T. 27). Petitioner stated that he has been receiving short-term disability while he has been off work. (T. 28). Petitioner testified that group insurance has paid his medical expenses. (T. 29).

When asked about his prior medical history, Petitioner testified that he had never fallen in the past. (T.40). He stated he would have been able to remember if he had fallen in the past. (T. 46). The records submitted at trial reflect that Petitioner does have a history of falls (Respondent's Ex. 1; Respondent's Ex. 2; Respondent's Ex. 5). On August 12, 2009. Petitioner presented to Danville Polyclinic and reported he fell on his deck "on Sunday night." Petitioner

returned to Dr. Naveed Sadiq at Danville Polyclinic on February 8, 2011 complaining that he slipped and fell on ice (Respondent's Ex. 5).

Petitioner testified that he had a history of ear surgery (T. 41). He further testified that he had never been diagnosed with syncope (R. 40). The records submitted at trial reflect that Petitioner has a history of blood pressure problems and has been diagnosed with Syncope (Respondent's Ex. 3; Respondent's Ex. 4). It was established on cross-examination of Petitioner that he understood syncope to be when an individual has a history of falling/falls and is unable remember what happened. (T. 40). On cross-examination, Petitioner testified that he is not a smoker and that he has never smoked (T. 40-41). Petitioner's medical records indicate that he smokes and smokes a half a pack of cigarettes per day (Respondent's Ex. 1).

Petitioner further testified that he has not returned back to work in any capacity and that he is limited in doing certain daily activities. He stated that his shoulder is very painful and continues to have a lot of pain (T. 23). The Arbitrator was able to observe the Petitioner use his right arm during the trial and notes that Petitioner was able to quickly raise his right arm without issue to be sworn in at hearing. The Arbitrator further observed Petitioner take off and adjust his glasses multiple times throughout trial, moving his right shoulder.

The Arbitrator acknowledges that Petitioner testified that he was honest and truthful with his doctors, that he told them all of his symptoms because he wanted to get better (T. 41-42).

CONCLUSIONS OF LAW

In support of the Arbitrator's Decision as to C. WHETHER PETITIONER SUFFERED AN ACCIDENTAL INJURY ARISING OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH RESPONDENT the Arbitrator finds the following:

Petitioner failed to meet the burden of proof necessary to show that he suffered accidental injuries that arose out of and in the course of his employment with Respondent. It is the petitioner's burden to prove to the Arbitrator through sufficient evidence that he suffered a work-related injury. The Arbitrator finds that Petitioner has failed to provide sufficient evidence to establish that he suffered an accidental injury that arose out of and in the course of his employment on December 17, 2016.

Petitioner testified that he is right hand dominant (T. 28). He stated he clocked out of work early the morning of December 17, 2016 to go home and salt his driveway before his wife left for work (T. 21). He further testified that after he clocked out he went to the front of the store to start his car. Once he saw that his car was started, Petitioner went back into the store to shop for personal items (T. 38; T. 44). Petitioner stated that he bought ice melt, ham, and beans. Petitioner testified he fell trying to get into the car after he had loaded his personal groceries into

his truck (T. 45). Petitioner testified that he was in "so much pain that he thought he broke his shoulder" (T. 16; T. 19).

Petitioner testified that he was seen by an emergency room doctor. The Emergency Room Physician Report indicates that Petitioner gave a history of his accident. He reported he was salting his driveway at home when he fell on his right shoulder (Respondent's Ex. 1).

This Arbitrator is to place significant weight on the histories provided in the initial medical treatment records. See *Sleeter v. Industrial Comm'n*, 805 N.E.2d 1227 (4th Dist. 2004) (The Commission found claimant's testimony at hearing grossly inconsistent with the more trustworthy contemporaneous medical histories.)

The Arbitrator finds that Petitioner's testimony is inconsistent with the medical records and finds this Petitioner not credible. Petitioner's medical records establish that he has a history of falls and syncope, despite his testimony the contrary (T. 40). Petitioner further testified that he was not a smoker (T.40) . Petitioner's December 21, 2016 Emergency Room records indicate that he is a smoker and smokes about half-a-pack of cigarettes per day (Respondent's Ex. 1). Petitioner further testified that he had never fallen prior to December 17, 2016 (T. 40; T. 46). However, Petitioner's lengthy medical treatment records indicate he does have a history of falling. (Respondent's Ex's 1-5).

Moreover Petitioner testified that he had never injured his right shoulder prior to December 17, 2016 (T. 17; T. 18; T. 42). He further testified that he never had any treatment done to his right shoulder prior to December 17, 2016 (T. 17). However, upon examination of Petitioner's right shoulder at his initial doctor's visit, Dr. Robert Gurtler reported that "certainly we can see where he had his old surgery" (Respondent's Ex. 6).

When asked how he fell on December 17, 2016, Petitioner was incapable of giving a thorough narrative of what happened and stated he does not "remember it real well" (T. 12). Petitioner did not indicate that he remembered slipping on ice outside of his truck. He only testified to the general condition of the parking lot on the morning of December 17, 2016. Further it was not until Petitioner was prompted by his attorney that he described the lot as icy (T. 18).

For the foregoing reasons, the Arbitrator cannot conclude that this Petitioner met his burden of proving that he actually fell on ice in the parking lot of his employer on December 17, 2016.

Even if the Arbitrator were to believe that Petitioner fell on ice in the parking lot, Petitioner failed to meet his burden of proof that his fall arose out of and in the course of employment. Petitioner alleges that he fell in the parking lot near his employer Wal-Mart following icy weather. The Appellate Court has already determined that a similar fall by a Wal-Mart employee in an icy parking lot is not compensable under the Act. Petitioner has provided

no evidence that would convince this Arbitrator to sway from the Court's previous findings in *Wal-Mart Stores, Inc. v. Industrial Commission*, 326 Ill. App.3d 438 (4th Dist. 2001), which is analogous to the matter at hand. Both petitioners fell in a parking lot utilized by both Wal-Mart patrons and employees. In *Wal-Mart*, the petitioner, a Wal-Mart Associate, clocked out for her meal break and slipped and fell on ice on her way out to the car. *326 Ill.App.3d* at 440. The Wal-Mart parking lot was covered with ice as a result of an ice storm. *Id.* at 443. The parking lot in question was the only parking lot provided by Wal-Mart. *Id.* at 443. The parking lot was used by both employees and patrons. *Id.* at 443. Wal-Mart employees were requested to park on the south side of the lot. *Id.* at 443. The south side of the lot, however, was not restricted from patron use. *Id.* at 443.

The Court found that the purpose of the Act is to protect employees against hazards and risks that are peculiar to the nature of the work they do. *Id.* at 444. To arise out of one's employment, an injury must (1) have an origin of some risk connected with or incidental to the employment; or (2) be caused by some risk to which the employee is exposed to a greater degree than the general public by virtue of his employment. *Wal-Mart*, 326 Ill.App.3d at 444. Typically, an injury arises out of employment if, at the time of the occurrence, the employee was performing an act that he or she was instructed by the employer to perform, an act that he had a common-law duty or statutory duty to perform, or an act that might reasonably be expected to perform incident to assigned duties. *Id.* at 444. The *Wal-Mart* Court concluded that the mere fact that the duties take the employee to the place of injury and that but for the employment, the employee would not have been there, is not sufficient to give rise to compensation. *Id.* at 444. The Court further concluded that it was clear the entire Wal-Mart parking lot was available for use by both patrons and employees and Petitioner's fall resulted from a hazard to which she and the general public were equally exposed. Thus her injury did not arise out of her employment. *Id.* at 445.

Here, just as in *Wal-Mart*, Petitioner allegedly fell in a parking lot open to both employees and patrons, after he had clocked out. In both cases, there was ice present in the parking lot. Petitioner in this case testified that patrons were able to park anywhere (T.33). Petitioner in this case testified that Wal-Mart patrons could park next to him and even in the spot he was parked in (T. 32-33). Petitioner testified that Wal-Mart was open for the public to shop in that morning (T. 35). Petitioner, just like the claimant in *Wal-Mart*, was subject to the same icy parking conditions as Wal-Mart patrons. Petitioner, just like the claimant in *Wal-Mart*, was off-the-clock when he fell. He testified that he fell after he loaded his personal groceries into his car (T. 45). After he clocked out, Petitioner went to the front of the store and started his car (T. 44). He then came back into the store, freely chose to shop after he clocked out of his shift, freely purchased items from Wal-Mart, and subsequently loaded these personal items into his car (T. 44-45). These actions do not correlate to any duty to his employer nor was it a common-law or statutory duty to be performed. Petitioner allegedly falling after he had shopped around, purchased personal items, and loaded these items into his car was not incident to any duty

assigned by Wal-Mart. Instead, Petitioner's actions subsequent to him clocking out further establish that he was at no greater risk than other Wal-Mart patrons. Further, this Arbitrator cannot even conclude in this case that Petitioner was in the parking lot because his employment placed him there. This was not the beginning or end of a shift or a scheduled lunch break. This was Petitioner's personal choice to leave work early in the ice storm to salt the driveway for his wife, purchase salt and food for personal use, and go into the parking lot. Petitioner's risk, therefore, was not related to his employment but instead completely personal, one which any patron of Wal-Mart Stores was and could have been exposed to the morning of December 17, 2016. *See Noonan v. Illinois Workers' Compensation Commission*, 65 N.E. 530 (The Court finding that injuries from a personal risk are not compensable).

Similarly, the Court in *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill2d 52 (1989), determined, much like the *Wal-Mart* Court, that an employee's injury from tripping on a curb in his employer's parking lot was not compensable simply because the employee traversed to and from a parking lot where he was instructed to park. 129 Ill. 2d at 63-64. In *Caterpillar*, Petitioner twisted his ankle when he stepped off of a curb walking to his car, which was located in an employee parking lot. The curb he twisted his ankle on was part of the blacktop driveway utilized by both employees and by the general public to pick up employees.

The *Wal-Mart* and *Caterpillar* Courts clearly found the determining factor to be the public access to the particular parking lot involved and Petitioner in the case at hand testified to similar public access to all parts of the Wal-Mart parking lot.

At trial Petitioner attempted to establish that after shopping he returned to the same walking route he would have returned to if he had not shopped after he clocked out (T. 14-15). The Arbitrator finds that whether Petitioner may have made a reasonable detour and returned to his route is irrelevant. Further, the Arbitrator finds that if Petitioner had not shopped he would have had no extra items to load into the truck before getting into the truck. He testified that he had loaded the items then fell trying to get into his truck. The extra step in loading the items is not one that he would have taken returning to his vehicle from his shift and was a personal one.

The Court has awarded benefits for a detour for a clocked out employee by determining that the employee was exposed to the same risks whether he had taken the detour or not. See *Hiram Walker & Sons, Inc. v. Industrial Commission*, 41 Ill.2d 429 (1968). However, in *Hiram Walker* the Petitioner, unlike Petitioner in this case, was in a company controlled lot, with no indication that the general public had access to the lot or was exposed to the risk. Moreover, the Court in *Hiram Walker* found it significant that Petitioner fell *at about the time at which he had customarily checked in for work* the morning of his accident (Emphasis Added). *Hiram Walker*, 41 Ill.2d at 431. In the case at hand, Petitioner chose to clock out early that morning to go home and salt the driveway for his wife. Petitioner's employment is not what placed him in the parking lot at 4:40 a.m. the morning of December 17, 2016 - Petitioner freely chose to clock out early during icy weather and purchase ice melt to salt his driveway. Unlike in *Hiram Walker*,

Petitioner did not allegedly fall at a time during a normal beginning or end of his shift at a time where he would customarily be going to or coming from his work. The sole purpose of his existence in the lot at that particular time was a personal one.

Even assuming that this Arbitrator finds that Petitioner proved an accident that arose out of his employment, Petitioner failed to meet the burden of proof necessary to prove that his alleged fall occurred in the course of his employment. "In the course" refers to the time, place, and circumstances under which the accident occurred. *Wal-Mart,* 326 Ill.App.3d at 444; *Illinois Consolidated,* 314 Ill.App.3d at 349. An injury occurs in the course of employment when it occurs during one's employment and at a place where the claimant may reasonably perform employment duties, and while a claimant fulfills those duties or engages in some incidental employment duties. *Mores-Harvey v. Industrial Comm'n,* 345 Ill.App.3d 1034, 1037 (2004).

Mores-Harvey is distinguishable from this case because, unlike this Petitioner, the Petitioner in *Mores-Harvey* established that she understood that her employer maintained the parking lot and she was directed to park in the lot behind the restaurant so that customers could park in the front. *Mores-Harvey,* 345 Ill.App.3d at 1036. Unlike the petitioner in *Mores-Harvey,* Petitioner failed to establish that his parking spot placed him further from the store nor did he establish he was told to park there to make it easier for customers. The Arbitrator can reasonably conclude that his spot placed him closer to the door than many other spots in the lot as he testified he was capable of seeing his car remotely start from the front of the store. Further and more importantly, there is nothing in the record that indicates Wal-Mart even controls, owns, or maintains the lot. Petitioner, a maintenance worker since 2009, did not testify whether this lot was solely a lot for the use of Wal-Mart employees and customers or whether or not this store was associated with a strip mall or other connected business. Unlike the Petitioner in *Mores-Harvey*, he provided no evidence at hearing that he believed or had knowledge that Wal-Mart controlled or maintained the parking lot which was the primary basis for the recovery in *Mores-Harvey* - the theory of liability for an injury on the employer's premises.

For the foregoing reasons, the Arbitrator finds Petitioner has failed to meet his burden of proof on accident and that even if he did fall while getting into his vehicle, it did not constitute an accident which arose out of and in the course of his employment with Wal-Mart Stores.

In support of the Arbitrator's Decision as to F. WHETHER PETITIONER'S CURRENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY, the Arbitrator finds the following:

Assuming that this Arbitrator were to find that Petitioner met his burden of proof to establish an accident, this Arbitrator finds that Petitioner failed to meet the burden of proof that his current condition is causally related to the accident. To obtain compensation under the Workers' Compensation Act, the petitioner has the burden of proving that some act or phase of his employment was a causative factor in ensuing injury. *Vogel v. Industrial Comm'n,* 354

Ill.App.3d 780, 786 (2005). For an injury to arise out of one's employment its origin must be in some risk connected with or incidental to the employment so as to crease a causal connection between the employment and the accidental injury. *Caterpillar*, 129 Ill.2d at 58.

The Arbitrator notes that Petitioner testified that he was honest and truth with his doctors, that he wanted to get better (T.41). The records submitted at trial indicate that it was not until a month after Petitioner's alleged accident date that surgery was even a consideration. Further in his January 24, 2017 Doctor's note, Dr. Gurtler relates his subsequent surgery to Petitioner's December 21, 2016 accident and not the alleged December 17, 2016 accident. Petitioner testified that there was no discussion of surgery after he went to the emergency room on December 17, 2016 and surgery is not mentioned in the medical records on this date.

Petitioner first went to Presence United Samaritan Hospital's Emergency Room the morning of December 17, 2016. (T. 19; Respondent's Ex. 1). Petitioner was diagnosed with a shoulder dislocation and advised to follow up with his orthopedic doctor (T. 23-24; Respondent's Ex. 1)

Petitioner testified that four days later, on December 21, 2016, he dislocated his shoulder again at home (T. 24). Petitioner testified that he re-dislocated his shoulder while he was asleep in his recliner chair (T. 25). He stated that while he was asleep, he wore his immobilizer, which restricted his arm from moving (T. 25). Petitioner further stated that his immobilizer was not off and he just suddenly woke up in a lot of pain (T. 25). Petitioner then went back to the E.R. on December 21, 2016 (T. 25-26; Respondent's Ex. 1). The doctor's reduced his arm again.

On January 19, 2017, Dr. Gurtler examined Petitioner's right shoulder and reviewed Petitioner's x-rays. Dr. Gurtler stated that "certainly we can see the old surgery he had" (Respondent's Ex. 7).This is in direct contrast to Petitioner's testimony in which he testified that he had never had a prior right shoulder injury before (T. 17; T.42).

On January 24, 2017, Dr. Gurtler reported that he was very suspicious of a massive rotator cuff tear, but we would need an MRI to tell whether that is *what happened to his shoulder on December 21, 2016 with his dislocation* (Emphasis added) (Respondent's Ex. 7). Petitioner testified that he subsequently underwent right shoulder surgery (T. 27).

The medical records further reflect that Petitioner has a history of hypertension and blood pressure problems and that Petitioner had previously been diagnosed with syncope (Respondent's Ex's 2-5). The records also indicate that Petitioner has had two prior fall incidents leading to medical care (Respondent's Ex. 2 & 5). The Arbitrator finds that the records at trial clearly establish that Petitioner has a history of falls and a history of syncope in relation to his medical history despite his denial of having any history of falling at hearing and reiterating that denial on redirect. The Arbitrator finds that he cannot rely on Petitioner's testimony that he had no prior right shoulder treatment any more than he can rely on his testimony as to his other prior

medical issues. The record is certainly suggestive to this Arbitrator that Petitioner may not have been straightforward about a prior right shoulder treatment.

It is the burden of the Petitioner to prove that his current condition of ill-being and the surgery he underwent and is claiming at hearing is related to this alleged accident. The Petitioner has provided no evidence to this Arbitrator that any physician ever opined that the December 21, 2016 re-dislocation was in any way related to his December 17, 2016 dislocation. The Petitioner provided no evidence or explanation as to the extent of any prior right shoulder. He merely denied it which is inconsistent with the records and is not the only inconsistency between his testimony and the records. The medical treatment records indicate the referral for the MRI was due to the second dislocation, December 21, 2016, not the first dislocation. Further, Petitioner's own treating physician noted that the surgery discussion was due to the second dislocation which there is no dispute occurred at home and not the first dislocation which Petitioner is attempting to link to his alleged accident. In fact, the treating physician specifically notes that the first dislocation would *not* have resulted in surgical intervention. The treating surgeon further noted that massive rotator cuff tears were not uncommon for Petitioner's age suggesting that the tear itself may have been age-related.

Petitioner had the burden overcoming these issues and proving that this tear and resulting surgery, as well as his current condition, are related to the original dislocation and not the subsequent dislocation or a degenerative condition.

For the foregoing reasons, the Arbitrator finds that Petitioner has not met his burden of proving that his current condition is causally related to the an accident on December 17, 2016 even if an accident occurred.

In support of the Arbitrator's Decision as to J. WHAT AMOUNT OF REASONABLE AND NECESSARY MEDICAL EXPENSES SHOULD BE AWARDED, the Arbitrator finds the following:

Because Petitioner failed to meet his burden of proof as to accident and causal connection, the Arbitrator finds that all medical benefits are denied.

Even if this Arbitrator were to somehow rectify Petitioner's inconsistent testimony with the medical records, Petitioner's surgery and treatment subsequent to his March 6, 2017 surgery are not related to Petitioner's alleged December 17, 2016 accident. Rather, it was noted to be related to the December 21, 2016 dislocation or due to an age-related tear. The medical treatment records specifically indicate that surgery would not have been a consideration following the first dislocation.

Thus, even if this Arbitrator were to find Petitioner's December 17, 2016 accident to be compensable, the only medical expenses awarded that could possibly be awarded are the medical expenses pertaining to his December 17, 2016 Emergency Room visit at Presence United

Hospital. Petitioner has not met his burden of proof with regard to any other medical expenses. Nothing in evidence, as this Arbitrator has determined, relates Petitioner's current condition or the surgery he underwent, to December 17, 2016.

Per stipulation of the parties, and as shown in Respondent's Ex. 8, the Arbitrator acknowledges that if medical expenses were awarded to the Petitioner, Respondent will be entitled to an 8(j) credit in the amount of $17,977.78 plus adjustments under the Blue Cross Blue Shield Group Insurance Payment plan.

In support of the Arbitrator's Decision as to K. WHETHER ANY PROSEPCTIVE MEDICAL SHOULD BE AWARDED, the Arbitrator finds the following:

Because Petitioner failed to meet his burden of proof as to accident and causal connection, the Arbitrator finds that the issue of prospective medical is moot. Should, however, the Arbitrator find Petitioner met his burden on all prior issues, Petitioner failed to provide any evidence that Petitioner is in need of prospective medical treatment. The Arbitrator finds that Petitioner's current condition of ill-being does not relate to the alleged December 17, 2016 accident. The Arbitrator further recognizes that Petitioner's orthopedic doctor related Petitioner's need for surgery and now the need for prospective medical treatment to the December 21, 2016 dislocation. Moreover, Petitioner failed to provide evidence at trial that he is in need of prospective medical treatment in relation to his December 17, 2016 accident.

For the foregoing reasons, the Arbitrator finds that Petitioner failed to prove that he is entitled to prospective medical and therefore denies any and all prospective medical treatment.

In support of the Arbitrator's Decision as to L. WHAT AMOUNT OF TEMPORARY TOTAL DISABILITY EXPENSES SHOULD BE AWARDED, the Arbitrator finds the following:

Because Petitioner failed to meet his burden of proof as to accident and causal connection, the Arbitrator finds that all temporary total disability benefits are denied.

Even if this Arbitrator were to consider entitlement to temporary total disability benefits, Petitioner has failed to provide any evidence that due to his alleged December 17, 2016 work he was placed off work (T. 24). Petitioner failed to provide evidence such as office notes or a work status slip that established his off-work status. Instead, Petitioner merely testified that he has not returned to work since his alleged accident (T. 24).

It is Petitioner's responsibility to produce evidence to support an award of TTD. See *Paule v. Schnucks*, 14 IWCC 0485. The Commission has found that TTD should not be awarded when no off work slips are issue and when there is no medical testimony that Petitioner is temporarily totally disabled from all employment (Emphasis added). See *Martinez v. Alternative Staffing*, 14 IWCC 14.

Even if the Arbitrator were to find in favor of the Petitioner as to liability, the Arbitrator finds that Petitioner has failed to provide any documentation or off-work slips that prove he is entitled to TTD. The Arbitrator is not persuaded by Petitioner's testimony alone regarding work status, specifically given that Petitioner has been found to not credible in his prior testimony. Therefore, the Arbitrator finds that all total disability benefits are denied.

The Arbitrator acknowledges that if an award of TTD were rendered, the Respondent is entitled to a credit of $3,571.43 for short term disability benefits paid.

In support of the Arbitrator's Decision as to M. WHETHER PENALTIES OR FEES SHOULD BE IMPOSED UPON RESPONDENT. the Arbitrator finds the following:

Because the Arbitrator has denied all benefits, all penalties and attorney fees under Section 19(k), 19(l), and 16 of the Act are denied.

Even if the Arbitrator were to award benefits in this case, the Arbitrator finds that penalties and fees are not warranted. Respondent did not act in an unreasonable or vexatious manner with regard to denial of benefits. There is significant evidence in the Record that supports Respondent's initial denial of benefit.

The Arbitrator acknowledges that nowhere in Petitioner's initial emergency room reports does it indicate he was injured at work lot. Instead, the triage notes state he fell while walking to his truck and the Emergency Room Physician's report states that Petitioner fell while salting his driveway (Respondent's Ex. 1).

Petitioner's subsequent emergency room records form December 21, 2016 relate his condition to his injury that occurred at home. They mention the prior dislocation but do not indicate that it occurred at work or in a parking lot. Petitioner's doctor visit notes and MRI from Dr. Robert Gurtler further relate his condition to Petitioner's December 21, 2016 accident at home and not the alleged December 17, 2016 accident. They further state that it was the second, not the first, dislocation that actually led to the surgery recommendation.

Further, the Petitioner provided no evidence at hearing that off work status slips or medical expenses were ever submitted to the attorney or carrier prior to the hearing. The Petitioner is required under the Act to make a written request for benefits and the record contains no evidence that Petitioner made a written request or provided the Respondent with any evidence that would support a demand for benefits was made.

For the foregoing reasons, this Arbitrator finds that penalties and attorney fees under Section 19(k), 19(l), and Section 16 are not warranted and therefore shall not be imposed on Respondent.

In support of the Arbitrator's Decision as to Sections N and O. WHAT AMOUNT OF CREDIT FROM SHORT TERM DISABILITY AND GROUP INSURANCE PAYMENTS SHOULD BE DUE TO RESPONDENT, the Arbitrator finds the following:

Petitioner testified that since his alleged accident, he has received short term disability benefits (T. 28). Respondent has provided proof, and Petitioner agrees, that Respondent is entitled to $3,571.43 in credit. For the foregoing reasons, Respondent is entitled to $3571.43 in credit for the short term disability payments made.

Per stipulation of the parties, and as shown in Respondent's Ex. 8, the Arbitrator acknowledges that if medical expenses are awarded to the Petitioner, Respondent will be entitled to an 8(j) credit in the amount of $17,977.78 plus adjustments under the Blue Cross Blue Shield Group Insurance Payment plan.

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

Salvador Larios,

Petitioner,

vs. NO: 16 WC 11980

Hayes Mechanical/PMC,

Respondent.

18IWCC0108

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 9, 2017, is hereby affirmed and adopted.

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

18IWCC0108

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 22 2018
o020818
DLG/mw
045

David L. Gore

Stephen Mathis

Deborah Simpson

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

LARIOS, SALVADOR
Employee/Petitioner

Case# **16WC011980**

HAYES MECHANICAL/PMC
Employer/Respondent

18IWCC0108

On 5/9/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

3067 KIRKPATRICK LAW OFFICES PC
ERIC KIRKPATRICK
#3 EXECUTIVE WOOD CT SUITE 100
BELLEVILLE, IL 62226

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

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)

Salvador Larios
Employee/Petitioner

v.

Hayes Mechanical/PMC
Employer/Respondent

Case # **16** WC **11980**

Consolidated cases: **N/A**

18IWCC0108

An *Application for Adjustment 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 29, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What 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 _____

18IWCC0108

FINDINGS

On the date of accident, **March 12, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

Per the stipulation of the parties, the average weekly wage was **$2,600.00**.

On the date of accident, Petitioner was **41** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

Petitioner has failed to meet his burden of proving that he is entitled to temporary total disability benefits for the timeframe of March 18, 2106 through March 29, 2017. As such, Petitioner's request for temporary total disability benefits 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.

Melinda M. Pope-Sullivan
Signature of Arbitrator

5/3/17
Date

MAY 9 - 2017

ICArbDec19(b)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Salvador Larios
Employee/Petitioner

Case # 16 WC 11980

v.

Consolidated cases: N/A

Hayes Mechanical/PMC
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The transcript of the deposition of Petitioner Salvador Larios taken on February 15, 2017 was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Petitioner testified that he currently lives in Washington State and is a boilermaker and welder. He testified that as a boilermaker, he works out of union halls and travels various places across the country. (PX1).

Petitioner testified that on March 12, 2016 he was working for Respondent Hayes Mechanical/PMC. He testified that they were working in a power plant inside the boiler. He testified that they were working in a confined space and were working on their knees. He testified that they were using air bags, which were placed inside tubes and sprayed. He testified that the air bags weighed 45-50 pounds. He testified that it was overhead work and that when he grabbed an air bag to shove it in, the air bag did not want to go in and that he felt pain in his right shoulder as he was pushing the air bag through. He testified that after the accident he told his foreman, who took him to the supervisors and safety personnel. He testified that John Bush, the "safety guy," took him to the hospital. (PX1).

Petitioner testified that his shoulder was swollen and that he was told he would have to wait until the swelling went down, and that he again returned to the doctor and underwent an x-ray. He testified that he was then told to undergo an MRI, to take his medications and not use his right hand. He testified that with these restrictions, he returned back to work and was told that he had to sit in the break room all day every day. He testified that he was in the break room for approximately one week and that he was being paid to sit in the break room. He testified that Respondent then started laying off people. He testified that John Bush and his union steward, "Little Arkie," told him that he was going to be laid off. He testified that he was told that they were working on arranging the MRI and that they were going to try to set it up in Washington in case he needed surgery and that they would send him his layoff paper and last check. He testified that he was "pretty sure" they were going to lay him off on Thursday or Friday. (PX1).

Petitioner testified that he asked Mr. Bush and "Arkie" that since they were going to lay him off the following day, whether they minded if he took off on Wednesday. He testified that he was told that they did not mind that and that he could take off, and that they were going to set up his MRI in Washington. He testified that this occurred on a Wednesday at approximately 12-1 p.m., and that "Arkie" picked him up from the break room, drove him to the gate and told him that he promised that he was going to get his checks and layoff paper. He testified that he was still waiting for the MRI. He testified

that his last day was a Wednesday. He testified that he was mailed his paycheck, but that he was never mailed his layoff sheet. (PX1).

Petitioner testified that he contacted Mr. Bush and his union steward after he returned to Washington. He testified that the first two times they answered the phone and told him that they were working on it. He testified that when he continued calling, they stopped answering his calls so he stopped calling. He testified that he last spoke with Mr. Bush and his union steward about one week after he arrived in Washington. He testified that while in the break room, he was doing absolutely nothing. He testified that he was told that he could not go in the plant and that he had to stay in the break room. He testified that he did not try to set up an MRI on his own but that he did try to go to a clinic. He testified that he was told that the visit was not approved and that he had tried multiple times to get in to see a doctor. He testified that he was recently able to get approval to see a doctor and was had an appointment on March 10th. (PX1).

Petitioner testified that he was never sent any workers' compensation checks and that he ended up applying for unemployment. He testified that he applied for unemployment about two months after he saw that he was not being sent any money and he was behind on his bills. He testified that he received unemployment and that he would not have gotten benefits if he would have quit his job. He testified that he never quit his job in Illinois and that he was told he was going to be laid off. He testified that since he returned to Washington, he has not worked. (PX1).

Petitioner testified that he is still having problems with his shoulder. He testified that he is still in pain and takes medications including Tylenol and Ibuprofen. He testified that he cannot raise up his right arm and twist it, that he gets a sharp pain and that he cannot move his right shoulder high. He testified that if he tries to reach behind his back, it "crack[s]" and makes a noise. He testified that it is difficult to go to the restroom. He testified that his shoulder has not improved since he returned to Washington and that he is still in pain, but that the swelling has gone down some. He testified that as a boilermaker he is required to crawl in holes, climb ladders and use his right hand all the time. He testified that he has been a boilermaker for nine years. (PX1).

Petitioner testified that he has worked various jobs over the last nine years exclusively out of union halls and that he is familiar with union contracts for boilermakers. He testified that he was not allowed to be sent out of the union hall to work as a boilermaker if he had any restrictions. He testified that in the contracts he was required to answer a question about whether he had any injury and that he could not be sent for work if he was hurt or had any restrictions. He testified that he would not be able to do his job with restrictions of using only one arm. (PX1).

On cross examination, Petitioner testified that there were tools that could be handled with just the left arm or hand, but that there were also tools that were very heavy. He testified that he did not know the real name of "Little Arkie" but that he was the union steward. He testified that when he was laid off in the past with other employers, he had always received a layoff slip or paper from payroll. He testified that he did not speak with anyone else besides Mr. Bush and "Little Arkie" about being laid off, and that for every job he had had, the steward was the one that laid him off. (PX1).

On cross examination, Petitioner testified that he tried to see the same doctors in the same clinic multiple times. He testified that he thought it was the orthopedic clinic in 16th Avenue, which was the same clinic he was scheduled to go to in March. (PX1).

On cross examination, Petitioner testified that he did not remember the date on which he applied for unemployment, but that it was approximately a month or so after he did not receive anything in the mail. He testified that the doctor that ordered the MRI also told him not to use his right hand. Petitioner's work slips were attached to the deposition transcript as Exhibits 1 and 2. He testified that

after he was laid off by Respondent he did not ask them to take him back to work in a light duty capacity because the boilermakers had no light duty and that was why he was kept in the "break shack." (PX1).

Mark Pinkel was called as a witness on behalf of Respondent at the time of arbitration. Mr. Pinkel testified that he works for Respondent as a Payroll Supervisor for the Belleville division. He testified that he reviewed the records looking for information regarding Petitioner and his possible layoff status following the accident. He testified that he found records regarding people being laid off from the same job that Petitioner was on and that those individuals had an "L" designation in the records. He testified that there was not, however, an "L" next to Petitioner's name. He testified that there was a termination slip that Petitioner would have received if he was laid off or subject to a reduction in force, but that Petitioner did not receive such a slip.

On cross examination when asked how long the job went on before there were general layoffs at the facility, Mr. Pinkel responded that he did not have the records with him. He confirmed that in order for a union boilermaker to go on the job, they had to sign off that they were able to work in a full duty capacity. He agreed that Petitioner was placed in the break room after his injury. He testified that he did not know, however, what individuals did in the break room when they were on light duty status.

John Bush was called as a witness on behalf of Respondent at the time of arbitration. Mr. Bush testified that he is currently employed by Respondent and that he was employed as a Site Safety Manager on Petitioner's date of accident. He testified that he performs audits and oversees safety and the preparation of plans for such activities as lifting.

Mr. Bush testified that he is familiar with Petitioner and that he was aware that he had a claimed accident on March 12th. He testified that he was also aware that Petitioner stopped working on March 17th. He testified that between March 12th and March 16th when Petitioner left the premises, he was performing light duties including mostly sitting/sedentary work. He testified that he was familiar with Respondent's light duty program and that individuals could perform such duties as working in the tool room, helping in the safety office and doing paperwork. He testified that Respondent could accommodate virtually any restriction.

Mr. Bush testified that he had a conversation with Petitioner when he left the premises. He testified that Petitioner came to his office and that they had already taken him for his second doctor's appointment. He testified that they were waiting for a call back from the insurance company and that Petitioner stated that he had to go, that he had an airplane ticket and that he did not way to stay on 40 hours. He denied that Petitioner asked him to lay him off, but testified that he would not have been the one to ask about that. He testified that he told Petitioner that he should stay and follow up with the MRI and that there was sedentary work for him.

On cross examination when asked when the conversation about the plane ticket took place, Mr. Bush responded that it was approximately 10:00 am on the morning of March 17th which was Petitioner's last day on the job. He agreed that Petitioner was working in the break room. He testified that Respondent would have someone in the break room not doing anything potentially until a diagnosis was made, after which he would have been assigned duties within his restrictions. He testified that Petitioner was put on no duty until they knew what was going on.

On cross examination, Mr. Bush testified that he did not remember how long the job lasted before layoffs. He testified that sometimes duties continued after the main part of the outage was over and that it was hard to say when those were finished. He testified that they kept 60 people there a year generally so there were activities going on year-round. He testified that he did not have an opinion whether Petitioner would have been laid off.

On redirect, Mr. Bush testified that if no work was available within Petitioner's restrictions at the site where he was working, there were other locations where he could have been placed including the Belleville office in the warehouse.

Richard Churchwell was called as a witness on behalf of Respondent at the time of arbitration. He testified that he is currently employed by Respondent. He testified that he is a union member and that his position on March 12, 2016 was that of a union steward representing the boilermakers. He testified that he was familiar with Petitioner and that he was aware that Petitioner filed an Application for Adjustment of Claim. He testified that he was also aware that Petitioner left the premises of Hayes Mechanical on March 17, 2016.

Mr. Churchwell testified that Respondent's Exhibit 1 was a copy of the statement that he prepared about the events that took place. He testified that his signature appeared at the bottom of the statement and that the statements in the paragraphs were true and accurate.

Mr. Churchwell testified that to his knowledge, Petitioner was not laid off. He testified that he had a conversation with Petitioner about his employment status with Respondent somewhere in the timeframe of March 12th and March 17th. He testified that Petitioner told him that his roommate was getting laid off and that he needed to leave the job site immediately. He testified that Petitioner never said that he was being laid off. He further testified that Petitioner never asked him to be laid off. He testified that their conversation also concerned an MRI and whether it could take place in Washington State and that he said he did not know but would check on it. He testified that as an injured boilermaker with Respondent, one would not be laid off and that there would be light duty work.

On cross examination, Mr. Churchwell testified that he put Petitioner on a list, but that it was the list of individuals not on the job site. He testified that when he reported to the union hall, he did not indicate that Petitioner was laid off. He testified that the list consisted of men no longer on the job and that it could have been reasons such as a failed welding test, an emergency, layoffs or the like.

On redirect examination, Mr. Churchwell testified that his nickname was that of "Arkie." He confirmed that he did not have the authority to lay anyone off who was a fellow union member and an employee of Respondent. He testified that to his knowledge, Petitioner was not laid off at any point between March 12th and the time of arbitration.

Bryce Pearson was called as a witness on behalf of Respondent at the time of arbitration. Mr. Pearson testified that he is the current Corporate Environmental Health and Safety Manager and that his position in March of 2016 was that of the Corporate Environmental Health and Safety Coordinator. He testified that his responsibilities included workers' compensation claims. He testified that he was familiar with Respondent's corporate policy regarding light duty work for injured workers and that anyone placed on light duty was to continue to work and that they would modify job duties for them at their current work location. He testified that if the job ended, they would then have them work at another job or take them to the office to have them continue working. He testified that Respondent will accommodate virtually any restriction that an employee has.

Mr. Pearson testified that in his review of the records, he saw nothing indicating that Petitioner was laid off. He testified that because Petitioner was an injured employee as of March 12th, he would not have been the subject of a layoff. He testified that Respondent would have accommodated the restrictions issued by Petitioner's physician and would have placed him in a position where would have been receiving his regular pay. He testified that the position would have depended on what the doctor's restrictions were and that examples included a "hole watch" where one monitored a hole and the people inside in order to make sure no one was left behind. He testified that in Petitioner's case, there would

have been positions available either on the job sites or at the Belleville headquarters where he could have performed light duty work.

Mr. Pearson testified that he saw no evidence that Petitioner was ever laid off. He testified that Petitioner would have been working to the time of arbitration at his regular pay had he stayed in Illinois.

On cross examination when asked how many individuals Respondent had on light duty in the southwest Illinois geographical area, Mr. Pearson responded that it varied and that they currently had four who were working at the Belleville tool room. He testified that Respondent would accommodate light duty indefinitely, but that if permanent restrictions were involved that was a different issue. He testified that they had individuals continue to work light duty until they were released to full duty. He testified that an individual would receive their full pay if they were working light duty for Respondent.

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 2.

Various medical records were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on March 14, 2016 for a right shoulder strain. Petitioner was recommended to undergo x-rays of the right shoulder, work as tolerated, ice the right shoulder and take anti-inflammatory medications. Petitioner was seen again on March 16, 2016, at which time it was noted that the diagnosis was that of persistent right shoulder pain and decreased range of motion. Petitioner was instructed to use the right arm as tolerated, undergo an MRI of the right shoulder and change his pain medications from Ibuprofen to Aleve and Tylenol. The interpretive report for x-rays of the right shoulder taken on March 14, 2016 were interpreted as revealing no fracture or dislocation of the right shoulder. The Work/School Status Note from Orthopedics Northwest dated March 10, 2017 noted that Petitioner's work status was light work/activity and that he could return to work on March 17, 2017. (PX3).

The Statement of Richard Churchwell was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The statement noted that Petitioner was hired on March 3, 2016 by Hayes Mechanical as a boilermaker for work at Prairie State Generation in Marissa, Illinois. The statement noted that on or about March 12, 2016, Petitioner reported that he had injured his shoulder and was taken to Midwest Occupational Medicine for treatment on the morning of March 14, 2016. The statement noted that Petitioner was told he needed to have an MRI. The statement noted that Petitioner came in on Thursday morning and said he and his partner had made the decision for him to come home and that she had bought him an airplane ticket back to Washington. The statement noted that Petitioner made the decision to leave and that he left just before noon on March 17, 2016. (RX1).

CONCLUSIONS OF LAW

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner has met his burden of proving that his current condition of ill-being is causally related to the accident.

Petitioner testified that he sustained an accident at work for Respondent on March 12, 2016. Petitioner testified that at that time, he was working as a boilermaker for Respondent and was in a confined space lifting and placing air bags into tubes inside the boiler of a power plant. Petitioner testified that the tubes weighed 45-50 pounds and that while pushing on an airbag and performing overhead work in the process, he felt pain in his right shoulder.

Neither Petitioner nor Respondent has introduced any evidence linking his shoulder injury to any personal condition of the Petitioner or any trauma other than the work accident of March 12, 2016. As a

result thereof, the Arbitrator concludes that Petitioner has met his burden of proving that his current condition of ill-being in the rights shoulder is causally related to the accident.

With respect to disputed issue (K) pertaining to temporary total disability benefits, the Arbitrator finds that Petitioner has failed to meet his burden of proving that he is entitled to temporary total disability benefits for the timeframe of March 18, 2106 through March 29, 2017. As such, Petitioner's request for temporary total disability benefits is denied.

The Arbitrator notes that Petitioner seeks temporary total disability benefits for the timeframe of March 18, 2016 through March 29, 2017, arguing that he was laid off from his job with Respondent as of March 18, 2016. (AX1). Prior to that date, Petitioner concedes that Respondent accommodated his purported restriction of no use of his right hand/arm. Petitioner testified that John Bush and his union steward, "Little Arkie," however, purportedly told him that he was going to be laid off.

Having reviewed and considered the entirety of the witness testimony in the case, the Arbitrator finds that not only did Respondent have a modified duty program that could accommodate the restrictions of any injured worker including those of Petitioner had he stayed in Illinois, but that the evidence in the case reveals that Petitioner was never, in fact, laid off.

Petitioner's union steward, Richard Churchwell, testified that Petitioner was not laid off and that he made it clear that he had to get home to Washington and was leaving Illinois as of Thursday, March 17, 2016. Mark Pinkel testified that he reviewed Respondent's records and confirmed that Petitioner was not listed as an employee being laid off or having been laid off. John Bush testified that on the morning of March 17th, they were waiting for a call back from the insurance company and that Petitioner stated that he had to go, that he had an airplane ticket and that he did not want to stay on 40 hours. He testified that he told Petitioner that he should stay and follow up with the MRI and that there was sedentary work for him. Bryce Pearson testified that there was no record of Petitioner having been laid off following his work accident.

As a result thereof, the Arbitrator finds that Petitioner has failed to meet his burden of proving that he is entitled to temporary total disability benefits for the timeframe of March 18, 2106 through March 29, 2017. As such, Petitioner's request for temporary total disability benefits 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 Accident/Causation	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Randall Ashcraft,

Petitioner,

vs. No. 16 WC 09045

18IWCC0109

Pana Limestone Company,

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 accident, causal connection, medical expenses, prospective medical care and temporary disability, and being advised of the facts and law, reverses the Decision of the Arbitrator for the reasons stated below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation, medical benefits or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327 (1980).

Petitioner, who was 64 years old at the time of the arbitration hearing, testified that he worked for Respondent for over 40 years. For the last 20 years, Petitioner was a plant operator. His workstation was "a little building at the top." To get to his workstation, Petitioner used a manlift, unless it was broken, in which case he walked up the stairs. The manlift was usually in good repair. Respondent had been providing a manlift for his use since he underwent surgery on the right knee in 2007. Petitioner described his job duties as "[b]asically just push buttons" "[t]o run the plant screens, belts, impactor, things like that." If there was a breakdown, someone had to go outside and "[s]plice belts, shovel, change bearings and things like that." When asked how often he performed non-tower duties, Petitioner responded: "Seemed like sometimes two or three

times a day, but it was once a week, twice a week, something like that." There were no other physically demanding duties. On cross-examination, Petitioner did not remember the last time he helped splice belts. Petitioner maintained he was "getting on loaders and skidsteers" "[w]henever [he] was told to do it," which was "[m]aybe once every week or once every two weeks." Petitioner stated his non-tower duties with Respondent were "maybe 20 percent." Petitioner denied any difficulty performing his regular job duties prior to December 4, 2015. Petitioner admitted suffering from high blood pressure and diabetes and having a pacemaker/defibrillator. When asked whether there was ever an instance of left knee complaints in 2011, Petitioner responded: "Not that I recall, no. If there was I don't remember it." He denied any prior treatment relative to the left knee. Upon further questioning, Petitioner affirmed the left knee was "fine" between 2007 and 2015.

Petitioner described the accident on December 4, 2015, as follows: "We were going out to go down to my job, scrape the windows on the truck and start to get in, and it was a pick up and I slipped on the mud or ice getting in the truck and I felt something pop in my knee." Petitioner got in the truck, drove "to work," and took the manlift up to his workstation. The knee continued to hurt, so Petitioner reported the injury to his supervisor, Nathan. When asked to describe the accident in greater detail, Petitioner testified the accident took place on Respondent's premises near a "shed" where employees gathered in the morning before reporting to their workstations in the quarry. It was customary for employees to take work trucks to their posts, rather than walk. The trucks were owned by Respondent. The truck Petitioner took on the day of accident was a pick-up truck, which had no heater to defrost the windows. After Petitioner scraped the ice off the windows, he went to climb into the truck. His left foot slipped while he was climbing into the truck. Petitioner believed "[e]ither ice or mud on the ground" caused his foot to slip. The record contains photographs of Respondent's facility, showing uneven ground like one would expect in a quarry.

Nathan Moreland, a working foreman, testified that Respondent's business was to "make rock." Mr. Moreland confirmed that on December 4, 2015, Petitioner worked as a plant operator. When asked to comment on Petitioner's testimony regarding the non-tower tasks he performed, Mr. Moreland stated: "Every once in a while he would get on the skidsteer for sure, and if there was work to be done he would be the ground man. I mean he wouldn't get up—he would hand tools every once in a while." In a typical week, Petitioner would not leave the tower. If there was a breakdown, Petitioner "would sit down there and every once in a while he would hand them tools." Mr. Moreland confirmed that Petitioner used a manlift to get into the tower. Petitioner told Mr. Moreland he could not climb the stairs because of his knees. Petitioner walked with a "shuffle." Mr. Moreland had observed Petitioner limp in November of 2015. Near the end of December of 2015, Respondent laid off six workers, including Petitioner, because there was not enough work. Mr. Moreland acknowledged that on December 4, 2015, Petitioner reported hurting his knee while scraping off a truck and getting into it. Specifically, Petitioner reported slipping on ice while getting into the truck.

Petitioner, during his rebuttal testimony, agreed that Mr. Moreland's testimony regarding the extent of his work during a breakdown was fair, adding: "[Y]ou would think after you were there for over 40 years you would expect somebody a lot younger than you to have to do the hard part of the work" and "the young dogs would *** take care of the old guys a little bit." Petitioner stated before the accident his limitations were due to "[the] right knee mostly ***, but other issues of being overweight."

Robert Ishmael, a blasting and drilling worker in the pit, confirmed that employees took work trucks from the shed to their job posts. Petitioner worked in the tower and used a manlift to get up there. Petitioner spent most of his workdays in the tower. Mr. Ishmael testified that Petitioner rarely did troubleshooting when there was a problem. When he helped troubleshoot, he did minimal physical work. Petitioner was a ground man during a breakdown. Mr. Ishmael further testified that Petitioner had had a limping gait "forever," more than 25 years.

The medical records in evidence show that Petitioner sought treatment for a left knee injury with his primary care physician, Dr. D. F. Quizon. The medical records from Dr. Quizon show no recent left knee complaints. The last time Petitioner complained of left knee pain before the accident was on October 27, 2011, when the following was noted: "Patient is having pain on the left knee, probably secondary to being obese and weakness of his core muscles." Petitioner's weight on December 4, 2015, is listed as 300 pounds. Dr. Quizon noted the following history: "The patient has long-standing history of diabetes mellitus, coronary artery disease resulting in pacemaker defibrillator. The patient was trying to get in his pickup truck when he slipped and hurt his left knee. This happened this morning." On physical examination, tenderness was noted along the lateral aspect and the posterior area of the knee. On December 14, 2015, Petitioner followed up, complaining of persistent pain in the knee and now walking with a cane. He was referred to Dr. John Kefalas, an orthopedic surgeon.

Dr. Kefalas testified by evidence deposition on October 14, 2016, that Petitioner consulted him about the left knee on December 16, 2015, having previously treated with him in 2006 and 2007 for a right knee problem. Petitioner presented with an acute left knee injury, reporting that "he was working December 4th, 2015, at his place of employment when he slipped and fell, injuring his left knee." Petitioner reported feeling a pop in his knee at the time of the accident. Physical examination findings were as follows: "[The patient] *** was ambulating with a cane, and he had a very altered or antalgic gait. His hips had no pain with motion, either right or left hip. His right knee, ankle and foot had no pain with palpation or when you push on it or range of motion. His left knee, however, was tender over the inner part of the knee and the medial collateral ligament or MCL. His patellar and quadriceps ligaments were intact, or in continuity, which means they weren't ruptured, and his left knee motion was 5 to about 110 degrees. ¶ When I would *** try to take the knee and put what's called a valgus movement or actually hold the knee and then push the ankle out to the side, he had pain on the inside of the knee. The rest of the neurovascular function was normal." Dr. Kefalas suspected an injury to the medial collateral ligament, which was consistent with the mechanism of injury Petitioner described. X-rays showed some underlying arthritis in the joint. Dr. Kefalas diagnosed an acute

left knee injury with a medial collateral ligament sprain, as well as an aggravation of the underlying osteoarthritis, and performed a steroid injection into the knee. Dr. Kefalas further prescribed a support brace and released Petitioner to return to work on sedentary duty.

Dr. Kefalas further testified that on January 6, 2016, Petitioner followed up, reporting some relief and complaining of posterior and lateral symptoms in the knee. Dr. Kefalas could not obtain an MRI because Petitioner had a pacemaker and defibrillator. Physical examination was "[p]retty similar." Dr. Kefalas ordered an ultrasound, prescribed physical therapy, and kept Petitioner on sedentary duty. On February 25, 2016, Petitioner followed up, complaining of persistent posterior and lateral pain in the knee. The symptoms were unchanged from the last visit. Dr. Kefalas was still awaiting authorizations for the ultrasound and physical therapy. Dr. Kefalas kept Petitioner on sedentary duty. On March 16, 2016, Petitioner followed up after attending a section 12 examination and being released to return to work full duty. Petitioner reported to Dr. Kefalas the knee was better and physical therapy was helping. He still had difficulty climbing stairs or squatting. On physical examination, the range of motion was better, but still limited. Dr. Kefalas did not think Petitioner would need surgery, explaining: "I think that the MCL sprain was healing and that we were returning his osteoarthritis symptoms and resolving those with therapy and injection." Dr. Kefalas kept Petitioner on restricted duty. On April 20, 2016, Petitioner followed up, reporting his left knee symptoms had stabilized. He was doing a self-directed rehab program and reported having good and bad days. On physical examination, the range of motion was the same. There was no fluid in the knee. The tenderness over the medial joint line and the medial collateral ligament was better. Dr. Kefalas declared Petitioner at maximum medical improvement and released him to return to work full duty. However, Dr. Kefalas mentioned that Petitioner might need intermittent cortisone injections for his osteoarthritis. Dr. Kefalas explained: "I suspect that his osteoarthritis potentially could continue to become symptomatic periodically. I think at this point *** he had gotten good relief from the injection I had done previously, and I tell patients sometimes as the body metabolizes the drugs, oftentimes if their symptoms come back, I'd be more than happy to give them another injection."

On June 8, 2016, Petitioner returned. Dr. Kefalas understood that "since he had been back trying to do his regular duty work, he was having difficulty with stairs and kneeling, all with regard to his left knee." On physical examination, the range of motion was decreased. Repeat x-rays of the knee showed no interim change. Dr. Kefalas recommended Hyalgan injections and imposed the restrictions of no climbing ladders or climbing in and out of equipment. In the event the injections did not work, Dr. Kefalas would recommend physical therapy and weight loss. If conservative treatment failed, Petitioner would need a knee replacement.

On cross-examination, Dr. Kefalas agreed that Petitioner was probably morbidly obese, and "it's one of the contributing factors to developing osteoarthritis." Dr. Kefalas also agreed that "for every ten pounds of extra weight you carry, an additional 30 to 60 pounds of force is placed on your knee with each step." Dr. Kefalas had no reason to dispute the finding of the

section 12 examiner that 45-degree and PA flexion x-rays showed a complete loss of joint space with bone-on-bone deformity in the knee, as well as a small osteophyte formation. Dr. Kefalas classified Petitioner's osteoarthritis as moderate to severe. When asked about his understanding of the mechanism of injury, Dr. Kefalas testified that Petitioner reported slipping while getting out of his truck and ultimately falling, qualifying: "I don't know if he went all the way to the ground. I don't know that, but I know there was a slip and fall and he felt a pop on the inside part of his knee." Dr. Kefalas agreed that on April 20, 2016, he thought whatever aggravation Petitioner had suffered was now resolved and he was back to baseline. Any further treatment would be driven by Petitioner's subjective complaints. Upon further questioning, Dr. Kefalas reiterated that Petitioner clearly had an injury to his medial collateral ligament, which resolved by April 20, 2016. On redirect examination, Dr. Kefalas testified that he considered Petitioner's complaints on June 8, 2016, to be a continuation of the original injury based on his understanding that Petitioner had returned to work full duty.

Physical therapy records from Pana Community Hospital show that Petitioner underwent physical therapy from February 2 through March 15, 2016. Petitioner reported improvement and met most of the physical therapy goals. On March 15, 2016, Petitioner told the physical therapist he had recently returned to work and wanted to be done with physical therapy. Petitioner testified the physical therapy "helped but it didn't fix it," explaining that he had "[s]harp stabbing pain" when "[w]alking and trying to climb stairs; climbing stairs at home getting out of the basement was almost impossible."

At Respondent's request, Petitioner was examined by Dr. Jacob Sams. Dr. Sams, an orthopedic surgeon, testified by evidence deposition on October 27, 2016, that he examined Petitioner on February 25, 2016. Petitioner reported a left knee injury when he was scraping ice from his truck on December 4, 2015. He also reported feeling a twisting motion in his knee when he slipped. Dr. Sams reviewed a first report of injury and medical records from Dr. Kefalas, noting that Petitioner "had had appropriate conservative management of the injury; that the knee was concerned for a sprain of the medial collateral ligament; that they had tried some job modifications or restriction of duty; and that they had given an injection." Dr. Sams obtained weightbearing and sunrise view x-rays. The 45-degree PA flexion view showed "bone-on-bone contact involving the medial compartment in that position." Dr. Sams diagnosed "severe joint space narrowing of the medial compartment indicating complete loss of articular cartilage in that area." On physical examination, Dr. Sams noted that Petitioner "had full range of motion; that he had no maltracking of the patella; that he had stability to the stress testing of the medial collateral ligament, the lateral collateral ligament, the ACL, as well as the PCL. ¶ He did not have any evidence that the knee pain could be referred pain from the lumbar spine; and that he, in fact, had a negative McMurray's test, which is a test concerning the meniscus." Dr. Sams also noted a BMI over 52, which is classified as morbidly/super obese. Dr. Sams stated that "weight, which accordingly corresponds to the BMI as part of that calculation, can influence the outcomes of the amount of arthritis." Dr. Sams continued: "The general rule as you look at the joint surface of each joint and where that body weight is carried that will typically talk about a lot of

obesity is carried in the mid section or the abdominal region, that 10 pounds of extra weight there can add up to 80 pounds of pressure on the knee with each step."

Dr. Sams opined: "[The claimant's] knee was clearly arthritic with a severe loss of joint space within the medial compartment, and *** his symptoms were related to the arthritis that he had." Dr. Sams opined the arthritis was long-existing. Dr. Sams further opined that Petitioner had reached maximum medical improvement and could return to work full duty, "[g]iven the fact that his knee was completely stable to all cruciate and collateral ligaments."

On cross-examination, Dr. Sams was unaware of any preinjury complaints in the medical records relative to the left knee. Dr. Sams acknowledged that an injury can make preexisting arthritis symptomatic, qualifying: "[The injury] absolutely could have rendered [the osteoarthritis] symptomatic, but it should be for a defined period of time. If he's really been asymptomatic for this long and he has bone-on-bone arthritis, having this type of injury wouldn't lead it to be chronically symptomatic." Dr. Sams reiterated that at the time he examined Petitioner, "his MCL was completely stable."

Petitioner testified regarding his current situation that he was unemployed and receiving Social Security disability benefits and a pension through his union, Operating Engineers Local 965. Petitioner initially stated he began receiving these benefits in mid-2016. On cross-examination, Petitioner agreed that he was awarded Social Security disability benefits in March of 2016. Also in March of 2016, he retained an attorney and signed the application for adjustment of claim. Petitioner acknowledged that between April 20 and June 7, 2016, he did not seek any further medical treatment. Petitioner stated he returned to Dr. Kefalas on June 8, 2016, because his knee still hurt and limited his activities. Dr. Kefalas imposed restrictions and recommended injections into the knee. Petitioner would like to proceed with the recommended injections. Petitioner did not feel he could perform his job duties for Respondent that went beyond pushing buttons at his workstation. Petitioner last performed his job for Respondent on December 4, 2015. After Petitioner was released to return to work by Dr. Sams, Mr. Moreland suggested that he try to find a job through the union hall. Petitioner interpreted that as being terminated from his job with Respondent.

The Arbitrator found that Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment with Respondent. We disagree. We note that Petitioner's workplace was a quarry. Petitioner's risk of injury from climbing in or out of a work truck on Respondent's premises where the ground was icy, muddy and probably uneven was greater than the general public's, assuming a neutral risk analysis. Alternatively, Petitioner's risk of injury was inherent in the nature of his employment. We further note that Respondent had stipulated to accident.

The Commission does agree with the Arbitrator that Petitioner is not credible on the issues of causation and maximum medical improvement. The Commission relies on the opinions of Dr. Sams and finds that Petitioner is not entitled to temporary total disability or medical

benefits after the section 12 examination on February 25, 2016. The Commission notes that the parties stipulated Respondent is responsible for reasonable medical expenses Petitioner incurred through February 25, 2016, and temporary total disability benefits from December 5, 2015 through February 25, 2016.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 1, 2017, is hereby reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled only to the stipulated temporary total disability and medical benefits. No further benefits are awarded.

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 have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

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

DATED: FEB 23 2018
o-01/11/2018
SM/sk
44

Stephen J. Mathis
Stephen Mathis

David L. Gore
David L. Gore

DISSENT

I respectfully dissent from the Decision of the majority. I would have affirmed and adopted the well-reasoned Decision of the Arbitrator.

At the time of the alleged accident, Petitioner was 62 years old, 5'6", and 326 pounds. In 2007 he had right knee meniscus surgery. Also at the time of the alleged accident, Petitioner was plant manager and assigned to work in the tower. He testified that he used a man-lift to get up to

18IWCC0109

the tower because of his bad right knee. His job involved mostly pushing buttons. Petitioner testified on December 4, 2015, he was leaving the shed in which workers congregate prior to work. He went out of the shed and went to a pick-up truck to drive to the tower. He scraped ice off the front of the truck and slipped on mud or ice while trying to get into the truck. In my opinion, the Arbitrator correctly found that Petitioner "was not engaged in an employment-related risk at the time of the accident."

In addition, the Arbitrator found that the alleged accident did not cause the current condition of ill-being of his left knee. Petitioner testified he had no previous problem with his left knee. However, on a doctor visit in 2011, Petitioner reported pain in the left knee. X-rays taken after the alleged accident showed end-stage, bone-on-bone, arthritis of the left knee. In this regard the Arbitrator, and I, believe the opinion testimony of Respondent's Section 12 medical examiner, Dr. Sams, more persuasive than Petitioner's treating doctor, Dr. Kefalas. Dr. Sams opined that Petitioner's condition of ill-being of the left knee was caused by his underlying end-stage arthritis and not any alleged accident.

Finally, the Arbitrator found Petitioner not to be a credible witness. While, the Commission has original jurisdiction to assess the credibility of witnesses, in my opinion there was no reason for the Commission to disturb that determination of the Arbitrator, who actually observed Petitioner's demeanor. In fact, in its decision, the Commission agreed "with the Arbitrator that Petitioner is not credible on the issues of causation and maximum medical improvement." Based on that determination, the Commission terminated benefits as of the date of Dr. Sams' report. Therefore, I find the Decision of the Commission somewhat internally inconsistent.

Based on the reasoning stated above, I would have affirmed and adopted the Decision of the Arbitrator and denied compensation. For these reasons, I respectfully dissent.

Deborah L. Simpson

Deborah L. Simpson

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

ASHCRAFT, RANDALL
Employee/Petitioner

Case# **16WC009045**

PANA LIMESTONE COMPANY
Employer/Respondent

18IWCC0109

On 5/1/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1727 LAW OFFICES OF MARK N LEE LTD
KEVIN MORRISSON
1101 S SECOND ST
SPRINGFIELD, IL 62704

0332 LIVINGSTONE MUELLER ET AL
KEN BIMA
620 E EDWARD ST PO BOX 335
SPRINGFIELD, IL 62705

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Randall Ashcraft
Employee/Petitioner

Case # **16** WC **9045**

v.

Pana Limestone Company
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield**, on **February 28, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **12/04/2015**, 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 **$38,188.80**; the average weekly wage was **$734.40**.

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

Respondent has or will pay all reasonable medical bills incurred through February 25, 2016 pursuant to the Medical Fee Schedule.

Petitioner was temporarily totally disabled from **December 4, 2015** through **February 25, 2016**, a period of **11 6/7 weeks**.

Respondent shall be given a credit of **$6,364.80** for TTD.

Respondent shall be given a general credit for any and all medical bills paid by it or its group medical for which credit is allowed under Section 8(j) of the Act and to the extent it is receiving a credit under Section 8(j) will hold Petitioner harmless from same.

ORDER

Petitioner failed to prove he sustained an accident on December 4, 2015 that arose out of and in the course of his employment with Respondent or that his current condition of ill-being in his left knee is causally related to the alleged injury. Petitioner's claim for compensation is denied.

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

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

Nancy Lindsey — 4.26.17

Signature of Arbitrator — Date

MAY 1 - 2017

Randall Ashcraft v. Pana Limestone Company, 16 WC 009045(19(b))

Petitioner alleges an accident date of December 4, 2015 and claims injury to his left knee as a result thereof. While Respondent originally stipulated to accident prior to the presentation of testimony, Respondent subsequently placed it into dispute. The other issues are causal connection, prospective medical care, and temporary total disability benefits.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner sustained a work-related injury to his right knee for which he sought treatment in July of 2006 at Pana Medical Group. (PX 2[1]) When initially reporting the injury to his family doctor in July of 2006 Petitioner reported that he weighed 260 lbs. Petitioner subsequently underwent right knee surgery with Dr. Kefalas and was released to return to full duty work with no restrictions and at maximum medical improvement on January 10, 2007. (PX 3)

Petitioner periodically presented to Pana Medical Group between July of 2006 and October of 2011 for various conditions. However, no mention of left knee pain is found during any of these visits. In April of 2008 his weight was recorded as 285 lbs. In March of 2009 his weight was recorded as 250 lbs. As of October 15, 2009 Petitioner weighed 300 lbs. (PX 2)

Petitioner presented to Pana Medical Group on October 25 (or 27), 2011 regarding a medication refill. Petitioner also reported left knee pain which the doctor noted was "probably secondary to being obese and weakness of his core muscles." (PX 2)

Petitioner was seen at Prairie Cardiovascular on February 11, 2015, reporting that he was doing fairly well and his only complaint of limitation at the time was "knee pain." (PX 2)

Dr. Quizon's records note that the last time that Petitioner complained to him of left knee pain was on October 27, 2011. On that date, Dr. Quizon thought that Petitioner's left knee pain was the result of being obese (RX1)

As of November 11, 2011 the doctors at St. John's Hospital noted Petitioner's weight was 154 kg. (339.5 lbs.) (PX 2)

Petitioner was examined at Springfield Clinic on December 6, 2011 regarding severe obstructive sleep apnea. His weight was recorded as 330 lbs. (PX 2)

Petitioner continued to be seen periodically at Pana Medical Group between that visit and December 4, 2015; however, no further left knee complaints were noted. In October of 2014, Petitioner's weight was recorded at "300 +." (RX1; PX 2)

[1] See also RX 1 which is a duplicate of many of the Pana Medical Group records found in PX 2.

On December 4, 2015, Petitioner was seen by his primary care physician, Dr. Quizon. The history in that record states "Randy Ashcraft came in today. The patient has long standing history of diabetes mellitus, coronary artery disease resulting in pacemaker defibrillator, the patient was trying to get in his pickup truck when he slipped and hurt his left knee. This happened this morning." On examination, the doctor noted tenderness along the lateral aspect of the posterior area of Petitioner's knee. Petitioner was 5'8" tall and weighed 300 lbs. Dr. Quizon diagnosed Petitioner with a left knee strain and prescribed an x-ray that was interpreted as revealing degenerative changes. Petitioner was prescribed Norco. Petitioner was taken off work. (RX1)

A left knee x-ray taken at Pana Community Hospital on December 4, 2015 was negative for fractures or dislocation. Degenerative changes were noted. (PX 2; PX 5)

Petitioner returned to Pana Medical Group on December 14, 2015 with "questions about his knee." He continued to complain of left knee pain along the lateral aspect of the posterior area. Petitioner was walking with a cane. The x-ray was noted to have been negative. Petitioner was referred to Dr. Kefalas. (PX 2)

Petitioner saw Dr. Kefalas on December 16. 2015. As part of the examination, he completed a questionnaire and while he stated he was hurt at work he set forth no details. When examined by the doctor, he was complaining of medial-sided left knee pain. The history in Dr. Kefalas' record states that Petitioner injured his knee while getting out of his truck while working on December 4, 2015. He told the doctor he slipped getting out and felt his left knee pop. Dr. Kefalas diagnosed the Petitioner with an MCL sprain and possible aggravation of his underlying osteoarthritis. Dr. Kefalas elected to inject the Petitioner's left knee on that date. Dr. Kefalas placed Petitioner on sit down work only which Petitioner testified Respondent could not accommodate. (PX 4)

Petitioner returned to Dr. Kefalas on January 6, 2016. Dr. Kefalas noted that Petitioner had slipped and fallen on December 4, 2015 at which time he felt a "pop" in his knee. On that date, Petitioner noted that the steroid injection only helped briefly "but now he notes more pain to the posterior knee which is new for him as well as to the lateral aspect." He was diagnosed with a fall at work and MCL sprain and aggravation of left knee osteoarthritis. An ultrasound was recommended to rule out a Baker's Cyst given his worsening pain. Petitioner inquired as to the cause of a Baker's Cyst and was told they can be idiopathic. Physical therapy was prescribed and Petitioner was continued on sedentary work restrictions. (PX4)

Petitioner began attending physical therapy at Pana Community Hospital on February 2, 2016. Petitioner was referred for therapy due to knee pain difficulty while walking. His diagnosis was left knee osteoarthritis and an MCL sprain. Petitioner reported having injured his knee at work on December 4th "while trying to get in the truck. He feels he slipped on ice or mud." Petitioner reported a pain level of "7/10." Aggravating factors included steps, sitting a long time without moving his knee, walking, and morning stiffness. Petitioner's job was listed as a "plant supervisor" which involved "prolonged sitting." Petitioner would sit 75% of his day and might have to lift 50# or more on occasion and maybe 20# frequently. He reportedly did steps "45 feet in the air." (PX 5)

On February 3, 2016 Dr. Kefalas and his PA-C saw Petitioner regarding his "slip and fall" while working for Respondent. Petitioner was having a difficult time ambulating due to knee pain. He was told to continue with formal therapy and posterior popliteal knee pain was noted but an ultrasound to rule out a Baker's Cyst had not yet been approved. He was to limit himself to sit down work. (PX 4)

While undergoing physical therapy, Petitioner was examined by Dr. Jacob Sams on February 25, 2016 at the request of Respondent. A written report was issued after the examination. Petitioner told the doctor he was climbing back into the truck when he slipped causing a twisting motion to his knee. Petitioner was listed as being 5'6" and weighing 326 .4 pounds and having a BMI of 52.68. Petitioner advised Dr. Sams that prior to the December 4, 2015 incident, he would rate his left knee at 90% with pain noted when with climbing or descending stairs and getting down on his knees. He noted that the 45 degree PA flexion x-ray showed complete loss of joint space with bone-on-bone deformity and other indicia of a long-standing arthritic process pre-dating the alleged injury. Dr. Sams felt Petitioner had sustained an acute injury of the left knee with a long-standing arthritic process and he felt Petitioner could return to work without any restrictions as the knee itself was stable although afflicted with osteoarthritis. He did not feel an ultrasound was necessary. (RX 2, dep. ex. 2)

Petitioner continued with physical therapy through March 1, 2016 at which point he was discharged as he had met some of his goals and was returning to work. At that visit Petitioner reported seeing Dr. Sams who felt he was all healed from the initial injury. His pain was marked at "4/10." (PX 5)

Petitioner signed his Application for Adjustment of Claim herein on March 14, 2016 alleging he injured his left knee "due to a slip and fall during the course of employment." (AX 2)

The therapist's March 15, 2016 record states "He recently went back to work and wanted to be done with therapy." Petitioner was discharged on that date. (PX5)

Dr. Kefalas re-examined Petitioner on March 16, 2016 with Petitioner reporting he had been released back to regular duty by the IME doctor and that "overall" his left knee was better and therapy was helping. His main issue was squatting and climbing stairs at work. Petitioner was advised to continue with additional therapy for six visits in an effort to strengthen his leg and allow him to return to full duty. He was kept on work restrictions of no squatting or climbing and was to return in four weeks. Dr. Kefalas didn't feel any operative treatment would be needed at this point. (PX 4)

Petitioner was awarded social security disability income in March of 2016.

Petitioner returned to see Dr. Kefalas on April 20, 2016. He reported that his left knee symptoms were "overall" stabilized and he was performing self-directed rehab with good and bad days. He was ambulating weightbearing, as tolerated, and had only mild tenderness over the medial joint line. His left knee motion was 5 to about 125 degrees of flexion. Dr. Kefalas felt Petitioner had reached maximum medical improvement and he was encouraged to lose weight and use anti-inflammatories. Petitioner was released to

regular work duty as of April 20, 2016. Dr. Kefalas felt Petitioner had the "potential in the future" for intermittent cortisone injections for his osteoarthritis and he would be happy to perform them. (PX 4)

Petitioner was seen at Prairie Cardiovascular on June 1, 2016. Petitioner reported doing fairly well over the last several months although his activity had been limited due to knee pain. Petitioner also reported having not worked since December. It was noted that he did walk a few times a day with his dogs. (PX 1)

Petitioner returned to see Dr. Kefalas on June 8, 2016 reporting ongoing difficulty with stairs and kneeling as related to his left knee. He denied any new trauma and was taking occasional Tylenol. Petitioner was ambulating weight bearing as tolerated. He had some tenderness over the medial joint line on the left knee and could not squat or kneel. Early arthritic changes in his hips were noted on x-rays. His knee radiographs showed osteoarthritis with varus deformity. Petitioner was given work restrictions of no climbing of ladders or climbing on/off equipment. Hyalgan injections were recommended. (PX 4)

The deposition of Dr. Kefalas was taken on October 14, 2016. (PX 4) Dr. Kefalas is a board certified orthopedic surgeon. He had performed surgery on Petitioner's right knee back in 2007. The last time that Dr. Kefalas saw Petitioner prior to this incident was on January 10, 2007. On that date, Petitioner was doing well. Petitioner had no pain in his right knee and was walking with a normal gait. Dr. Kefalas first saw Petitioner following the December 4, 2015 incident on December 16, 2015. On that date, Petitioner provided Dr. Kefalas with a history of slipping and falling on December 4, 2015 and injuring his left knee. Dr. Kefalas ordered plain x-ray films and interpreted that study as revealing underlying arthritis. Dr. Kefalas felt that Petitioner sustained an acute left knee injury with an MCL sprain, as well as an aggravation of the pre-existing osteoarthritis. Dr. Kefalas injected Petitioner's left knee with a steroid and placed him on modified duty. When Petitioner returned to Dr. Kefalas' office on January 6, 2016, Petitioner had signs of a healing MCL sprain. Physical therapy was prescribed. Dr. Kefalas saw Petitioner again on February 25. 2016 and March 16, 2016. Petitioner reported that his left knee was better and physical therapy was helping. Dr. Kefalas continued Petitioner's restrictions and saw him again on April 20, 2016. On that date, Dr. Kefalas testified that Petitioner reported that his left knee symptoms had stabilized. On that date, Dr. Kefalas placed Petitioner at maximum medical improvement and allowed him to return to full duty work. Dr. Kefalas testified that Petitioner returned to his office on June 8, 2016. On that visit, Dr. Kefalas testified that "He was still - - since he had been back trying to do his regular duty work, he was having difficulty with stairs and kneeling, all with regard to his left knee. He was at that point using occasional Tylenol for his symptoms." On that date, Dr. Kefalas placed restrictions on Petitioner of no climbing of ladders or climbing on and off equipment. Dr. Kefalas also recommended Hylagan injections.

Regarding the issue of causation, Dr. Kefalas was posed a hypothetical in which he was asked to assume that prior to December 4, 2015, Petitioner was required to "do this heavy job full-time" (climbing ladders, stairs, hauling heavy materials and sometimes he would do lighter task, just whatever was needed, about a 50/50 match) and that he had little or no left knee complaints other than one time in October of 2011 until on December

4, 2015 Petitioner was getting out of his work vehicle when he slipped on ice, twisted his knee and "kind of hit it against the car," felt a pop and noted pain. Based upon that hypothetical set of facts (PX 4, p. 23), it was Dr. Kefalas' opinion that the December 4, 2015 incident aggravated Petitioner's left knee condition. (PX 4, pp. 23-24, 26)

Dr. Kefalas agreed that Petitioner had osteoarthritis in his knee long before the injury even though he had not seen him for any left knee issues. (PX 4, p. 25)

On cross-examination, Dr. Kefalas agreed that Petitioner's BMI placed him in the obese category. He further testified that for every 10 pounds of extra weight one carries, an additional 30 to 60 pounds of force is placed on one's knees with each step. (PX 4, pp. 30 – 33) The doctor also agreed that Petitioner's bilateral knee osteoarthritis was moderate to severe. (PX 4, p. 35) Dr. Kefalas testified that he did not review Petitioner's 45 degree flexion x-rays. (PX 4, p. 33)

Dr. Kefalas testified that Petitioner did fall ultimately on December 4th. According to the doctor, "He slipped getting out of his truck, felt a pop in his knee." (PX 4, p. 36) He then testified that he wasn't sure if Petitioner went all the way to the ground or not. (PX 4, p. 36)

Dr. Kefalas agreed that aggravations of osteoarthritis can be temporary and permanent. Dr. Kefalas further testified that by April 20, 2016 he felt Petitioner's aggravation had resolved and Petitioner was back to baseline. He also agreed that any further treatment will be driven by Petitioner's subjective complaints of pain. Dr. Kefalas also acknowledged being unfamiliar with Petitioner's left knee condition prior to the accident although he knew Petitioner had no left knee complaints in 2007. Dr. Kefalas testified that he was under the assumption that Petitioner's left knee was asymptomatic prior to December 4, 2015 and if that was inaccurate or incorrect his causation opinion might be inaccurate or incorrect. Dr. Kefalas acknowledged lacking any knowledge of Petitioner's specific job duties for Respondent. (PX 4, pp. 36 – 38) Regarding the issue of causation, Dr. Kefalas was asked:

> Q: Right. And that's the extent of what you can testify to as far as the causation issue is you can't go further and say that his current complaints are a result of this accident, as opposed to his underlying condition, because you don't know what his baseline was, how symptomatic he was prior to December 4, 2015.
>
> A: I guess that's possible. Yea. (PX4, p. 41)

The deposition of Dr. Jacob Sams was taken on October 27, 2016. (RX 2) Dr. Sams is a board certified orthopedic surgeon who focuses on large joint reconstruction and arthroscopy to the hip, knee and shoulder. Five percent of Dr. Sams' practice consists of performing independent medical evaluations. Dr. Sams saw Petitioner on February 25, 2016. Dr. Sams secured a history from Petitioner, performed a physical examination, reviewed his medical records and secured weight bearing x-rays. Dr. Sams testified that these x-rays allowed him to see Petitioner's left knee during a load. Dr. Sams thought that these x-rays were revealing in that they revealed bone on bone contact involving the

medial compartment. Dr. Sams testified that based on the x-ray film, Petitioner had severe joint spacing narrowing of the medial compartment of his left knee indicating complete loss of articular cartilage in that area. Dr. Sams testified that his physical examination revealed that Petitioner's left knee was stable. Dr. Sams testified that as of the date of his examination with Petitioner, Petitioner had reached maximum medical improvement following the December 4, 2015 incident and that he was able to return to full duty work.

Dr. Sams agreed that the December 4, 2015 accident could have caused the pre-existing osteoarthritis to become symptomatic. However, Dr. Sams testified that this that would be for a defined period of time. Dr. Sams testified that if Petitioner's left knee was really asymptomatic prior to the December 4, 2015 incident, having the type of injury that Petitioner described would not lead to it being chronically symptomatic (RX2).

Respondent secured a labor market survey by vocational specialist Michelle Barns. It was Ms. Barns' opinion that even if one assumes that Petitioner needed the restrictions imposed by Dr. Kefalas, employment was available to Petitioner in the job categories of a customer service representative, receptionist/information clerk, dispatcher and other categories. Ms. Barns located employers within these categories that were hiring within the salary range of $9.00 - $21.00 per hour (RX5).

The Arbitration Hearing

Petitioner's case proceeded to arbitration on February 28. 2017. At the time of the hearing the initial disputed issues were causal connection, temporary total disability benefits, and prospective medical care. Nathan Moreland was present as Respondent's representative. Witnesses testifying at the hearing included Petitioner, Nathan Moreland, and Robert Ishmael.

Petitioner testified that he is currently 64 years old and for the past 40 years he has worked for Respondent, the last twenty of which were spent as a plant operator. Petitioner has not worked for Respondent since December 4, 2015. Petitioner testified that his job as a plant operator consists of sitting in a tower and "basically pushing buttons" to run the plant screens, belts and impactors. Petitioner agreed that the job is essentially sedentary with the only physical activity arising when there's a "breakdown" and Petitioner has to go outside the tower to assist. He explained that if there is a breakdown in the plant, he would leave the tower and go help do things such as splice belts, shovel, change bearings and things like that. Petitioner estimated that there would be a breakdown two or three times a day maybe once or twice a week or "something like that."

Petitioner testified that he had surgery on his right knee by Dr. John Kefalas back in 2007. Petitioner was released back to full duty following that surgery. He further testified that he continued to have pain in that knee through 2015. Petitioner testified that since that surgery, Respondent provided him with a man-lift which he used to get up and down the tower (as indicated in the photos found in RX 3.) If the man-lift wasn't working (which wasn't very often) he would have to climb the stairs to the tower.

Petitioner testified that he did everything he was told to do before December 4, 2015. He testified that he could make it up the stairs to the tower but it took him awhile due to

his operated right knee. Petitioner acknowledged having pain in his right knee but being able to perform his job.

Petitioner's medical history includes treating for hypertension, diabetes, a heart condition, and obesity. Petitioner was asked if he had any left knee complaints in 2011 and he testified that he couldn't recall or remember any. When asked about a visit with the doctor on October 27, 2011 regarding some left knee pain, Petitioner was not sure if it was an isolated incident or if the doctor marked something wrong. Petitioner testified that his left knee was fine from 2007 through 2015.

Petitioner denied missing any work for either of his knees between 2007 and 2015.

Petitioner testified that on December 4, 2015 he, was going out to go down to his job, scraped the windows on the truck and started to get in it when he slipped on mud or ice getting into it and felt something pop in his knee. Petitioner was asked if he hit his knee and he didn't know. He thought he just stretched it out and there was a pop. Petitioner testified that he then drove the truck to the work station and used the man-lift to get up the tower. Petitioner also testified that the pain in his left knee continued to get worse, so he called his supervisor, Nathan Moreland, who told him to seek medical treatment.

Petitioner further testified that Dr. Quizon, his family doctor, examined him, told not to go back to work and advised he should see Dr. Kefalas who recommended sedentary duty and therapy. Petitioner testified that Respondent couldn't accommodate the restrictions and he was off work. Petitioner testified that the therapy helped but didn't "fix" the problem as he continued to feel a sharp stabbing pain in the front and back of his knee. He especially noticed problems with walking and stair climbing.

Petitioner testified that after seeing Dr. Sams at the request of Respondent, he received a call from Mr. Moreland telling him to go to the union hall and sign up for work. Petitioner interpreted this to mean he was no longer employed by Respondent. Petitioner testified that he had never been requested to do this in the past.

Petitioner testified that Dr. Kefalas released him to return to full duty work on March 16, 2016. Petitioner testified that his left knee was still hurting when he was released.

Petitioner testified that he returned to see Dr. Kefalas in April of 2016 his knee still hurt especially with walking and climbing stairs at home. Petitioner testified that when he returned to Dr. Kefalas in June of 2016 the doctor imposed work restrictions and recommended some injections. Petitioner would like to undergo the injections.

Petitioner testified that his left knee currently hurts quite a bit. Petitioner testified that, at times, he feels a sharp pain in the back of it and towards the right side on the outside and his left knee hurts more than his right knee although both are bothersome.

Petitioner testified that he didn't believe he could climb up into an end loader right now. When asked how often he would have to do that Petitioner explained that if he was

asked to do it he did it but it was difficult to do so. He wouldn't have to do it that often, maybe once a week. Petitioner testified that the climbing is the difficult part. He didn't think he could climb up the stairs to the tower anymore.

Petitioner testified that he is currently receiving both a pension and social security disability. He explained that in the middle of 2016 he was awarded social security disability income in the amount of $2,264.00 per month. Petitioner also testified that he notified Union Local 965 that he was retiring and that he wanted to start collecting his pension. He would have liked to have waited on both but couldn't.

Petitioner testified that he no longer can push a lawn mower or use his weed eater. Petitioner testified that he has not returned to Dr. Kefalas for further treatment as he is waiting for Dr. Kefalas to contact him.

On cross-examination Petitioner was asked if he was doing anything more at work than sitting in the man-lift 8 hours/day and he indicated he helped splice belts; however, he could not recall when he last spliced a belt or when he physically walked up the steps to the tower.

With regard to the accident, Petitioner testified that he was scraping ice off the front windows of a regular pick-up truck and he was going around the truck to get in and put his feet down to push into the truck and his left foot slipped. He then went to the man-lift, got in it and went up to the tower. He could not recall if December 4, 2015 was a "service to plant day" (a day in which he is not in the tower but helping do service work).

At this point in the hearing Respondent's attorney placed "accident" into issue.

Petitioner also testified that he returned to see Dr. Kefalas in June of 2016 because his knee still hurt. He acknowledged that in order to receive pension benefits he had to advise the Local he was retiring. He didn't recall when he began receiving his pension benefits.

Petitioner estimated that he spent eighty percent of his time in the tower and the remaining twenty percent was spent engaged in the other activities he had discussed on direct.

On redirect examination Petitioner testified that he and others came out of the shed and he headed towards the quarry's pick-up truck which had frost or ice on the front of it. He took an old scraper and walked to the front of the truck to scrape the ice off because the truck did not have a heater or defroster. He then went around to get in the truck and started to get in when his left leg slipped out from under him, due to either ice or mud on the ground, and he then proceeded to get in and drove to work. Petitioner explained that it's easier to get in a truck and drive down to the pit to go to work. He also explained that the shed is the place where everyone gathers in the morning before the go to work and they drink coffee and "tell lies and go to work."

Petitioner testified that he weighed the same in 2006 as he does now as he hasn't gained a pound nor does his weight fluctuate much.

Mr. Nathan Moreland testified on behalf of Respondent. He has worked for Respondent since May of 2002 and currently works as a working foreman. He has worked in that capacity for the past couple of years. Mr. Moreland testified that Respondent's business basically consists of making rock. Mr. Moreland was Petitioner's supervisor on December 4, 2015. He testified that prior to that date Petitioner's job consisted basically of working the tower. Mr. Moreland testified that every once in a while Petitioner would be the "ground man" which consisted of handing tools to co-workers or riding a skidsteer which is essentially a machine that he would sit in that would have a bucket on it. Mr. Moreland testified that in a typical week Petitioner would not leave the tower. Mr. Moreland testified that Petitioner would use a man lift to get up and down the tower. Mr. Moreland testified that he told Petitioner that it would help his health if he would use the stairs but Petitioner indicated that he could not because of his knees. Mr. Moreland testified that Petitioner always walked with a limp or shuffle which he documented prior to December 4, 2015 (See RX4). Mr. Moreland testified that the hypothetical posed to Dr. Kefalas in his evidence deposition indicating that prior to December 4, 2015 Petitioner was performing a heavy full-time job was not accurate. Mr. Moreland testified that other than pushing buttons in a tower, if there was a breakdown in the plant, Petitioner would sit on a machine and hand tools to co-workers. Mr. Moreland testified that this is the way that it was for the past 13 years.

Mr. Moreland also testified that near the end of December of 2015, Petitioner, along with five other workers were laid off as business was slow. Mr. Moreland testified that at approximately 8:33 a.m. on December 4, 2015, Petitioner reported to him that he fell while getting into his truck.

Mr. Robert Ishmael testified on behalf of Respondent. Mr. Ishmael has worked for Respondent for the past eight years. He currently works as a blaster and driller. On December 4, 2015 Mr. Ishmael was working in this capacity in the pit. Mr. Ishmael has known and worked with Petitioner for a long time. Mr. Ishmael testified that Petitioner's job on December 4, 2015 was to run the tower. Petitioner would take a man lift up to the tower and for the most part would stay there all day. If there was a problem at the plant, Mr. Ishmael testified that Petitioner would rarely help. Mr. Ishmael testified that Petitioner has limped around the quarry for 25 years.

On redirect examination, Petitioner agreed that what Mr. Moreland testified to was fair. Petitioner testified that he cannot do job duties now that he could when he first started because of his knees. Petitioner testified that after 40 years, he would expect that someone a lot younger than him would do the hard part and take care of the old guys.

The Arbitrator concludes:

Issue (C) Did Petitioner sustained an accident on December 4, 2015 that arose out of and in the course of his employment with Respondent?

Petitioner failed to prove that he sustained an accident on December 4, 2015 that arose out of and in the course of his employment with Respondent.

In order to recover benefits under the Workers' Compensation Act an employee must prove, by a preponderance of the evidence, that he sustained an accident that "arose out of" and "in the course of" his employment with Respondent. *First Cash Financial Services v. Industrial Comm'n*, 367 Ill. App. 3d 102, 105 (2006). Whether an employee's injury arises out of his employment requires the injury to have its origin in some risk connected with, or incident to, the employment so as to create a causal connection between the employment and the accidental injury. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003). The Illinois courts have consistently held there are three types of risk to which an employee can be exposed: (1) risks distinctly associated with the employment; (2) risks that are personal to the employee; and (3) neutral risks that have no particular employment or personal characteristics. *First Cash Financial Services*, supra, at p. 105.

It has been further held by the Illinois appellate courts that employment-related risks are those distinctly associated with one's employment so that at the time of the injury one can conclude that the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties. "A risk is incidental to one's employment where it belongs to or is connected with what an employee has to do in fulfilling his duties. See *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 58 (1989).

The courts have also recognized that neutral risks are compensable only when the employee has been exposed to the risk to a greater degree than the general public and such increased risk may be either qualitative (as when some aspect of the employment contributes to the risk) or quantitative (as when an employee is exposed to a common risk more frequently than the general public. *Metropolitan Water Reclamation District of Greater Chicago*, 407 Ill. App. 3d at 1014.

In the instant case Petitioner was not engaged in an employment-related risk at the time of the accident. No evidence was presented suggesting that Petitioner was engaged in some action on behalf of his employer or as part of his job duty as a plant operator at the time of the accident. Indeed there were some contradictions in terms of exactly what happened at the time of the alleged accident as Petitioner wasn't sure if he slipped on ice or mud and there is evidence suggesting he may have been getting out of his truck rather than trying to get into it. Either way, his actions at the time of the accident bore no relationship to his job duties. The purpose of the Workers' Compensation Act is to protect employees against the risks and hazards "peculiar to the nature of the work they are hired to perform." *Orsini v. Industrial Comm'n,* 117 Ill. 2d 38, 44 (1987). Petitioner was not encountering a risk peculiar to his job at the time of his injury. Petitioner injured his left knee while getting into a regular size truck before heading to the work site. Petitioner also failed to prove either a qualitative or quantitative degree of increased risk at the time of his injury. Accordingly, Petitioner's claim for compensation is denied and no benefits are awarded.

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

Even assuming, arguendo, that Petitioner sustained a compensable accident, Petitioner failed to prove that his current condition of ill being in his left knee is causally related to the work accident.

Petitioner bears the burden of proof on the issue of causation. In this instance, Petitioner tendered the opinion of Dr. Kefalas, his treating doctor. Dr. Kefalas' opinion in this case was based upon a hypothetical set of facts which were not borne out at trial. Dr. Kefalas testified at one point that he was under the impression that Petitioner fell at the time of the accident. He later testified that maybe Petitioner did not fall. He further testified to his understanding that Petitioner was exiting the truck at the time of the accident (and, indeed, the hypothetical posed to him asked him to erroneously assume that). Petitioner testified he was getting into, and not out of, the truck. Even more significantly, Dr. Kefalas was asked to assume that Petitioner hit his left knee at the time of the accident. Petitioner did not testify to hitting his knee. Petitioner did not testify to twisting his knee. Petitioner, at most, stretched out his leg and heard a pop. Dr. Kefalas was also under the impression (as stated in the hypothetical) that Petitioner worked heavy labor for Respondent. Such was not the case. He had an 80% sedentary job. In sum, Dr. Kefalas' causation opinion was based upon an incomplete and inaccurate understanding of the accident. Petitioner failed to meet his burden of proof on causation.

Furthermore, the Arbitrator notes that both Dr. Kefalas and Dr. Sams agreed that the December 4, 2015 incident caused only a temporary aggravation to Petitioner's underlying degenerative joint disease in his left knee and that the temporary aggravation had resolved either in February or April of 2017. Subsequently, after retaining an attorney, applying for and receiving social security disability, and applying for pension benefits through his union, Petitioner returned to Dr. Kefalas in June of 2016 at which time Dr. Kefalas imposed restrictions of no climbing on ladders or equipment based upon Petitioner's subjective complaints. While Dr. Kefalas, in his evidence deposition, changed his mind and opined that Petitioner was no longer at maximum medical improvement his opinion was based on the assumption that Petitioner had returned to work and was experiencing difficulties and, most significantly, that Petitioner prior to December 4, 2015 had been working in a heavy duty job. This was not the case. The evidence indicates that prior to December 4, 2015, Petitioner had difficulties due to various medical conditions performing all aspects of his job and prior to December 4, 2015 Petitioner's job essentially consisted of taking a man lift up and down a tower and pushing buttons for the entirety of his shift. Dr. Kefalas also agreed that regarding the causation issue, he could not say what Petitioner's current complaints were related to because he did not know what Petitioner's left knee baseline condition was prior to December 4, 2015.

The Arbitrator also notes that Petitioner is 5'6", weighs 326 pounds, and has a BMI of 52.68. Weight bearing x-rays on his left knee revealed bone on bone. Based on these facts, Petitioner's left knee would not have been asymptomatic prior to December 4, 2015 and, despite Petitioner's testimony that his knee was asymptomatic, medical records suggest otherwise.

Lastly, Petitioner has not treated since June 8, 2016 for nine months. Petitioner offered no evidence beyond the deposition of Dr. Kefalas to establish that his current complaints are related to the December 4, 2015 incident or his underlying osteoarthritis.

The Arbitrator further notes that she did not find Petitioner to be a credible witness. Petitioner had trouble remembering matters or issues that didn't necessarily work in his favor. For example, he was asked about any prior left knee problems. He adamantly denied any. Even when asked about a visit in 2011 for left knee complaints he explained that it was either just an isolated visit or the doctor got it wrong. Petitioner appeared unwilling to acknowledge some prior left knee problems and address them in a forthright manner. Additionally, Petitioner was not forthright about his weight. Petitioner denied any change in his weight between 2006 and the date of accident testifying that his weight "fluctuated very little" whatsoever. The Arbitrator cannot help but note that in 2006 he weighed 260 lbs., that in 2011 he weighed 339.5 lbs. and that in 2014 he weighed "300+." Finally, Petitioner misrepresented his employment status to Dr. Kefalas when presenting to him on June 8, 2016. Petitioner testified that he never returned to work after the accident. Indeed, he had applied for social security and his pension. Petitioner's credibility issues undermine causation in this matter as well as the validity of his subjective complaints when presenting to Dr. Kefalas in June of 2016.

Petitioner's claim for compensation is denied. All remaining issues (temporary total disability and prospective medical care) are rendered moot. No benefits are awarded.

****

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

Joshua Skelly,

Petitioner,

vs.

No. 15 WC 22548

18IWCC0110

Baine Roofing,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review under §19(b) having been filed by the parties herein and proper notice given, the Commission, after considering the issues of accident, medical expenses, prospective medical care and temporary disability, and being advised of the facts and law, expands, 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 shares the Arbitrator's concern about Petitioner's credibility—particularly his unrebutted statement to Mr. Tarrants, a coworker, about leaving the job with Respondent "with a pocket full of cash." The Commission spent much time deliberating whether this statement indicates Petitioner lied about the accident taking place, as well as his motivation to exaggerate or magnify his symptoms. After careful consideration of the entire record, the Commission agrees with the Arbitrator that "what appears to have occurred in this case is a loss of trust between the Petitioner and Respondent, including Mr. and Mrs. Baine. As a result, we have both parties paying more attention to the 'case' at hand than the injury itself and the Petitioner's recovery." Returning to the issue of accident, the Commission notes that Petitioner

18IWCC0110

testified he had worked for Respondent for eight years. Mr. Tarrants testified that Petitioner was a good employee and did good work. The Commission finds no evidence of prior workers' compensation claims. Petitioner's description of slipping on a piece of felt paper and falling while tearing shingles and felt paper off a roof is credible on its face. Jeff Baine, Respondent's owner, confirmed that Petitioner told one of his sons that he had slipped and fallen. A first report of injury prepared by Respondent's insurance carrier states Respondent was notified of the accident on May 29, 2015. The mechanism of injury was a slip and fall on a roof. Mr. Baine testified that he did not believe Petitioner had injured himself at work, although he had no evidence that Petitioner had injured himself elsewhere. The clinical note from Dr. Blaise from June 1, 2015, states a history of Petitioner "tearing off a roof on Thursday [May 28, 2015] and slipped on some tar paper. Jarred his back when [he] did. Has a lot of pain with certain movements and a lot of tingling and numbness to LLE." It is further noted: "This occurred 4 day(s) ago at work. The injury resulted from a fall."

The Commission decides to give deference to the Arbitrator's finding, after the Arbitrator observed the demeanor of all witnesses, that Petitioner proved he sustained an accidental injury arising out of and in the course his employment with Respondent on May 28, 2015. The Commission agrees with the rest of the Arbitrator's decision in all respects.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 8, 2017, is hereby expanded, 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 23 2018

DATED:
o-01/11/2018
SM/sk
44

Stephen Mathis

David L. Gore

Deborah Simpson

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

SKELLY, JOSHUA
Employee/Petitioner

Case# **15WC022548**

BAINE ROOFING
Employer/Respondent

18IWCC0110

On 3/8/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 RICH RICH & COOKSEY PC
MICHELLE M RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

1337 KNELL LAW LLC
LLIR IMERI
504 FAYETTE ST
PEORIA, IL 61603

18IWCC0110

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)

JOSHUA SKELLY
Employee/Petitioner

v.

BAINE ROOFING
Employer/Respondent

Case # **15** WC **22548**

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 25, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident 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, **May 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* 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 **$33,586.12**; the average weekly wage was **$645.89**.

On the date of accident, Petitioner was **36** 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 **$18,856.42** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$18,856.42**.

Respondent is entitled to a credit for any awarded medical paid prior to hearing under Sections 8(a) and 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$430.59 per week** for **4-1/7 weeks**, commencing **September 25, 2016 through October 23, 2016**, as provided in Section 8(b) of the Act.

Respondent shall pay the reasonable and necessary causally related medical services contained in Petitioner's Exhibit 2, as provided in Sections 8(a) and 8.2 of the Act. However, any charges related to MRI spectroscopy testing is denied, and Respondent is not liable for same.

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

The Arbitrator finds that the Petitioner is not entitled to the proposed surgery recommended by Dr. Gornet, specifically L5/S1 fusion and L4/5 disc replacement, based on the Arbitrator's finding that this treatment is not reasonable and necessary within the meaning of Section 8(a) of the Act.

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

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

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

Signature of Arbitrator

March 3, 2017
Date

ICArbDec19(b)

MAR 8 - 2017

STATEMENT OF FACTS

The Petitioner has worked for the Respondent for approximately 8 years as a roofer. He testified that, in the process of tearing off a roof, he was walking up while holding a scoop shovel full of material, slipped on a piece of felt paper and fell. He indicated that he injured his back and may have hurt his elbow. He believed that the incident occurred on 5/28/15, though he also said it could have been the week prior. 5/28/15 was consistent with the Form 45 (completed by the Respondent on 6/16/15), which indicates the Petitioner reported the accident on 5/29/15. (Rx1). Petitioner testified that he's had no prior or subsequent back injuries.

The Petitioner continued to work, but testified he was in pain and tried not to do too much. He also worked the next day, a Friday, noting he took medication. Sometime around their pre-lunch break that day, Petitioner said he asked his boss Jeff Baine's son Ross what was wrong with Ross's back, noting Baine's sons were in charge when he wasn't there, and told Ross that he thought he did something to his own back. Ross replied that Petitioner would have to inform his dad, Jeff Baine, Respondent's owner. Petitioner testified he did not do so that day because Jeff Baine wasn't around, but did report it the following Monday (6/1/15). He testified that he called Mr. Baine that Monday morning because he could barely put his pants on and needed medical treatment, and that Mr. Baine just asked him not to go to the emergency room. Petitioner testified he had planned to see his family physician, Dr. Blaise, and saw him on 6/1/15.

The 6/1/15 report of Dr. Blaise notes complaints of back pain and numbness in his feet. The history stated that four days prior, which was 5/28/15: "Patient words: was tearing off a roof on thursday and slipped on some tar paper, jarred his back when he did, has a lot of pain with certain movements and a lot of tingling and numbness to LLE." The report notes it was a workers' compensation claim. Petitioner reported a sudden onset of symptoms, which at that time included left low back pain into the lower left leg, spasm and stiffness. The pain was sharp and tingling with leg numbness. On physical exam, tenderness in the medial low back and over the spinal column was noted, as well as muscle spasm and limited range of motion in trunk extension. Lumbar x-rays revealed mild disc space narrowing at L3-4 and L5-S1. The diagnosis was left low back pain with sciatica. Medication was prescribed and there was no indication of work restrictions. (Px3 & Px4).

Petitioner continued to complain of left-sided low back pain when he followed up with Dr. Blaise on 6/10/15. An MRI was recommended and Petitioner was taken off work. A 6/19/15 note indicates Respondent's Diane Baine, the wife of Jeff Baine, called indicating that Respondent had light duty available to Petitioner, and requested parameters. Dr. Blaise responded indicating sedentary work, no lifting, pushing or pulling. Id. According to the records, Respondent then requested "a specific pound limit." (Px3).

Claimant returned to Dr. Blaise on 6/22/15 complaining of increasing left leg numbness over the past week and worse cramps at night. He also reported difficulty with arising from a chair, walking and lifting. The record contains a 6/24/15 note indicating Mrs. Baine again called indicating light duty work was available, including desk work, and that "they'd really like to get him back on the job." On 6/26/15, Petitioner reported increased back pain since returning to light duty, noting that bending over and walking seemed to be aggravating his back pain. Hydrocodone was prescribed and he was restricted to a desk job with no pushing or pulling and no lifting over 15 pounds. (Px3).

Petitioner next sought treatment with orthopedic surgeon Dr. Gornet on 7/10/15, noting he was recommended by a friend. He reported complaints of left low back pain into the left buttock, hip and leg to the knee after slipping on felt paper while carrying trash on a roof on 5/28/15, causing him to twist and fall to the roof. He initially thought he pulled a muscle, worked the next day, and then after a three day holiday weekend, he attempted to return to work the following Tuesday but had severe pain. He reported this to his boss, who asked him to get treatment but not at the hospital. After being taken off work for a week, he continued to have severe pain upon his return. Dr. Gornet reported no prior problems of significance with regard to Petitioner's low back, and that his constant symptoms worsened with bending, lifting, prolonged sitting or standing, and improved with a change in position or leaning to the right side. Numbness and weakness in the left leg were also noted. Examination revealed decreased EHL and ankle dorsiflexion and plantar flexion on the left, and decreased sensation on the left at L5-S1. Dr. Gornet also noted positive left straight leg raise and crossed straight leg raise. Lumbar x-rays showed some mild loss of disc height at L5-S1, but no significant degeneration. Dr. Gornet's impression was an acute disc injury at L4-5 and L5-S1. (Px5).

Lumbar MRI was prescribed and performed that same day. (Px6). The report reflected mild disc desiccation from L3 to S1. At L3/4, there was a right disc protrusion contributing to right foraminal stenosis, with no canal or left foraminal stenosis. At L4/5, there was a likely left annular tear with a left disc protrusion contributing to minimal central canal stenosis and encroaching upon the existing left L4 nerve root, with no central canal stenosis or right foraminal stenosis. At L5/S1, there was a likely left annular tear and minimal diffuse annular disc bulge, as well as left foraminal disc protrusion contributing to mild left foraminal stenosis and encroaching upon the left L5 nerve root. (Px6).

Following the MRI, Dr. Gornet opined that the objective findings were consistent with Petitioner's subjective complaints, in terms of left lateral disc herniations and annular tears at L4/5 and L5/S1, while the right foraminal herniation at L3-4 did not correlate with his symptoms. Prior to the MRI, Dr. Gornet indicated Petitioner should be off work, but subsequently recommended light duty work with a 10 pound lifting limit, no repetitive bending or lifting, alternating between sitting and standing as needed - "essentially sedentary or office work only." Dr. Gornet also prescribed medication and physical therapy, and Petitioner was to follow up in six weeks. (Px5).

Petitioner testified that when he returned to work, the Respondent had him washing trucks, building a "contraption" to haul recycling bins, scraping tar off of machinery and cleaning Mr. Baine's personal car's tires. He reported this to Dr. Gornet.

The initial physical therapy report of 7/15/15 notes the Petitioner reported he was injured at work and was able to keep working but had progressive pain over the Memorial Holiday weekend. (Px9).

Petitioner followed up with Dr. Hanson at his primary care physician's office on 7/24/15. Despite two week of physical therapy, Petitioner reported ongoing pain in the left hip and lower back. He reported that the

Respondent was not following Dr. Gornet's work restrictions, and Dr. Hanson took him off work from 7/24 through 8/31/15. A subsequent 7/27/15 note indicates the employer came into the office today with a written request wanting to know what changed from his last work note that put him on light duty to being off until 8/31/15. Dr. Hanson issued an amended work note allowing Petitioner to return to light duty (no lifting over 10 pounds, requires a sitting/sedentary desk job for entire shift which should not exceed 8 hours), two days a week until 8/31/15, and noted the Petitioner was notified of this. The note did state that the change in work status was based on the Petitioner's report of increased pain with physical therapy. (Px3). The Arbitrator notes that Dr. Hanson also appears to have prescribed medications, but it is unclear if this reflects the medication prescribed by Dr. Gornet, or if it was an additional prescription. (Px3).

A 7/29/15 report indicates Petitioner was working two days per week, mostly sitting with the ability to change positions. On 8/10/15, Petitioner reported the same thing, but that he had 10 out of 10 pain after a workday. (Px9).

At a 9/21/15 follow up with Dr. Gornet, Petitioner reported persistent left-sided low back, buttock, hip and leg pain. The note also states: "In spite of my recommendations for a 10 pound limit, alternating between sitting and standing and no repetitive bending or lifting, his employer stuck him in the warehouse cleaning and scraping different things, scraping tar off of machines, all of which would have to involve repetitive bending and lifting. At this point, he states that now the employer is trying to accommodate him with him sitting there cleaning tools and I have no problem with this, but if they continue to violate the instructions that I have given him, then I will place him off work completely." Physical therapy, noted as "failed", was discontinued, and epidurals were planned at L4/5 and L5/S1, noting surgery would be recommended after further workup if these failed to result in improvement. Dr. Gornet performed these injections along with facet blocks on 9/30/15 (L4/5) and 10/9/15 (L5/S1). (Px5 & Px7).

On 10/26/15, Petitioner reported persistent, significant symptoms following the injections. Examination was unchanged. Noting his belief that Petitioner had a significant foraminal herniation at L5-S1 on the left, as well as a smaller herniation at L4-5 and annular tear at both levels on the left side, Dr. Gornet recommended a left-sided L5/S1 microdiscectomy. He noted that because this procedure weakens the spine and decreases stability, and would not fix his structural problem, Petitioner might ultimately require a fusion surgery. Petitioner again reported that the Respondent was not following his restrictions, including having to wash trucks, but Dr. Gornet kept Petitioner's restrictions in place. (Px5 & Px7).

The Arbitrator notes that a utilization review with orthopedic surgeon Dr. Yousuf indicated that authorization of the prescribed microdiscectomy surgery was recommended. (Px10).

The 12/15/15 operative report notes Dr. Gornet performed a laminotomy, foraminotomy and microdiscectomy at L5-S1. He reported visualizing a very far left herniation, and noted that several small disc fragments were removed. (Px5 & Px7). The Petitioner testified that he initially had reduced pain but ongoing numbness, and by the time he went back for his check up, he was back to the same pain he had before the surgery. Dr. Gornet's 12/28/15 post-op report notes Petitioner appeared to be improving clinically with good strength and improved leg pain, but some ongoing numbness. He was prescribed medication and kept off work through 1/25/16. (Px5).

On 1/25/16, Dr. Gornet reported that Petitioner's initial improvement seemed to be slowly fading away, noting increasing pain in Petitioner's low back, left buttock, left hip and left leg symptoms, and even tingling in his foot. Dr. Gornet stated: "I have discussed with him that for the most part this is somewhat predictable. I would like him to begin physical therapy and rehab. The real issue is whether I can pull him out of his current condition of ill being with simply conservative care or whether he will require further treatment. Given his

problem, my push would be to try and minimize further operative intervention and I have discussed this with him today. He remains temporarily totally disabled." (Px5).

The physical therapy records reflect no significant improvement between 1/29 and 3/14/16, with Petitioner reporting his pain was never less than 5 out of 10. He did have increased tolerance for cardio and core stabilization exercises, but without change in pain or mobility. (Px9).

On 3/17/16, Petitioner returned to Dr. Gornet, reporting he again felt physical therapy was making him worse. Dr. Gornet indicated this was consistent with post-discectomy discogenic low back pain and possibly a recurrent disc herniation. He believed Petitioner suffered from a structural failure, as described in his 10/16/15 note, and "it is often a predictable result of a simple decompression procedure." Dr. Gornet recommended a new MRI and kept Petitioner off work, stating the only other option for him would be a multilevel L3 to S1 fusion versus fusion in combination with disc replacement. (Px5).

The 6/2/16 repeat lumbar MRI noted, as compared to the 7/10/15 films: 1) left-sided micro decompression changes at L5-S1 with persistent enhancing annular material in the left lateral recess and left neuroforamen. A mild degree of left foraminal stenosis persists. No new central canal stenosis is observed; 2) Central broad-based protrusion at L4-5 and right foraminal protrusion at L3-4 unchanged. Mild to moderate right foraminal stenosis at L3-4 is unchanged. No new central canal stenosis is observed. The radiologist's report also noted the prior surgery, with "operative bed enhancement dorsally, in the left lateral epidural space, extending into the left lateral recess and left foramen. The disc enhances to the left of midline at the site of the previous protrusion. There is persistent left L5 lower endplate spurring and minimally bulging annular material resulting in mild left foramina stenosis. No new central canal or right foraminal stenosis is observed." (Px6).

On 6/2/16, Dr. Gornet reviewed the MRI, noting a large left L5/S1 annular tear, but no recurrent disc herniation. Although he noted the standard treatment for Petitioner's injury would be spinal fusion anteriorly at L5-S1, he was concerned about the effect on the adjacent levels at L3-4 and L4-5. He indicated that medical literature indicates that spinal fusion causes structural changes at adjacent levels, including increased motion and biomechanical forces, and thus those adjacent levels had to be contemplated in determining a surgical procedure. He recommended lumbar MRI spectroscopy and a discogram with CT scan, and kept Petitioner off work through 8/18/16. (Px5).

Testimony was elicited from multiple witnesses with regard to the Petitioner's attendance at a concert event in Marion, Illinois on 6/18/16. Petitioner testified he was at the concert for three hours or so. His party had access to bleacher seats, and every once in a while when his foot hurt or tingled, he'd go sit down for 15 minutes at a time, and this was not depicted in the short videos. Mrs. Skelly testified consistent with the Petitioner. Mr. Baine testified that he and his wife saw the Petitioner at the concert, and that he was standing, visiting with people, talking, walking, "being his normal self". There was no seating, all standing, other than VIP section – "we (him and P) weren't in that area". Petitioner's wife, Diane, testified consistently with Mr. Baine, and she was the one who took some short films (Rx9) of the Petitioner. They were able to see the Petitioner for about 3 hours or so of the concert until it got dark out. In the time they saw him, they testified they did not observe him in pain or limping, which is completely different than he is at work, where he limps and struggles. They also indicated that in the section at the concert they were in, there was no seating available. The Arbitrator reviewed the video of this event, submitted by Respondent and filmed by Mrs. Baine. It consists of six very short snippets of the Petitioner standing at the concert and talking to friends. (Rx9). The video was very minimal, though Mrs. Baine testified that obtaining more video would have shown the same depictions. The Arbitrator notes that there is a seated bleacher area near where the Petitioner was standing. It does appear to be separated from the ground

level area where the Petitioner was, but the video does not show a complete view regarding whether there was general access.

The report from the 7/5/16 discogram performed by Dr. Gornet notes that testing was performed at L3/4 and L4/5, with provocative findings at L4/5 with a left-sided annular tear, and non-provocative findings at L3/4, despite the indication of a right annular tear. Dr. Gornet noted that L5/S1 was not addressed: "we assumed that L5/S1 would need to be treated as it already had a previous discectomy and at this point we were evaluating the disc above. . ." (Px7).

Post-discogram CT scan noted the right L3/4 and left L4/5 defects "which could, in part, be iatrogenic from needle injection site, though there does appear to be a contour abnormality on the left side at L4/5". This was to be correlated with the discogram, and the findings also included a left-sided disc abnormality at L5/S1 with foraminal narrowing. (Px8).

After reviewing the test results on 8/18/16, Dr. Gornet recommended an L5/S1 fusion and disc replacement at L4/5. He also anticipated Petitioner would require some level of permanent restrictions because the L3/4 level was not being addressed, and he didn't want to place any undue significant stress on this level. He believed, however, that he could substantially improve the Petitioner's symptoms and get him back to gainful employment. While there was no associated progress note located in the record, Dr. Gornet issued an undated note indicating Petitioner was to remain off work from 10/24 through 11/12/16. (Px5).

Respondent scheduled a Section 12 examination with orthopedic surgeon Dr. Mirkin on 9/7/16 but Petitioner failed to appear, and Respondent suspended TTD benefits, arguing that this was pursuant to the Act. Petitioner's counsel indicated that notice and a mileage check had been provided by Respondent, but a clerical error led to a failure to notify the Petitioner of the exam. The Petitioner testified he first learned of the issue when he contacted his attorney because he hadn't received his TTD. (Px11).

The rescheduled examination took place on 10/14/16. Petitioner provided Dr. Mirkin with a history of injury of falling and twisting his back on 5/28/15 with immediate back pain. He reported continuing to work the rest of that day and the next day, and that he did not seek medical treatment for the injury until returning to work after a long weekend off of work. His symptoms included low back pain and stiffness, left leg pain and left foot numbness. Petitioner reported that before surgery he couldn't get out of bed, but was able to after surgery, though he still had persistent back pain into the left leg. (Rx7).

Dr. Mirkin reviewed all of claimant's prior medical records regarding the treatment claimant received from Dr. Blaise, SH Medical, and Dr. Gornet, as well as the 7/10/15 lumbar MRI, noting it revealed disc desiccation and degenerative disease at L3/4 and L4/5. Dr. Mirkin also noted a small formal protrusion at L5/S1 on the left that abuts the nerve root. Dr. Mirkin also reviewed the subsequent, post-surgical 6/2/16 MRI, which he noted showed only slight bulging at L4/5 with no compression of the nerve root. X-rays performed at Dr. Mirkin's request showed the post-laminectomy at L5/S1, but no other abnormality. On examination, Dr. Mirkin noted that the Petitioner had significant loss of lumbar range of motion and multiple Waddell signs, indicating severe symptom magnification behavior, but that he reported improved with surgery. (Rx7 & Rx8).

Dr. Mirkin opined that, assuming the history of injury was correct, claimant suffered a lumbar strain and very minimal small disc protrusion at L5/S1 on the left which could have caused some neuroforaminal narrowing. Dr. Mirkin noted that claimant had already undergone surgery to correct this issue, the recommendation of which he did not dispute. Dr. Mirkin opined that claimant's current subjective complaints, however, do not correlate to the objective findings. The objective findings on MRI did not reveal any condition that would

require the additional surgery being recommended by Dr. Gornet, disc replacement and fusion. Dr. Mirkin indicated that discogram was "of dubious diagnostic quality". According to Dr. Mirkin, claimant essentially had severe symptom magnification and mild degenerative disc disease at L3/4, L4/5, and L5/S1, and there was no medical indication for the recommended surgery based on the objective records. He believed the only additional treatment that claimant needed was aggressive physical therapy, and that he was capable of returning back to work with a 50 lbs. lifting restriction. (Rx7).

Following Dr. Mirkin's evaluation, Petitioner returned to Dr. Gornet on 11/12/16. He noted that Petitioner's examination "for the most part is non-focal", but he continued to have pain into the left buttock and hip and what appeared to be intermittent left EHL weakness, though it seemed more normal on exam. He also noted that Petitioner wanted to discuss Dr. Mirkin's report. Dr. Gornet reiterated why the L5/S1 level was not tested during the discogram. He also discussed the MRI spectroscopy findings with Petitioner; specifically, that this study demonstrated a very high level of painful chemicals, which were objective and irrefutable. Dr. Gornet indicated he saw no signs of symptom magnification in Petitioner, noting there was objective explanation for his ongoing symptoms. He also noted that Dr. Mirkin had released Petitioner to work with up to a fifty (50) pound lifting limit, which Dr. Gornet described as essentially almost heavy labor. Dr. Gornet stated: "There is no indication that this patient's current condition and objective findings would allow him to do this and obviously I believe this is a set-up for him to have increasing pain or be terminated by his employer because he cannot do his job." He recommended Petitioner make his best good faith effort to do the work. Dr. Gornet also stated that Dr. Mirkin "appears to be biased in the record against this office", and that Dr. Mirkin did not explain his "contradictory" statements that Petitioner exhibited severe symptom magnification while Petitioner claimed to be improved. (Px5).

Dr. Gornet testified via deposition on 12/19/16. Dr. Gornet, a board certified orthopedic surgeon, testified that he is significantly involved in new types of treatment for lumbar and cervical spine conditions, including participation in authoring some of the largest prospective randomized clinical trials for cervical disc replacements, and for considering lumbar surgery versus conservative. Dr. Gornet is also heavily focused in new types of diagnostic evaluations for neck and low back pain, including MRI spectroscopy, which he testified is an objective measure of painful chemicals in the discs themselves. (Px7).

Dr. Gornet testified that Petitioner's examination was positive for findings of nerve root irritation at L5/S1. While x-rays were not impressive for significant degenerative changes, he opined that the MRI findings (lateral L4/5 disc herniation and large annular tear, and a left lateral L5/S1 foraminal herniation with an annular tear) were consistent with the exam and Petitioner's subjective complaints. The mild disc pathology at L3/4 did not correlate with Petitioner's symptoms. Dr. Gornet opined that the disc injuries at L4/5 and L5/S1 were related to the 5/28/15 accident, noting that twisting and falling could contribute to such disc injury, particularly since he was carrying material at the time which increased the mechanical spinal load. (Px7).

Dr. Gornet testified that Petitioner's condition may have been negatively impacted by working in excess of his restrictions, as it would cause inflammation while he was trying to reduce it via conservative treatment. He didn't believe that Petitioner could have been washing trucks without having to bend. (Px7).

Dr. Gornet initially wanted to attempt the L5/S1 microdecompression in order to try to relieve the leg symptoms, with plans to then try to rehabilitate the Petitioner's back. As he noted in his report, the disc surgery weakens the spine and decreases stability, leaving Petitioner susceptible to further structural spine treatment. In his opinion, trying the discectomy first was a "win-win": "It's a win for Mr. Skelly that he has less surgery on his body and a quicker recovery. It's a win for the employer/insurer because it's less costly and their employee will be back to work." (Px7).

While the surgery initially helped, with initial improvement of leg symptoms, it did not provide sustained relief. By 3/17/16, Dr. Gornet again documented left EHL and ankle dorsiflexion weakness, which he opined is consistent with a structural failure after discectomy. Dr. Gornet opined that the pathology noted on the 6/16 MRI films is a continuation of the original work injury. He performed a discogram at L3/4 and L4/5 to try to locate the pain generator. L5/S1 was not evaluated because surgery had already been performed at that level and would need to be included in the subsequent surgery. MRI spectroscopy was obtained to also try to pinpoint painful discs via objective chemical findings in the disc that are known to cause back pain. Discogram was concordant at L4/5 but not at L3/4. MRI spectroscopy showed essentially zero painful chemicals at L2/3; L3/4 was not interpretable because of noise; L4/5 showed moderate painful chemicals; L5/S1 had the highest level that can be detected. Dr. Gornet believed that Petitioner's subjective symptoms were consistent with these test results, and opined that L5/S1 fusion and L4/5 disc replacement were Petitioner's best option for long term relief. He noted that fusing L4/5 would increase the likelihood of worsening at the L3/4 level, while a disc replacement would keep some normal motion between the segments and reduce this likelihood. (Px7).

Dr. Gornet testified the recommended surgery would likely allow the Petitioner to return to work in some capacity, possibly moderate labor, though he questioned whether he would be able to return to work as a roofer. Dr. Gornet testified he did not find symptom magnification, and that Dr. Mirkin's findings of symptom magnification was inconsistent with the Petitioner's report to Mirkin of post-surgical improvement, and it was irrelevant anyway given the Petitioner had objective evidence of a problem. Dr. Gornet did not believe the Petitioner would significantly improve without surgery, and that Petitioner's condition has never returned to his preinjury status or baseline. (Px7).

On cross-examination, Dr. Gornet was asked if Petitioner's issues were disc bulges or herniations, and he noted torn annulus at L4/5 and L5/S1 and a left foraminal herniation at L5/S1, but that both L5/S1 and L4/5 could be causing his leg pain, though he only addressed L5/S1 in surgery. The surgery was to address a piece of disc that was hitting the L5/S1 nerve. He agreed that people can have asymptomatic disc herniations and bulges, and Petitioner's L3/4 disc is an example. He testified that if L4/5 were to now be decompressed, it would prohibit a disc replacement at that level in the future, and if it needed structural work, a two level fusion would be needed that would then impact L3/4. He had no personal knowledge of what Petitioner's activities were while on light duty, just what Petitioner told him. (Px7).

The evidence deposition of Dr. Mirkin was obtained on 1/9/17. (Rx8). A board certified orthopedic surgeon, Dr. Mirkin has been practicing medicine and performing surgeries for over 25 years, and testified he performs 250 to 300 surgeries per year. Dr. Mirkin noted that his initial report only involved a medical record review because the Petitioner did not appear for the initial scheduled examination. At the 10/24/16 exam, the Petitioner provided a verbal history of injury on 5/28/15, but indicated in an intake form a 5/25/15 date of accident. He also indicated the accident occurred before a long weekend, and when he returned to work he told his supervisor that he needed to go see a doctor. (Rx8).

Dr. Mirkin testified that the Petitioner's indication of severely limited lumbar range of motion (10% of normal) on exam did not make sense given the objective evidence, and this triggered his evaluation with Waddell signs. Taking these together, Dr. Mirkin opined that Petitioner was engaged in some level of symptom magnification. Dr. Mirkin's review of the initial, pre-surgical 7/10/15 lumbar MRI films indicated some degenerative disease and a very small left disc protrusion at L5/S1. The purpose of the microdiscectomy was to remove the herniation and to allow room for the nerves, and he took no issue with Dr. Gornet' s performance of the surgery following conservative treatment, noting the Petitioner did report post-surgical improvement. However, Dr. Mirkin did not agree with the current surgical recommendation of a disc replacement and fusion. Specifically, Dr. Mirkin

testified that he saw no objective evidence to support or justify such a significant surgery. He testified: "I don't know how we went from having a simple, small disc bulge at L5/S1 and requiring the simplest orthopedic operation of all, which even that was pretty aggressive treatment, to now needing very large fusions and disc replacements, including one disc that wasn't even mentioned in the original injuries as far as having a significant abnormality causing his symptoms." He testified that the post-operative lumbar MRI from June 2016 showed mild degenerative disease and no nerve compression, and indicated no pathology that he, or any of his "respected colleagues", would recommend the surgery Dr. Gornet was recommending. Dr. Mirkin opined that findings of annular tears, "little abnormalities on the outside of the disc that are consistent with degenerative disease", do not indicate a need for a fusion or disc replacement. Dr. Mirkin's review of the records indicated no objective pathology that would have been amenable to a disc replacement or fusion, and thus believed such surgery here is unnecessary. (Rx8).

Dr. Mirkin's diagnosis was lumbar strain with mild L5/S1 disc protrusion on the left, which could cause some of the Petitioner's symptoms. He subsequently had surgery, which Petitioner indicated improved his condition. Given the additional finding of symptom magnification, Dr. Mirkin recommended aggressive work conditioning therapy to get back to work. In the meantime, he would restrict him to 50 pounds lifting. (Rx8).

On cross examination, Dr. Mirkin testified that Petitioner verbally said he was injured prior to a three day weekend, but had no specific indication that the Petitioner was injured prior to 5/25/15. Much of the cross examination involved Dr. Mirkin's criticisms of how Dr. Gornet makes surgical determinations, and Dr. Mirkin's own involvement with patients involved in injury litigation. (Rx8).

Dr. Mirkin indicated that the initial discectomy was reasonable, given Petitioner did have a small left-sided disc herniation. However, he thus questioned why Petitioner claimed he was not doing well post-surgically. Dr. Mirkin testified that a disc replacement surgery should not be performed simply because someone complains of pain, as there must be a pathology that is amenable to such surgery. In reviewing the original MRI films, he opined that the findings were all minimal, with the only one of significance being at L5/S1, and that Dr. Gornet obviously agreed as that was the only level that was addressed in the original surgery. He did not see any significant or severe nerve compression at either L3/4 or L4/5. Asked if he agreed that a person can have spinal pain even if there is not nerve compression, Dr. Mirkin testified: "not really", and that if you are going to operate on a person, you are essentially looking to remove pressure from a nerve, and that there are many things that can cause back pain, including a strain, which do not warrant surgery. As such, Dr. Mirkin testified that in order to justify a surgery there would first need to be some finding affecting the nerve root a doctor can physically go in and alleviate with surgery. (Rx8).

Dr. Mirkin agreed that Dr. Gornet's initial exam noted decreased EHL, ankle dorsiflexion and plantar flexion on the left, and that this could indicate nerve involvement. He also agreed that Dr. Gornet noted post-surgical left EHL and ankle dorsiflexion weakness on 3/17/16, and thus further investigation via repeat MRI was appropriate to see if there was nerve compression. However, his review of the 6/16 films did not show any such compression. He testified the updated MRI did not indicate a persistent or recurrent disc herniation, and indicated no evidence of foraminal stenosis at L3/4 or L4/5, both according to the radiologist and his own review of the films. There was an indication of right-sided foraminal stenosis in the report at L3/4, but noted no one was indicating a need for treatment to that disc level. As to the discogram, he opined that it is not considered a valid or reliable test in most of the medical community, and if performed, it should only be done by someone who is not aware of the patient's symptoms or complaints, and thus Dr. Gornet's performance of it was not done "in a scientific manner." He admitted he does occasionally refer patients out for discogram. As to the MRI spectroscopy, he testified: "Now we're really reaching here for scientific validity." He reiterated his reasons for performing Waddell sign testing, and noted that he didn't see any other records of the Petitioner

indicating another physician did such testing. He did agree that if the Petitioner's history of accident and pain onset was correct, that the initial discectomy was causally related to the accident. Dr. Mirkin noted in his practice, discectomy patients are generally returned to light duty within two weeks and full duty within 4 to 6 weeks, and that "I'm not accustomed to having people out for months and months and months after a simple procedure." He agreed that he opined to a 50 pound restriction with a return to work, but that aggressive therapy and work conditioning would allow him to get back to full duty "if that's what he wanted", noting it was to Petitioner's benefit to return to the workforce as soon as possible. (Rx8).

Witness Shannon Tarrants appeared pursuant to subpoena. He has worked for the Respondent and with Petitioner for 5 years, on a daily basis prior to the alleged accident date, but they have not worked together since the accident. He testified Petitioner was a good worker. He agreed that sometime around 5/28/15 the Petitioner said he slipped on felt paper and hurt his back. He had no knowledge of the Petitioner hurting his back in any other fashion. Mr. Tarrants understood that the Petitioner had work restrictions after the alleged accident, though he didn't know exactly what they were, and that he was working light duty. He testified that while the Petitioner was on light duty, he asked Tarrants to repair a motorcycle. The two of them went to pick up the motorcycle in July 2015 using Petitioner's truck and trailer. Mr. Tarrants testified that while he was holding the front end of the 1980's Kawasaki Ninja 1000, the Petitioner lifted the back end onto an approximate 12" trailer. He did not notice the Petitioner having a problem doing so, and Petitioner did not complain of pain. He also testified that on the way back, the Petitioner asked Mr. Tarrants not to tell their boss, Jeff Baine, about it.

The Petitioner was present for Mr. Tarrant's testimony. Petitioner testified that "his statement was totally false". His agreed he asked Tarrants to work on his motorcycle a short time after the work accident. After work that day, Petitioner said he picked up a trailer and then picked up Tarrants. They went to DeSoto, Illinois. Mr. Tarrants untarped the bike and pushed it to the trailer. He testified that Tarrants loaded the bike and all he did was steady the motorcycle while Tarrants strapped it down. He indicated the trailer was only about 4" high, and denied pushing or lifting the motorcycle. He also denied asking Tarrants not to tell the Respondent. On redirect examination, Mr. Tarrants reiterated that it was the Petitioner who lifted the bike onto the trailer while he steadied the bike, noting he is unable to lift a motorcycle by himself. He agreed that lifting the cycle onto the trailer was all the Petitioner did.

Mr. Tarrants indicated that in December 2016 the Petitioner told him he had been deer hunting and showed him a picture of himself in the back of a truck holding the deer he shot. The Petitioner indicated that he had a friend pull the deer from the woods with a four wheeler. Petitioner did not indicate to him how long he spent hunting. Petitioner admitted he did go deer hunting, but testified he used a ground blind that his friend had set up for him, walked to the blind and shot a deer within an hour. His friend Jim did the rest. Petitioner never indicated to Tarrants how long he spent hunting.

Mr. Tarrants did indicate that the Petitioner had been limping since his back injury. He agreed he no longer worked with Petitioner since Petitioner went on light duty, but would see him in the mornings, and Petitioner would go and sit in the office, then go to his truck to go and do whatever work he was doing. Mr. Tarrants testified that on one of those mornings, the Petitioner made a statement, not necessarily verbatim, to the effect that "I came here looking for a job, I'll leave here looking for a job, but this time I'll be leaving with a pocket full of cash." Mr. Tarrants testified that he had no animosity towards Petitioner. P never told him how long he spent hunting.

Petitioner's wife, Stefanie Skelly, testified that she believed that she and Petitioner went camping over Memorial Day weekend in 2015, but she couldn't recall for sure. She testified that whichever weekend occurred following Petitioner's accident, he spent the weekend laid up in bed due to pain. They typically camp every

weekend, but the Petitioner did not injure himself while camping. As a hairdresser, she testified that she did cut Mr. Baine's hair between January and June of 2015, but that it was awkward since he was Petitioner's boss, and that after the accident Mr. Baine would attempt to elicit information from her. She didn't recall telling Mr. Baine that Petitioner was limping over Memorial Day weekend.

Respondent's owner, Jeff Baine, testified that Petitioner has been his employee for quite a few years. As to the claimed 5/28/15 work accident, he agreed that Petitioner reported that he slipped and fell to one of Mr. Baine's sons. However, he testified that he did not believe the Petitioner was injured at work, noting things "did not add up." He testified that Petitioner's wife cut his hair sometime between 5/25 and 5/28/15 and said he was walking differently than normal, though she didn't specifically say he hurt his back. This was prior to the alleged work injury and Petitioner's report of same. With regard to Petitioner working light duty, Mr. Baine testified that he had been able to accommodate Petitioner's work restrictions, but typically doesn't have need for light duty work. He testified that the Petitioner never complained about the work he was being asked to do or that it went beyond his restrictions. He told him the first day to make sure he didn't do anything he should not be doing. He would try to have work for him to do each morning and would tell the Petitioner what he wanted him to do. He testified that he had a makeshift table set up for Petitioner with a chair and would clean tools. If it was a larger item, they would put it on a pallet for him. He never asked him to get on his hands and knees. He would not have asked the Petitioner to do anything he reported being unable to do. He never asked him to wash a vehicle. He did ask him to remove tar from a piece of equipment with a brush or putty knife, which he believed was within his restrictions. In addition to the concert viewing, Mr. Baine testified that he recently saw the Petitioner walk out of a local restaurant without a limp or other evidence of injury. Currently the Petitioner's light duty involves the Petitioner sitting in the car watching to make sure that people from the neighboring college didn't use their parking lot, and if they did he would put a notice on their windshields.

Petitioner testified that his current pain stays about the same as that, depending on what he's doing. He wants to have the surgery recommended by Dr. Gornet so he can get back to normal life. Dr. Gornet encouraged him to stay active, which he does as long as he is not in too much pain.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, and WITH RESPECT TO ISSUE (D), WHAT WAS THE DATE OF THE ACCIDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner sustained accidental injury arising out of and in the course of his employment on 5/28/15.

While there are questions relative to the date the incident occurred, both based on the Petitioner's testimony as well as the medical histories, the evidence nevertheless supports a consistent history of the Petitioner slipping and twisting and/or falling on the roof with the immediate development of symptoms. The evidence in this case indicates that Memorial Day was Monday, 5/25/15. There are several pieces of evidence in this case which indicate that the accident occurred prior to a long, three day weekend in May 2015. As logic indicates that a long weekend at this time of year would very likely be Memorial Day weekend, an accident which occurred prior thereto would have occurred prior to 5/23/15.

The Arbitrator believes, however, that the preponderance of the evidence supports that the accident occurred on 5/28/15. In particular, the Arbitrator notes the 6/1/15 report of Dr. Blaise referencing an injury 4 days prior, as well as the Form 45 indicating that the employer was notified on 5/29/15 of a 5/28/15 accident.

While the Arbitrator notes there are some questions in this case with Petitioner's credibility regarding the severity and duration of his symptoms, as noted in more detail below, the contemporaneous records in this case solidly support that a work accident occurred. In particular, this includes the testimony of Mr. Baine that Petitioner reported the injury to one of his sons, which was consistent with Petitioner's testimony that he discussed his back with Ross Baine. Again, the Arbitrator believes the preponderance of the evidence supports a 5/28/15 accident date.

As the Arbitrator finds that the Petitioner sustained injury as described, while working for Respondent and moving roofing materials on a roof and slipping on tar paper, it is clear that the accident arose out of and in the course of the Petitioner's employment with Respondent.

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 current lumbar condition of ill-being is causally related to the 5/28/15 accident.

As noted above, the evidence supports the finding that the Petitioner injured his low back on 5/28/15 while working on a roof while in the Respondent's employ. Evidence was presented by Respondent in support of the argument that it was questionable that the Petitioner sustained an injury at work. However, this evidence tends to be based on a dispute regarding the date of accident rather than whether an accident occurred. As the Arbitrator has made a finding regarding accident in the Petitioner's favor, the question is whether evidence exists that rebuts the Petitioner's claim that his low back was injured that day, or whether his complaints and lumbar condition were preexisting or were caused in some other fashion than the Petitioner describes.

There really is no solid dispute in the Arbitrator's mind that the Petitioner has fulfilled his burden of proof in this regard. The only evidence that seems to dispute the claim that an accident occurred at work is Mr. Baine's testimony that Mrs. Skelly indicated that Petitioner was limping prior to 5/25/15, and prior to the reporting of a work accident. While this is competent evidence, the Arbitrator finds that the greater weight of the evidence supports the fact that the Petitioner's lumbar condition began when he slipped on a roof. As a roofer, the Arbitrator would note that the evidence supports that a worker has to climb to get atop a roof, and Petitioner's testimony confirms that the job involves scraping off old shingles and carrying the debris in shovels. The evidence supports that the Petitioner was doing this job with no known difficulty prior to the accident date. No evidence has been presented indicating that the Petitioner had any prior low back injuries or low back treatment. Thus, the Arbitrator finds that the Petitioner's post-5/28/15 condition is causally related to the 5/28/15 accident, and remains causally related through the hearing date. The condition that the Arbitrator finds remains causally related to the accident would be based on the 6/2/16 MRI findings: left-sided micro decompression changes at L5-S1 with persistent enhancing annular material in the left lateral recess and left neuroforamen with a mild degree of persistent left foraminal stenosis and no new central canal stenosis; and central broad-based L4/5 disc protrusion. The Arbitrator finds that the right foraminal disc protrusion noted at L3/4 is not related to the accident, as both Dr. Gornet and Dr. Mirkin agree that this disc level is not responsible for the Petitioner's symptoms.

While the Arbitrator finds that the Petitioner's current condition remains related to the accident, the Arbitrator also finds that the severity level of Petitioner's current complaints appear to lack credibility. While the evidence presented in this case of the Petitioner's activities do not show heavy labor being performed by Petitioner outside of his restrictions, it does indicate to the Arbitrator a level of distrust in the degree of symptoms he claims to have. The Arbitrator believes that the most credible testimony in this case came from Mr. Tarrants. In the Arbitrator's view, his testimony both hurt and helped both parties in terms of the workers' compensation case. As such, he did not appear to have a bias in this case in any way, but rather appeared to testify very honestly. The Arbitrator gives his testimony great weight in this case. The Petitioner's lifting of the motorcycle, while prior to the surgery that no doctor has argued was unreasonable in this case, is something the Arbitrator believes is in opposition to the Petitioner's complaints of pain during that time. Additionally, the Petitioner's testimony that he hunted in December 2016, used only a ground blind, and had a deer within an hour seems a little convenient in this case. The Arbitrator also notes that these findings are made in the context of what the Arbitrator believes is the credible testimony of Mr. Tarrants that Petitioner asked that he not tell the Respondent about his lifting of the motorcycle, as well as his statement about leaving the job with Respondent "with a pocket full of money." While the video from the concert was quite limited in duration, and certainly does not carry the day in this case in terms of Petitioner's credibility, the Arbitrator's viewing of the limited time he was filmed does appear to go along with the fact that the Petitioner does not appear to be in the degree of severe pain that he relates to Dr. Gornet. While he may or may not have been able to sit down at the concert, it still appears to the Arbitrator that the Petitioner attended a concert where he had to do a significant degree of standing. While no one expects that an injured claimant should not be able to continue to enjoy life as they are able, this appears to the Arbitrator to involve standing activity that the Petitioner has indicated to his physicians as causative of pain.

The Arbitrator also notes that, while there are issues to some degree with the opinions of both Dr. Gornet and Dr. Mirkin in this case, as noted below, the opinions of Dr. Mirkin with regard to the Petitioner's current condition are given greater weight. Dr. Mirkin testified that it was the actions of the Petitioner during his examination, namely a significant lack of range of motion that did not make sense given his review of the prior medical, that led to his Waddell examination, and that this examination indicated symptom magnification. Dr. Gornet essentially testified that the Petitioner's complaints matched the objective findings and therefore no such Waddell-type examination was needed While there is nothing in itself wrong with that reasoning, the Arbitrator believes, as noted, that the Petitioner's subjective complaints are not completely credible. It is certainly possible that he has ongoing valid complaints, however when the determination is that the complaints appear excessive, it is hard to say what the valid complaints are. Dr. Gornet's reliance on those subjective complaints results in a lesser degree of weight given to his opinions regarding the Petitioner's current condition.

The Arbitrator notes that what appears to have occurred in this case is a loss of trust between the Petitioner and Respondent, including Mr. and Mrs. Baine. As a result, we have both parties paying more attention to the "case" at hand than the injury itself and the Petitioner's recovery. This has resulted in evidence being presented to the Arbitrator where there appears to be a lack of credibility on both sides, which required the Arbitrator to have to try to determine the more likely scenario based on the preponderance of the evidence.

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 payment by Respondent of the medical expenses contained in Petitioner's Exhibit 2. There was no indication from Dr. Mirkin that the treatment Petitioner has received to date is unreasonable and

unnecessary, and the Arbitrator finds no evidence of unreasonable or unnecessary treatment to date. As such, Respondent is liable for same, with the exception noted below, pursuant to Sections 8(a) and 8.2 of the Act. The Respondent is entitled to credit for any awarded bills that were paid by Respondent prior to the hearing date.

The Arbitrator notes that, based on the evidence in the record, the MRI spectroscopy appears to be an unreasonable and unnecessary test in this case. The Arbitrator notes that, based on his experience over twenty years in workers' compensation, including most recently, there is no evidence that any significant number of orthopedic spinal surgeons are utilizing such testing to determine a recommendation for operative care. The Arbitrator notes Dr. Mirkin questioned the science behind this test, and that the report itself (Px6) specifically states that "the meaning of this data is not yet determined or validated, and is the subject of on-going investigational study and subject to change." While this testing may one day turn out to be an asset in the determination of spinal surgery, on balance the preponderance of the evidence does not support that we are at that point today. As such, the Arbitrator finds that the Respondent is not liable for any charges related to the spectroscopy. Dr. Gornet indicated that this can be performed with any MRI. As such, while the costs of the MRI itself are awarded to the Petitioner, any costs associated with the performance or reading of the results of MRI spectroscopy in this case are denied, and the Respondent is entitled to credit for any payments made prior to hearing that were specifically paid towards MRI spectroscopy or charges that were paid which relate to the spectroscopy portion of the MRI.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the proposed surgery recommended by Dr. Gornet is not reasonable and necessary in this case pursuant to Section 8(a) of the Act.

Part of the problem in making a determination on this issue in this case is that we have two orthopedic surgeons who have provided opinions in this case that appear to be diametrically opposed. The Arbitrator believes both are very experienced orthopedic surgeons. That said, it is also clear in this case that Dr. Gornet's recommendations to date appear to have been relatively aggressive, while Dr. Mirkin's are relatively conservative. The Arbitrator also notes that the language used by both doctors in discussing the opinions and recommendations of the other are unfortunate, as it detracts from the credibility of both physicians.

Ultimately, the Arbitrator makes this determination based on the objective MRI films in this case, and the questions the Arbitrator has with regard to the credibility of the severity of the Petitioner's subjective complaints. The MRI does not show any significant degree of nerve compression at either the L4/5 or L5/S1 level. X-rays show minimal degenerative findings at both levels, with no loss of disc height at L4/5. It appears that the surgery proposed by Dr. Gornet is significantly based on the findings of annular tears at L4/5 and L5/S1, the prior L5/S1 discectomy and the Petitioner's pain complaints. As noted, the Arbitrator finds that the degree of pain complaints being voiced by Petitioner do not appear to be fully credible, and given that, along with what appear to the Arbitrator to be relatively minimal findings at the L4/5 and L5/S1 levels, both based on the reports themselves and the opinions of Dr. Mirkin, the proposed surgery does not appear to be reasonable and necessary within the meaning of the Act.

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 period of TTD requested by Petitioner pursuant to Arbitrator's Exhibit 1, 9/25/16 through 10/23/16, it appears that this was the period during which the Respondent terminated TTD based on the Petitioner's failure to appear for the initial Section 12 examination with Dr. Mirkin. As the Arbitrator indicated to the parties previously (see Px11 and Px12), the Arbitrator believes that Petitioner's counsel's admitted mistake in failing to notify the Petitioner, based on the evidence, was inadvertent, and should not result in a denial of TTD for this period. Respondent's counsel is accurate that TTD benefits may be suspended for a failure to appear for such examination, however the specific language of the Act indicates: "If the employee refuses so to submit himself to examination of unnecessarily obstructs same, his right to compensation payments shall be temporarily suspended until such examination shall have taken place, and no compensation shall be payable under this Act for such period." (820 ILCS 305, Section 12).

The Arbitrator finds that the Petitioner did not refuse or unnecessarily obstruct the Section 12 examination, based on the testimony of the Petitioner and the credible explanation of what occurred by Petitioner's counsel. As such, the Arbitrator finds that a suspension of TTD benefits was not applicable under the circumstances, and finds that the Petitioner is entitled to TTD benefits from 9/25/16 through 10/23/16. It appears that TTD benefits were resumed as of 10/24/16 following Petitioner's appearance for the examination with Dr. Mirkin on 10/14/16.

The Arbitrator notes that while a TTD credit is indicated in this decision, which is supported by Rx3, said credit does not apply to the TTD awarded here, but rather to a previously paid period of TTD which the Petitioner did not seek an award for in the hearing. The only way such credit would apply to the current award is if the parties agree that there was an overpayment of TTD during the agreed periods of TTD where benefits were previously paid prior to the hearing.

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

Thorin Hart,
Petitioner,
vs.

NO: 13WC 25432

Dumoulin Farms, Terry Adkins;
Injured Workers Benefit Fund,
Respondent,

18IWCC0111

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 arising out of and in the course of employement, employer-employee relationships, 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 15, 2017 is hereby affirmed and adopted.

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

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

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

DATED: FEB 26 2018

Charles J. DeVriendt

Joshua D. Luskin

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CJD/rlc
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DISSENT

"An employment relationship is a prerequisite for an award of benefits under the Act, and the question of whether a person is an employee remans 'one of the most vexatious *** in the law of compensation.' *O'Brien v. Industrial Comm'n, 48 Ill. 2d 304, 307, 269 N.E.2d 471 (1971)*." *Roberson v. Industrial Commission*, 225 Ill. 2d 159, 174, 866 N.E.2d 191 (2007). I believe Petitioner proved Terry Adkins was an employee of Dumoulin Farms and not an independent contractor thereby establishing Petitioner's employment relationship with Dumoulin Farms as its employee. Therefore, I respectfully dissent.

In order to determine whether a person is classified as an employee or an independent contractor, the Commission analyzes numerous factors: "whether the employer may control the manner in which the person performs the work; whether the employer dictates the person's schedule; whether the employer pays the person hourly; whether the employer withholds income and social security taxes from the person's compensation; whether the employer may discharge the person at will; and whether the employer supplies the person with materials and equipment." *Roberson* at 175.

Along with the above identified factors, the Commission considers: "'[B]ecause the theory of [worker's] compensation legislation is that the cost of the industrial accidents should be borne by the consumer as part of the cost of the product, this court has held that a worker whose services form a regular part of the cost of the product, and whose work does not constitute a separate business which allows a distinct channel through which the cost of an accident may flow, is presumptively within the area of intended protection of the compensation act.' *Ragler Motor Sales v. Industrial Comm'n, 93 Ill. 2d 66, 71, 442 N.E.2d 903, 66 Ill. Dec. 342 (1982)*." *Id.*

No one single factor is determative, and the weight to be afforded the respective factors will change depending on the specific case at hand. *Luby v. Industrial Commission*, 82 Ill. 2d 353, 412 N.E.2d 439 (1980). Control is "perhaps the most important single factor in determining the relationship [citation omitted]..." *Bauer v. Industrial Commission*, 51 Ill. 2d 169, 172, 282 N.E.2d 448 (1972). Specifically, it is the right to control the work not the exercise of such right. *Immaculate Conception Church v. Industrial Commission*, 395 Ill. 615, 71 N.E.2d 70 (1947).

Dumoulin Farms controlled the work of Terry Adkins. Dumoulin Farms dictated how Terry Adkins cared for Dumoulin Farms' hogs. Mr. Adkins testified he was responsible for the

daily care of Dumoulin Farms' hogs and in such capacity reported directly to Dumoulin Farms on a regular basis. T. 81. Mr. Adkins testified Dumoulin Farms set expectations as to how large the hogs should be; how the hogs should be fed; what veterinary care should be utilized (T. 81-82); in essence directing Terry Adkins in every aspect of the hogs' growth for eventual selling at market.

Mr. Pat Dumoulin echoed this arrangement testifying as follows: "Q. When you mentioned how you paid Mr. Adkins, what were the expectations of what with the hogs. What's he expected to do or provide at the end of the cycle? A. The care of the pigs during the growth period, washing, disinfecting the barns before the next group came in, ordering feed, letting us know any problems that would have had with any illness of the pigs." T. 101.

Mr. Adkins testified Dumoulin Farms provided 1) the hogs (T. 68); 2) the feed for the hogs (T. 81); 3) the veterinary care for the hogs' well-being (T. 81); and 4) the enclosures for the hogs (T. 67). Mr. Adkins testified Dumoulin Farms set standards and expectations for the hogs and provided performance reports to Terry Adkins regarding his work in caring for the hogs. T. 82.

Again, Pat Dumoulin echoed such testimony stating Terry Adkins was provided the hogs by Dumoulin Farms (T. 91) and expectations as to the size of the hogs; feed and veterinary services including antibiotics were all provided by Dumoulin Farms. T. 101-102. More importantly, Mr. Dumoulin testified he expected for Terry Adkins to contact him regarding any problems with the animals as "I want to be up to date on issues going on on the farms." T. 102.

Dumoulin Farms maintained complete control of Terry Adkins' work in caring for Dumoulin Farms' hogs. Dumoulin Farms did not control Terry Adkins' daily schedule, but Terry Adkins worked exclusively for Dumoulin Farms and received a monthly payment based upon the capacity of the enclosures for pigs. T. 62;82. As Mr. Dumoulin testified "Whether there were pigs in the buildings or no pigs in the building, he got paid." T. 86. Effectively, Terry Adkins received a monthly salary from Dumoulin Farms. Dumoulin Farms did not withhold income or social security taxes, but such factor does not overcome the overwhelming evidence of an employee/employer relationship.

Not only did Dumoulin Farms control Terry Adkins' work, it provided all the material and equipment as discussed above in detail (hogs, feed, and veterinary care including antibiotics) as well as the actual buildings for the hogs. Mr. Dumoulin testified he did not own this particular

farm as a partnership did, but Dumoulin Farms had an agreement to use the space for its hogs. As part of the agreement Dumoulin Farms performed minor maintenance on the buildings. T. 96-97; 99. Dumoulin Farms provided all the materials and equipment including the physical site to Terry Adkins. This agreement was a "handshake agreement" as testified to by Mr. Dumoulin, so presumably either party could terminate at will. T. 101.

Lastly Dumoulin Farms is in the business of raising hogs for market. Terry Adkins' job was to oversee the raising of Dumoulin Farms' hogs. Dumoulin Farms' and Terry Adkins' "businesses" are intimately connected. Mr. Dumoulin testified as to why the hogs were placed on a separate farm- biosecurity. T. 92. As Mr. Dumoulin explained, pigs are very sensitive to diseases, so in attempt to isolate the piglets born on his farm, the pigs are sent to a separate farm to be raised. T. 91-93. Terry Adkins' work is not a separate distinct business but is an intergral part of Dumoulin Farms' business and a part of the cost of production.

As such weighing the evidence as to the various factors, I would find Terry Adkins an employee of Dumoulin Farms. In his capacity of Dumoulin Farms' employee overseeing the raising of the hogs, Terry Adkins hired Petitioner who thereby is an employee of Dumoulin Farms. (Mr. Dumoulin testified he was aware Terry Adkins hired workers. T. 86). Dumoulin Farms falls under the Act as an employer pursuant to Section 3. Dumoulin Farms is not exempt pursuant to Section 3(19) of the Act as: 1) there is no evidence the exemption applies; and 2) Mr. Dumoulin testified he maintains workers' compensation insurance. T. 100. Dumoulin Farms is liable for benefits due to the Petitioner's undisputed accident which occurred on June 24, 2013.

Accordingly, I dissent.

L Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HART, THORIN
Employee/Petitioner

Case# **13WC025432**

DUMOULIN FARMS; TERRY ADKINS; IWBF
Employer/Respondent

18IWCC0111

On 5/15/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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CHICAGO, IL 60601

18IWCC0111

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

Thorin Hart
Employee/Petitioner

v.

Dumoulin Farms; Terry Adkins; IWBF
Employer/Respondent

Case # 13 WC 25432

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 **April 18, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0111

FINDINGS

On **June 24, 2013**, Respondent Terry Adkins ***was not*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$3,500.00**; the average weekly wage was **$500.00**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **3** dependent children.

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

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

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

ORDER

BECAUSE THE ARBITRATOR FINDS THAT PETITIONER FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT AN EMPLOYER/EMPLOYEE RELATIONSHIP EXISTED BETWEEN PETITIONER AND RESPONDENT DUMOULIN FARMS AND BECAUSE PETITIONER'S EMPLOYMENT WITH RESPONDENT TERRY ADKINS FALLS WITHIN THE AGRICULTURAL ENTERPRISE EXEMPTION TO THE ACT FOUND AT SECTION 3(19), PETITIONER'S CLAIM FOR COMPENSATION IS DENIED.

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

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

Signature of Arbitrator

May 12, 2017
Date

MAY 15 2017

ICArbDec p. 2

Statement of Facts

Petitioner Thorin Hart testified that on June 24, 2013, he was 41 years old. The medical records confirm his date of birth as March 8, 1972 (PX 6, p 29). He testified that he was married and had three children under 18 years old at that time.

He testified that he began work after he saw an advertisement in the newspaper for a job taking care of hogs and living on a farm. He applied by telephone and met with Terry Adkins at the farm. He was to work as a laborer for two farms, Creston and Stewart Farm, where he was provided a hours to live in. The farms were not owed by Dumoulin Farms or Terry Adkins. He began work in May, 2013. His job included feeding the hogs, included making sure that the feed augers were working properly, cleaning pens, caring for sick animals, and maintenance of the equipment. He assisted with loading and unloading hogs from trucks, and filling the feed hoppers. He testified his hours varied from 4 to 10 hours per day, but averaged 30-40 hours per week. Terry Adkins worked weekends. He was paid by check by Terry Adkins. The check was written by hand, taxes were not withheld. Petitioner did not have copies of these checks present at trial. Petitioner never received a 1099 or a W-2 form from Terry Adkins or Dumoulin Farms.

He was trained by Terry Adkins and by Mike Champlin, another farm laborer employed by Terry Adkins. He was not issued or required to wear a uniform but wore protective gear provided by Terry Adkins. Petitioner was allowed to have a second employment but did not do so while working Terry Adkins. Petitioner's day to day activities were directed by Terry Adkins. He understood that his supervisor was Terry Adkins, but Terry Adkins did not check his work. Petitioner was never disciplined.

Terry Adkins testified that he was hired by Dumoulin Farms as a contract finisher. He described this as a contract worker responsible for the day to day care of raising hogs. Mr. Adkins grew up on a farm and was familiar with livestock and agricultural work. He was responsible for hogs at two different locations. He was paid a fixed amount which was based on the number of animals he oversaw. He testified that Dumoulin set expectations for his work including death loss, feed efficiency and weigh gain for the hogs. He received a 1099 from Dumoulin Farms for 2013. Mr. Adkins reported to Pat Dumoulin regularly to report any issues or veterinary needs. Mr. Adkins primarily worked on the weekends as he was also employed full time in an unrelated business. He hired individuals to assist in this work in hog finishing. He had two individuals employed in 2013, Petitioner and Mike Champlin, who worked approximately 20 to 25 hours per week. He paid Mike Champlin by a hand-written check, withheld taxes, and provided him with a W-2. He testified that he did not require clearance from Dumoulin Farms when he hired or fired individuals to help him with his contract finisher work.

He did not provide Petitioner with a work schedule, but he was aware of approximately how long it would take for Petitioner to complete his assigned tasks. Petitioner turned in timesheet and Mr. Adkins did not have any issue with the hours he worked. He did not carry workers' compensation insurance coverage as he understood that he was not required to carry coverage for the type of work he engaged in, hog raising. The lack of coverage is confirmed by the Certificate of Non-Compliance (PX 4). He stopped working with Dumoulin Farms in 2015 when he moved and was unable to continue his contract with Dumoulin Farms.

Mr. Pat Dumoulin testified that he is self-employed as co-owner of Dumoulin Farms. Dumoulin Farms is an entity that raises and sells hogs. Dumoulin Farms owned the hogs, not the farms or buildings upon the farms. Dumoulin Farms also supplied feed and veterinary services. Dumoulin Farms contracted with Terry Adkins for

hog finishing services at two sites. Mr. Dumoulin testified that Terry Adkins was an independent contractor. Terry Adkins was free to run his business in the way he chose. Dumoulin Farms had no role in the hiring, training or firing of any employees of Terry Adkins' business. Dumoulin Farms provided no clothing or equipment for Petitioner. He testified that he was in contact with Terry Adkins about twice per week, more if he needed to schedule loads or deliveries. Dumoulin Farms paid Terry Adkins a monthly lump sum payment based upon the number of hogs going through the operation. Terry Adkins received a 1099 form from Dumoulin Farms (RX Dumoulin 2).

Pat Dumoulin testified to the nature of the operation. Hogs were isolated except for contact with Terry Adkins and his employees. Dumoulin Farms' employees who dropped off livestock did not exit the truck. Feed was delivered to the hoppers without the driver entering the buildings. An independent hauler picked up the hogs, without exiting the semi, to deliver the finished hogs to market. Great care was taken by Dumoulin Farms to avoid any potential transfer of infectious material to any hog operation. He testified he learned of Petitioner's accident when he received a call from Terry Adkins.

On June 24, 2013, Petitioner was repairing an auger that had jammed. Petitioner testified that he turned the electricity off. When cleared, the auger recoiled and grabbed his left hand and pulled it into the machine. His hand was cut on sharp piping from the middle of the top of his hand down to the fingernail of his small finger. Petitioner called Terry Adkins immediately and went to Swedish American Hospital Emergency Room. On the Patient Information Sheet, Petitioner stated that he was self employed (RX Dumoulin 1).

Petitioner presented with a laceration to the left little finger (PX 6, p 33). X-rays note possible foreign bodies, but no fracture or dislocation (PX 6, p 29). The wound was irrigated; sutures were applied and his hand was wrapped. Petitioner was advised to either see orthopedics or return to the emergency room for wound check (PX 6, p 34-36). On June 26, 2013, Petitioner returned to Rockford Orthopedic Associates. He was diagnosed with an abscess due to an infection and possible foreign body (PX 6, p 44). He underwent surgery at Swedish American Hospital on June 27, 2013 for irrigation and debridement and tendon laceration repair as well as removal of foreign bodies from the wound site (PX 6, p 36-37). He then spent 5 days in the hospital, undergoing IV antibiotics. Petitioner was discharged on July 1, 2013 (PX 6, p 46-47).

Petitioner had post operative care with Dr. Foster at Rockford Orthopedic Associates. On July 25, 2013, he reported complaints of shooting pain, numbness and tingling. He had been recommended for occupational therapy, but had not begun. He stated he was coaching football and working out using his hand. On August 22, 2013, he was released to full duty work (PX 6, p 55-56). After missing several appointments, Petitioner saw Dr. Foster on September 19, 2013. Petitioner reports continued pain, numbness and tingling. He is doing activities as tolerated including bench pressing and coaching football. Dr. Foster notes the repairs have healed and Petitioner may perform full duty. He notes that Petitioner may have pain, swelling and stiffness for several months, and may have permanent stiffness, pain or swelling (PX 6, p 50-51).

Conclusions of Law

In support of the Arbitrator's decision with respect to (B) Employer/Employee, the Arbitrator finds as follows:

An employment relationship is a prerequisite for an award of benefits under the Act, and the question of whether a person is an employee remains "one of the most vexatious in the law of compensation." *O'Brien v.*

Industrial Comm'n, 48 Ill. 2d 304, 307, 269 N.E.2d 471 (1971). The difficulty arises not from the complexity of the applicable legal rules, but from the fact-specific nature of the inquiry. No rule has been, or could be, adopted to govern all cases in this area. *Henry v. Industrial Comm'n,* 412 Ill. 279, 282, 106 N.E.2d 185 (1952). Instead, the courts have listed various factors that help determine when a person is an employee: whether the employer may control the manner in which the person performs the work; whether the employer dictates the person's schedule; whether the employer pays the person hourly; whether the employer withholds income and social security taxes from the person's compensation; whether the employer may discharge the person at will; and whether the employer supplies the person with materials and equipment. See *Wenholdt v. Industrial Comm'n*, 95 Ill. 2d 76, 81, 447 N.E.2d 404, 69 Ill. Dec. 187 (1983), quoting *Morgan Cab Co. v. Industrial Comm'n*, 60 Ill. 2d 92, 97, 324 N.E.2d 425 (1975). Additionally, the courts have also considered whether the employer's general business encompasses the person's work. No single factor is determinative, and the significance of these factors will change depending on the work involved. *Luby v. Industrial Comm'n*, 82 Ill. 2d 353, 358-59, 412 N.E.2d 439, 45 Ill. Dec. 88 (1980). The determination rests on the totality of the circumstances. The right to control the manner of the work is often called the most important consideration. See *Bauer v. Industrial Comm'n*, 51 Ill. 2d 169, 172, 282 N.E.2d 448 (1972); *Horwitz v. Holabird & Root*, 212 Ill. 2d 1, 13, 816 N.E.2d 272, 287 Ill. Dec. 510 (2004).

Using these criteria, Petitioner was an employee of Terry Adkins. Mr. Adkins hired him and he had the right to discipline or fire him. Petitioner testified he had no prior experience with hog finishing and was trained by Mr. Adkins. He was paid hourly for his services by Terry Adkins. Although Petitioner had leeway in the exact hours he worked, he reported to Terry Adkins and was supervised by Terry Adkins. Terry Adkins provided the protective equipment to Petitioner. The relationship demonstrates that Terry Adkins had the right to control Petitioner's work.

In contrast, there are no elements of employment with Respondent Dumoulin Farms. The evidence clearly establishes that Dumoulin entered an agreement with Terry Adkins for hog finishing at two locations. Both Pat Dumoulin and Terry Adkins testified that the relationship was as an independent contractor. This is corroborated by the evidence that Terry Adkins was paid based upon the number of hogs. He was provided a 1099 with no taxes removed. Dumoulin exercised no authority on day to day basis. The expectations were based solely on performance criteria. Dumoulin did not own the two farms serviced and did not provide any of the equipment or facilities. Dumoulin contact was limited to pick up and delivery of animals, delivery of feed and supplying veterinary services.

Dumoulin's relationship to Petitioner is even more attenuated. Petitioner answered an advertisement from Terry Adkins and was hired by him. Dumoulin did not have any say in who or how many employees were to be hired to perform the work necessary to discharge the duties required in Terry Adkin's hog finishing contract. The evidence is unrebutted that Terry Adkins had sole supervision of Petitioner's work and was the only person who would hire, fire or discipline. Dumoulin had no daily contact with Petitioner other that the pick up and delivery of animals, delivery of feed. The Dumoulin employees or drivers had no contact with the property. Petitioner had no contact with Dumoulin other that scheduling and assisting with the operations. He received no instructions or supervision of his work from them.

Based upon the record as a whole, the Arbitrator finds that Petitioner was an employee of Respondent Terry Adkins only. Terry Adkins was an independent contractor hired by Dumoulin Farms to perform hog finishing. The Arbitrator finds no employer/employee relationship between Petitioner and Respondent Dumoulin Farms.

In support of the Arbitrator's decision with respect to (A) Operating Under and Subject to the Act, the Arbitrator finds as follows:

Based upon the Arbitrator's finding with respect to Employer/Employee, Petitioner is an employee of Terry Adkins only. Petitioner was hired as a laborer to perform hog finishing including feeding, cleaning and health maintenance of hogs at the two locations. Petitioner testified that this work required repair of electrical augers and fans to insure the hogs were fed and kept at a safe temperature. It also required the use of skid loaders. Petitioner's accident occurred while adjusting an auger.

Under Section 3(19) of the Workers' Compensation Act, agricultural enterprises employing less than 500 working days of agricultural labor per quarter during the preceding calendar year are exempted from coverage under the Act. The evidence is unrebutted that Petitioner's employment to assist in finishing hogs is an agricultural enterprise. See *Delmar Ferguson v. Wonder Green, Inc.*, 8 IWCC 1116; 2008 Ill. Wrk. Comp. LEXIS 1313. Terry Adkins employed only Petitioner and Mike Champlin. Their combined employment would be less than 500 working days per quarter. The Petitioner's employment would therefore fall within the exemption of Section 3(19) of the Act.

Petitioner claims that the injury is not within the exemption because at the time of the accident, he was performing maintenance on the electric auger. If the activity at the time of his injury was merely extraneous to the agricultural enterprise, the exemption does not apply. If the activity was fundamental to the agricultural enterprise, however, the exemption does apply. *Dennis Hagemann, v. Illinois Workers' Compensation Commission*, 399 Ill. App. 3d 197; 941 N.E.2d 878; 2010 Ill. App. LEXIS 376; 347 Ill. Dec. 9 (3rd Dist., 2009). The operation of the augers was essential to the proper feeding of the hogs and was therefore fundamental to the agricultural enterprise. The operation of equipment has consistently been held to be within the exemption of Section 3(19) of the Act. See *Skerston v. Industrial Comm'n*, 146 Ill. App. 3d 544; 496 N.E.2d 505; 1986 Ill. App. LEXIS 2660; 99 Ill. Dec. 812 (3rd Dist.,1986) [Petitioner was injured when he used a tractor and bucket]; *Delmar Ferguson v. Wonder Green, Inc.*, 8 IWCC 1116; 2008 Ill. Wrk. Comp. LEXIS 1313 [Petitioner was hired to maintain equipment and buildings associated with the livestock and farming operation. Petitioner was operating a uniloader, removing slats of concrete from the cattle building at the time he was injured].

The augers were part of the equipment required to feed the hogs. And the activity performed by Petitioner at the time of his injury was fundamental to the agricultural enterprise of hog finishing. The Petitioner's employment was therefore covered by the exemption to the Act provided in Section 3(19).

Based upon the record as a whole, the Arbitrator finds that Petitioner's employment with Respondent Terry Adkins is exempt from coverage under the Act based upon the provisions of Section 3(19).

In support of the Arbitrator's decision with respect to (C) Accident, (E) Notice, and (F) Causal Connection, the Arbitrator finds as follows:

The unrebutted testimony established that Petitioner sustained accidental injuries arising out of his employment with Respondent Terry Adkins on June 24, 2013, Petitioner provided notice within the time required under the Act, and that Petitioner's condition of ill being to the right hand is causally connected to said accidental injury. But based on the Arbitrator's finding with respect to Operating Under and Subject to the Act,

the Petitioner's accident is not covered by the Workers' Compensation Act and his claim for benefits under the Act is denied.

In support of the Arbitrator's decision with respect to (G) Average Weekly Wage, the Arbitrator finds as follows:

Petitioner testified he earned $12.50 per hour. His hours varied from 4 to 10 per day depending on the work required. He testified he worked an average of about 40 hours per week. Terry Adkins confirms the hourly rate. Petitioner also testified to the use of a house on the property, but also testified to a dispute over whether the rent was paid. The Arbitrator therefore does not include the value of the housing in the average weekly wage.

Based upon the record as a whole, the Arbitrator finds that Petitioner's average weekly wage as an employee of Terry Adkins was $500.00 per week.

In support of the Arbitrator's decision with respect to (H) Age and (I) Marital Status, the Arbitrator finds as follows:

The unrebutted evidence shows that on June 24, 2013, Petitioner was 41 years old, married and had 3 dependent children under the age of 18.

In support of the Arbitrator's decision with respect to (J) Medical, (K) Temporary Compensation, and (L) Nature & Extent, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Employer/Employee and Operating Under and Subject to the Act (Agricultural Enterprise), the issues of Medical, Temporary Compensation and Nature & Extent are moot. Petitioner's claim for benefits is denied.

In support of the Arbitrator's decision with respect to (O) Liability of IWBF, the Arbitrator finds as follows:

In cases in which the IWBF is named, the award is entered against the Respondent-employer, and as such the Respondent-employer remains liable to pay any judgment entered against it. If, however, the Petitioner is unable to collect the award from the Respondent-employer, the IWBF pays out on the award. In other words, the IWBF is only derivatively liable in cases in which it is named as Respondent. *Illinois State Treasurer, as ex officio Custodian of the Injured Workers' Benefit Fund* v. *The Illinois Worker's Compensation Comm'n*, 2 N.E. 3d 351, 356 (2013) n.4. Thus, if a judgment cannot be entered against a Respondent-employer as it is exempt under the Act, the Commission cannot enter an award against the derivatively liable Respondent IWBF.

Based upon the Arbitrator's findings with respect to Employer/Employee and Operating Under and Subject to the Act, the Respondent-employer is exempt under the Act as an agricultural enterprise. Because an order cannot be entered against the primarily liable Respondent-employer, an order cannot be entered against the IWBF.

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	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Terry Benjamin,

Petitioner,

vs.

NO: 14 WC 154

18IWCC0112

Novestaff Service Group,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of the nature and extent of Petitioner's 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 15, 2017, is hereby affirmed and adopted.

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

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

18IWCC0112

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $30,000.00. 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 26 2018
TJT:yl
o 2/20/18
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BENJAMIN, TERRY
Employee/Petitioner

Case# **14WC000154**

NOVESTAFF SERVICE GROUP
Employer/Respondent

18IWCC0112

On 5/15/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2333 WOODRUFF JOHNSON & PALERMO
RUSSELL HAUGEN
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

0507 RUSIN & MACIOROWSKI LTD
THOMAS CROWLEY
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

18IWCC0112

STATE OF ILLINOIS)
)SS.
COUNTY OF LaSalle)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Terry Benjamin
Employee/Petitioner

v.

Novestaff Service Group
Employer/Respondent

Case # **14** WC **154**

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 **Doherty**, Arbitrator of the Commission, in the city of **Ottawa, IL**, on **4/28/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0112

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 **$21,143.58**; the average weekly wage was **$474.38**.

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 **$8,325.45** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$8,325.45**.

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

ORDER

Per the stipulation of the parties, Respondent shall pay reasonable and necessary medical services of $1,292.00, as provided in Sections 8(a) and 8.2 of the Act, and reimburse Petitioner $78.62 for out of pocket payments made by Petitioner. ARB EX 1.

Per the stipulation of the parties, Respondent shall pay Petitioner temporary total disability benefits of $316.25/week for 26 3/7 weeks, commencing 3/14/14 through 9/14/14, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $8,325.45 for TTD benefits paid. ARB EX 1

Respondent shall pay Petitioner permanent partial disability benefits of $284.63/week for 100 weeks, because the injuries sustained caused the 20% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Carolyn M. DeNeesy

Signature of Arbitrator

5/12/17
Date

ICArbDec p. 2

MAY 15 2017

FINDINGS OF FACT

The only issue in dispute at trial was nature and extent. ARB EX 1. The parties stipulated that on 11/11/13 the 55 year old Petitioner sustained a work related accident and injury. Respondent stipulated to pay agreed TTD of 26-3/7 weeks and outstanding medical expenses totaling $1,370.62. ARB EX 1. Petitioner was a loaned employee by Novestaff Service Group to Imperial Marble and worked as a carpenter. His duties included building shipping crates used to ship marble product.

The parties stipulated that on 11/11/13 Petitioner came into work one hour early to stock shelves with cardboard boxes in the warehouse. Petitioner testified that it was his first time working in the warehouse. Petitioner testified that he was using a forklift to pull a pile of what he thought was card board. Petitioner got off the forklift to verify the material in the pile. Petitioner testified that while awkwardly reaching and grabbing the cardboard, his foot got caught and he fell backward onto his left hip with his left arm outstretched. Petitioner testified that he felt and heard a pop in his left shoulder. Petitioner had immediate pain in his left shoulder. He testified that he had no prior pain, problem or treatment to his left shoulder. Petitioner is right hand dominant.

Petitioner initially treated with the occupational medicine clinic at Rush Copley on 11/11/13. He provided a consistent history of accident and injury to his left shoulder. He reported sharp pain in his left shoulder with use of his left arm. He was recommended conservative treatment and a follow up on 11/14/13. Petitioner returned on 11/14/13 with continued complaints of pain on motion. The Hawkins sign was positive. Petitioner was told to wean off the use of the sling and to continue exercises. He was to return in one week. At Petitioner's return visit on 11/19/13, he reported improved pain at 2/10. However, he reported a continued sharp stabbing pain when lifting the left arm. Following exam revealing pain and weakness and positive Hawkins on 11/19/13, Petitioner was referred for orthopedic care, physical therapy and an MRI. PX 1. Petitioner was continued on light duty with no use of the left arm.

Petitioner underwent a left shoulder MRI on 11/23/13 which showed a "massive rotator cuff tear involving the supraspinatus and infraspinatus with degenerative changes of the glenohumeral and AC joint and a grade 1 muscle strain of the infraspinatus. PX 1. The rotator cuff tear was a full thickness tear with retraction of the supraspinatus and infraspinatus. Petitioner was referred to Castle Orthopedics.

Petitioner saw Dr. Saleem who confirmed the rotator cuff tear and recommended surgery on 12/5/13. PX 2. The pre operative diagnosis was "massive rotator cuff tear of supraspinatus and infraspinatus tendons, left shoulder impingement, biceps tendinopathy with superior labral tear and extensive intra-articular synovitis with capsulitis." On 3/14/14, Dr. Saleem performed a left shoulder arthroscopic repair of the "infraspinatus tendon (retracted irreparable supraspinatus tear), left shoulder arthroscopic subacromial decompression, distal clavicle excision, biceps tendon tenotomy and debridement of extensive synovitis with capsular release."

Petitioner followed up with Dr. Saleem after surgery and completed physical therapy at Atlas on August 28, 2014. At his visit with Dr. Saleem on 9/4/14, Petitioner reported doing better overall but still had definite limitation. His physical exam revealed shoulder elevation to 95-100 degrees, abduction to 70 degrees, external rotation to 30 degrees, 4-5 external rotation strength, 4/5 resisted elevation strength and 5/5 internal rotation strength. Dr. Saleem noted his impression of "left shoulder status post repair of massive cuff tear with satisfactory outcome still with weakness." Dr. Saleem noted "I recommended putting him at MMI and giving him some permanent restrictions. These were written today, 15-20 pounds from floor to waist, 10 pounds from waist to chest, 5 pounds from chest to shoulder level, no overhead work, no reaching, pushing or pulling with

the left arm. ... We briefly talked about long term complications including rotator cuff arthropathy for which he may need to have a shoulder replacement." PX 2.

Petitioner did not seek any additional treatment between September 2014 and his next visit with Dr. Saleem on 12/16/15. On that date, Dr. Saleem noted Petitioner's continued complaints of persistent discomfort and weakness in the left shoulder. Petitioner stated, " ... he sometimes does work outside of his restrictions he thinks. He says specifically driving some particular forklift is very difficult for him because it requires a little bit more arm motion than he is able to tolerate. He does get grinding and popping in his left shoulder. He wanted to discuss future potential shoulder replacement and what the changes are that will be a possibility for him." Following an exam which showed limited elevation and rotation, weakness of resisted elevation and abduction, and crepitation throughout the range of motion, Dr. Saleem's impression was "left shoulder status post repair of a massive rotator cuff tendon likely persistent supraspinatus tear although the infraspinatus appears to be functioning, his supraspinatus is very weak and likely he is developing progressive cuff arthropathy symptoms" and an impression of "left shoulder likely chronic rotator cuff tear with pain, crepitation, and weakness." The plan read, "At this point I have recommended continue just doing his regular exercises as tolerated within his restrictions at work as well. He will see me back as needed. We previously talked about shoulder replacement today and the need for that in the future. We told him that I cannot obviously predict when that will be in eventuality for him but I told him it will probably be within the next likely 10 years if not sooner. It really would depend on how bad his symptoms were." PX 2.

Petitioner testified that he returned to work for Respondent in the shipping department and no longer worked as a carpenter for Respondent. He testified that work in the shipping department requires him to move pallets, stack boxes on the pallets and then shrink wrap the boxes. He also loads and unloads trucks. 70% of Petitioner's work requires him to use a forklift. Petitioner testified that he has difficulty doing this job as his left shoulder snaps and cracks while moving the steering wheel on the forklift which he moves with his left arm while his right hand is on the controls. He also testified that he is asked to manually move and pick up materials requiring him to reach, pull, push and work above shoulder level and beyond his restrictions. Petitioner testified that he complained about the work outside his restrictions to the lead man Tony, as well as two other employees Nava and Ricardo and was either told to do the work. When he did not perform the tasks he was not disciplined.

Laurie Krischel testified for Respondent in her capacity as a shipping supervisor for Imperial Marble. She testified that Petitioner works full time and that she is Petitioner's supervisor in the shipping department. She testified that Petitioner has never complained to her about his inability to do his assigned jobs and that he was not asked to perform duties outside of his restrictions. She testified that on occasion when Petitioner needed assistance to perform a job another worker handled the job for Petitioner and that if Petitioner asked her for help she would supply the requested assistance. The witness testified that on occasion when she saw Petitioner performing a job which she thought exceeded his restrictions she asked him to stop. She testified that Petitioner always replied that he was ok and could continue the work. Lastly, Ms. Krischel testified that Petitioner's job was permanent and not due to be eliminated.

Petitioner testified that outside of work activities, he is no longer able to fish or hunt either with a rifle or bow as he is unable to perform the over the shoulder motions required. He also testified that he now hires people to perform work around his home. Everyday activities are difficult and he is required to adjust all of his movement.

Petitioner attended a Section 12 exam with Dr. Weiss, an orthopedic surgeon, on 4/20/15. Petitioner reported that he continues to work and that his employer accommodates his limited lifting ability and inability to work

overhead. Petitioner reported that his shoulder is about 40% of normal in that he has not regained full motion and has continued weakness, tightness and pain with reaching or lifting away from his body or with any awkward positioning of his shoulder. RX 1. Dr. Weiss examined Petitioner's medical records. He confirmed left supraspinatus atrophy and slight infraspinatus atrophy and positive impingement signs. Crank, apprehension, and sulcus tests were negative. The diagnosis was status post left infraspinatus repair, Neer/Mumford procedure, biceps tenotomy and unrepairable full thickness surpraspinatus tear secondary to work injury of 11/11/13. He offered an impairment rating of 12% whole person or 15% upper extremity.

Petitioner testified that his condition has worsened since his QuickDash responses given to Dr. Weiss in April 2015.

CONCLUSIONS OF LAW

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

L. What is the nature and extent of Petitioner's injury?

Given the date of the accident on 11/11/13, the Arbitrator utilizes the factors in Section 8.1b(b) of the Act to determine the nature and extent of the Petitioner's injury.

With regard to Subsection (i) of Section 8.1b(b), the Arbitrator notes that the record contains an impairment rating prepared by Dr. Weiss pursuant to the 6th edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. (Rx.1) Dr. Weiss used the Range of Motion Method for rating impairment as it resulted in the highest rating. RX 1. Dr. Weiss assigned "Final Upper Extremity Impairment Rate = 15%" and "Final Whole Person Impairment Rating = 12%." The Arbitrator gives some weight to this factor.

With regard to Subsection (ii) of Section 8.1b(b), the occupation of the employee, Subsection (iii) of Section 8.1b(b), Petitioner's age at the time of the accident, and Subsection (iv) of Section 8.1b(b), the Petitioner's future earning capacity, the Arbitrator notes that the 55 year old Petitioner was employed as a carpenter at the time of the accident and that he is not able to return to work as a carpenter as a result of this injury. The Arbitrator further notes that significant permanent restrictions provided by Dr. Saleem will not allow him to return to his previous work and significantly restrict his current work ability. The Arbitrator notes that Petitioner was able to return to work in a different capacity in the shipping department where he currently works full time under these accommodated restrictions. The Arbitrator notes that Respondent's witness testified Petitioner's current position in the shipping department is permanent and that his accommodations will be continued. Nevertheless, the Arbitrator gives greater weight to these 3 factors in light of Petitioner's combined age, loss of original occupation and significant restrictions.

With regard to Subsection (v) of Section 8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the medical records regarding Petitioner's left shoulder injury and treatment indicate Petitioner underwent surgery to repair a massive rotator cuff tear but that the retracted supraspinatus tear was irreparable. Dr. Saleem placed significant restrictions on Petitioner's use of his left arm. Dr. Saleem further opined that Petitioner's cuff atrophy symptoms would continue to progress. As of the last visit with Dr. Saleem on December 16, 2015 Petitioner complained of pain with range of motion and weakness which was well documented by Dr. Saleem. At trial, Petitioner testified that he was limited with the use of his shoulder in his activities of daily living and in his recreational activities. Petitioner can no longer fish or hunt with a rifle or

bow. Because the Petitioner's treating medical records support Petitioner's testimony and document his continued problems with weakness, atrophy and range of motion, the Arbitrator gives great weight to this factor.

Based on the above factors and the record taken as a whole, the Arbitrator finds that the Petitioner sustained permanent partial disability to the extent of 20% loss of use of 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 comment	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
☒ Modify Down	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Trent Turner,

Petitioner,

vs. NO: 09 WC 46141

J.T. Butler Construction, Inc., and
Injured Workers' Benefit Fund,

18IWCC0113

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent Injured Workers' Benefit Fund herein and notice given to all parties, the Commission, after considering the issues of average weekly wage and nature and extent 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 Arbitrator's Decision finding Petitioner's permanent disability is 25% loss of the use of his right index finger under §8(e) of the Act. Petitioner, a 26 year old carpenter, sustained laceration injuries to his right index and middle fingers while working for Respondent J.T. Butler Construction on October 30, 2008. He was cutting a board and it got caught on the table saw blade, which spun the board and spun his right hand into the blade. T. 13. The saw blade cut his right index finger on the inside between and also cut the top of his middle finger. T. 14. Petitioner was taken to Loyola University Medical Center, where he underwent x-rays and the lacerations were sutured. Loyola University Medical Center records, PX4, indicate Petitioner saw Dr. Bednar on November 4, 2008. Dr. Bednar noted at the small finger, there was a laceration along the ulnar aspect of the digit involving the DIP joint and proximal phalanx. At the middle finger, there was a laceration over the middle phalanx and

over the small finger there was a laceration which included the nail. Dr. Bednar noted these wounds were elevated and closed in the emergency room on the date of injury. On examination, Dr. Bednar found poor sensation over the distribution of the ulnar digital nerve to the right index finger; good vascularity of the finger was seen; all flexor tendons appeared functioning. His plan was to perform surgery for repair of the right index finger ulnar digital nerve and this was scheduled.

Loyola University Health System Oakbrook Terrace records, PX3, indicate Dr. Bednar performed surgery at the Ambulatory Surgery Center on November 5, 2008. Dr. Bednar noted a pre-operative diagnosis of a right index finger ulnar digital nerve laceration and performed a repair of the index finger ulnar digital nerve. Dr. Bednar noted the injury occurred both over the proximal phalanx and distal phalanx. The distal phalanx laceration included the nail bed. He noted both were repaired in the ER. Dr. Bednar noted Petitioner had persistent loss of sensation over the ulnar side of the index finger and there was a positive Tinel's sign over the proximal incision site.

Petitioner followed-up with Dr. Bednar on November 11, 2008, who noted on examination there was an open portion of the wound dorsal to the area where the nerve tube was placed. He started wound care. On November 18, 2008, Dr. Bednar removed sutures and noted the small open area was healing within. Petitioner was to continue in therapy for active/passive range of motion of the digit. Dr. Bednar noted on December 2, 2008 all wounds were completely healed; there was a positive Tinel's sign still at the site of the nerve laceration as expected; the stiffness of the finger had improved; he was at approximately 60 degrees of motion through the PIP joint. On December 5, 2008, the occupational therapist noted Dr. Bednar had discontinued the splint and established a "as tolerated" activity level along with being returned to work with no restrictions. Petitioner testified he returned to work at Respondent J.T. Butler Construction on December 1, 2008 to his original job at his original hours and at his original level of pay. T. 22. On January 2, 2009, the occupational therapist noted Petitioner had attended nine sessions. The treatments consisted of scar/edema/pain control methods. On examination there was active range of motion of MP 0-95, PIP 8-95, DIP 0-55; grip was 95 pounds and three point pinch 10 pounds. It was noted Petitioner was independent and compliant with his home exercise program. The program included massage, exercises, alternating use of PIP flexion strap and PIP extension tube and silicone for scar management. At that time Petitioner was discharged from occupational therapy and was to continue with his home exercise program. PX4.

Petitioner testified he has lost some range of motion in his right index finger and has difficulty straightening it out. T. 22-23. His right index finger has lost some circulation, so it gets cold easier. When it gets cold, he has to wear gloves more often, which inhibits his ability to work outside in the winter. The cold will spread through a lot of the fingers quicker. T. 23. He has lost some feeling on the inside of his right index finger and it is not as strong as his left index finger. T. 24. He has no difficulties with his right middle finger and the only thing is a scar. T. 24. Based on the above the Commission modifies the permanency award to 25% loss of use of the right index finger.

18IWCC0113

The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's November 15, 2016 decision is 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 $746.67 per week for a period of 4-2/7 weeks, that being the period of temporary total incapacity for work pursuant to §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $11,858.11 for reasonable, necessary and related medical expenses under §8(a) of the Act, subject to the Medical Fee Schedule pursuant to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $672.00 per week for a period of 4 weeks, as provided in §8(c) of the Act, for the reason that the injuries sustained caused the serious and permanent disfigurement of the right middle finger.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $672.00 per week for a period of 10.75 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the permanent disability of the right index finger to the extent of 25%.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $25,100.00. 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 27 2018
KWL/maw
o01/17/18
42

Kevin W. Lamborn

Joshua D. Luskin

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TURNER, TRENT
Employee/Petitioner

Case# **09WC046141**

J T BUTLER CONSTRUCTION INC AND INJURED WORKERS' BENEFIT FUND
Employer/Respondent

18IWCC0113

On 11/15/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

5342 R MARK MARITOTE PC
107 3RD ST
BLOOMINGDALE, IL 60108

0000 J T BUTLER CONSTRUCTION CO
726 N ELMWOOD
OAK PARK, IL 60302

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

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

TRENT TURNER
Employee/Petitioner

v.

J.T. BUTLER CONSTRUCTION , INC., and INJURED WORKERS' BENEFIT FUND
Employer/Respondent

Case # **09** WC **46141**

Consolidated cases: **n/a**

18IWCC0113

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **OCTOBER 25, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **OCTOBER 30, 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 ten (10) months preceding the injury, Petitioner earned **$58,240.00**; the average weekly wage was **$1,120.00**.

On the date of accident, Petitioner was **28** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$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 the Petitioner temporary total disability benefits of **$746.67**/week for **4-2/7** weeks, for the period from **11-01-2008** through **11-30-2008**, as provided in Section 8(b) of the Act.

The Respondent shall pay the Petitioner reasonable and necessary medical services of **$11,858.11**, pursuant to the Medical Fee Schedule, as provided in Section 8(a) of the Act.

The Respondent shall pay the Petitioner PPD benefits of **$672.00** per week for **17.20** weeks as provided in Section 8(e) of the Act, because the injuries sustained caused **40% loss of use of the right index finger**. The Respondent also shall pay the Petitioner PPD benefits of **$672.00** per week for **4** weeks as provided in Section 8(c) of the Act, because the Petitioner suffered disfigurement to his **right middle finger** as a result of this accident.

THE ILLINOIS STATE TREASURER, AS EX OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND, WAS NAMED AS A CO-RESPONDENT IN THIS MATTER. THE TREASURER WAS REPRESENTED BY THE ILLINOIS ATTORNEY GENERAL'S OFFICE. AWARD IS HEREBY ENTERED AGAINST THE FUND TO THE EXTENT PERMITTED AND ALLOWED UNDER SECTION 4(D) OF THE ACT. IN THE EVENT OF THE FAILURE OF THE RESPONDENT-EMPLOYER TO PAY THE BENEFITS DUE AND OWING THE PETITIONER, THE RESPONDENT-EMPLOYER SHALL REIMBURSE THE INJURED WORKERS' BENEFIT FUND FOR ANY COMPENSATION OBLIGATIONS OF THE RESPONDENT-EMPLOYER THAT ARE PAID TO THE PETITIONER FROM THE INJURED WORKERS' BENEFIT FUND.

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

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

Signature of Arbitrator

NOVEMBER 15, 2016
Date

TRENT TURNER v. J.T. BUTLER CONSTRUCTION, INC., and INJURED WORKERS' BENEFIT FUND

09 WC 46141

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried before Arbitrator Steffenson in Chicago on October 25, 2016. All issues were in dispute.

FINDINGS OF FACT

The Petitioner, Trent Turner, was the only witness to deliver live testimony. The Respondent employer, J.T. Butler Construction, Inc., (*hereinafter*, "J.T. Butler"), received proper notice of said hearing via personal service on Jim Butler, President of J.T. Butler, on September 3, 2016. (Petitioner's Exhibit 5). No representative of J.T. Butler was present for the October 25, 2016 hearing. Furthermore, J.T. Butler did not have workers' compensation insurance on the date of accident, October 30, 2008. (Petitioner's Exhibit (*hereinafter*, PX) 1). The Illinois Attorney General's office appeared on behalf of the Illinois State Treasurer, the ex officio custodian of the Injured Workers' Benefit Fund.

The Petitioner testified he began working for J.T. Butler in 2002 and performed carpentry work. He would do this sort of work during remodeling projects and other construction jobs being handled by J.T. Butler. On October 30, 2008, he was performing carpentry work at a job site in River Forest, Illinois, and using a table saw to cut wooden The Petitioner testified one of the boards "bucked" as he was cutting it with the table saw

as a result, his right hand came into contact with the saw blade. He immediately felt pain in right hand and noticed injuries to his right index and middle fingers.

A co-worker drove the Petitioner to Loyola University Hospital in Maywood, Illinois where he received emergency medical care, including sutures to close the lacerations to his right index and right middle finger. (PX 4 and PX 7). The Petitioner reported that Jim Butler arrived at Loyola University Hospital to check on the Petitioner's medical care and, subsequently, drive the Petitioner back to the River Forest job site so the Petitioner could retrieve his own vehicle and drive himself home.

The Petitioner had follow-up visits for his right hand injury and reported a persistent loss of sensation along the ulnar side of his right index finger. On November 5, 2008, Dr. Michael Bednar performed surgery to repair the Petitioner's right index finger ulnar digital nerve. (PX 3). Thereafter, he underwent post-surgical physical therapy before returning to work on December 1, 2008. The Petitioner testified he concluded his medical care shortly after he returned to work and that neither his medical bills nor any TTD benefits were paid by J.T. Butler.

The Petitioner stated he was 28 years old at the time of his October 30, 2008 work accident, single, and had no dependent children at that time. He indicated he no longer for J.T. Butler and, instead, is working as a self-employed carpenter with no current work restrictions concerning his right hand or fingers. He testified he has appreciated impairment motion and strength over his right index and middle fingers. He also reported cold weather

increased the sensitivity of his injured right fingers and scarring was present on both the right index and right middle finger.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

Issue A: *Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?*

The Arbitrator finds that the Respondent employer was operating under and subject to the Illinois Workers' Compensation Act. The Petitioner's un-rebutted and credible testimony establishes that J.T. Butler was operating a construction and carpentry business. As such, the Respondent employer was operating as an employer under the Act which applies automatic coverage 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..." 820 ILCS 305/3(17(a)).

Issue B: *Was there an employee-employer relationship?*

The Arbitrator finds that there was an employee-employer relationship between Petitioner and J.T. Butler. The Petitioner credibly testified the Respondent employer hired him to perform carpentry work as a part of J.T. Butler's larger construction and carpentry business. The Petitioner also presented evidence in the form of payroll checks from J.T. Butler. (PX 6). The preponderance of the evidence in this case establishes a bona-fide employer-employee relationship.

Issues C & D: *Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent? What was the date of the accident?*

The Arbitrator finds that an accident did occur on October 30, 2008 that arose out and in the course of the Petitioner's employment by the Respondent employer. The Petitioner provided credible and detailed testimony as to the mechanism of injury and how it occurred while he was utilizing a table saw to cut wooden boards for his carpentry work. Further, the medical records support a work-related accident as described by Petitioner. (PX 4 and PX 7).

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

The Arbitrator finds that timely notice was given to the Respondent employer J.T. Butler. The October 30, 2008 accident happened at J.T. Butler's then-active job site in River Forest, Illinois. The Petitioner credibly testified a co-worker drove him to Loyola University Medical Center in Maywood immediately after his accident. His further unrebutted testimony noted J.T. Butler's President, Jim Butler, later appeared at Loyola during the Petitioner's emergency medical care and then drove the Petitioner himself back to the job site later that day so the Petitioner could retrieve his own automobile from the job site after the accident.

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

The Arbitrator finds that the Petitioner's present condition of ill-being is causally to the October 30, 2008 injury. He credibly testified to a work-related injury to his right hand

and fingers and the supporting medical records and other evidence establish that the was directly related to that injury. (PX 2, PX 3, PX 4, and PX 7). The Petitioner testified that his present complaints of impaired finger motion, weakness, circulation issues, and temperature difficulties were not present prior the accident and he continues to suffer from the same.

Issue G: *What were Petitioner's earnings?*

The Petitioner testified he made $28.00 per hour and worked a 40 hour work week while working for J.T. Butler. The Petitioner further testified he could work slightly more or slightly less hours per week depending on the Respondent employer's jobs. The Petitioner also presented wage records in the form of prior pay checks from J.T. Butler. (PX 6). He then testified some of the presented pay checks covered multiple pay periods and were issued to account for prior checks from J.T. Butler that had been denied for insufficient funds.

Based upon his stated weekly earnings of $1,120.00 per week, he could have earned approximately $58,240.00 per year. The Respondent employer provided no evidence to refute the Petitioner's testimony as to his earnings ***or*** his six years of work for J.T. Butler. The Arbitrator finds that Petitioner's earnings during the year preceding the accident were $58,240.00 which yields an average weekly wage (AWW) of $1,120.00.

Issues H & I: *What was Petitioner's age at the time of the accident? Marital Status? Dependent children?*

The Arbitrator finds on the date of accident, the Petitioner was 28 years of age, single, and had no dependent children.

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

The Arbitrator finds the medical services provided to the Petitioner were reasonable and necessary to treat the laceration injuries to his right index and right middle finger and orders the Respondent employer to pay the Petitioner the sum of $11,858.11 for necessary medical services, as provided in Section 8(a) of the Act. (PX 2 and PX 3). The Petitioner credibly testified regarding his October 30, 2008 work-related injury to his right hand and his medical records support the reasonableness and necessity of the medical treatment rendered to cure that condition of ill-being. (PX 2, PX 3, PX 4, and PX 7). Further, the Petitioner stated the Respondent employer did not pay any medical bills incurred for his medical care.

Issue K: *What temporary benefits are in dispute?*

The Petitioner credibly testified he was unable to work from October 30, 2008 through his return to work after November 30, 2008. His medical records also indicate the Petitioner demonstrated, during a December 10, 2008, physical therapy session, signs of restricted motion after he was able to "work() outside in the cold all day …". (PX 4). His un-rebutted testimony as to his time away from work and the severity of his right hand injury support his claim for TTD

benefits from November 1, 2008, through November 30, 2008. The Arbitrator orders the Respondent employer to pay 4-2/7ths weeks of TTD benefits at a rate of $746.67 per week.

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

The Arbitrator finds the Petitioner suffered serious and disabling injuries as a result of the work-related accident on October 30, 2008 and orders the Respondent employer to pay PPD benefits of $672.00 per week for 17.20 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused 40% loss of use of the ***right index finger***.

The Arbitrator also finds the Petitioner suffered disfigurement to his ***right middle finger*** as a result of this accident on October 30, 2008 and orders the Respondent employer to pay PPD benefits of $672.00 per week for 4 weeks, as provided in Section 8(c) of the Act.

Signature of Arbitrator

November 15, 2016
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

FRANCISCA RAMIREZ,

Petitioner,

vs. NO: 10 WC 49189

ASPEN MARKETING SERVICE, INC,

Respondent.

18IWCC0114

DECISION AND OPINION ON REVIEW

This matter comes before the Commission on Petitioner's review of Arbitrator Flores' order denying her petition for reinstatement. The Commission, after considering the record, hereby affirms the Arbitrator's order. In support, the Commission makes findings of fact and conclusions of law as follows:

1. On December 28, 2010, Petitioner filed her Application for Adjustment of Claim. At the time, Petitioner was represented by the Law Offices of James McHargue.

2. On April 17, 2013, Petitioner's attorney filed a Petition to Withdraw. This petition was granted on May 17, 2013.

3. On February 13, 2014, Arbitrator Flores dismissed the case for want of prosecution.

4. On April 4, 2014, the Law Office of Chad Hayward filed both an Appearance on behalf of Petitioner as well as a Petition to Reinstate; the Petition to Reinstate reflected a hearing date of May 15, 2014.

5. Petitioner's attorney did not file the requisite Notice of Motion and Order with the Petition to Reinstate.

6. The Petition to Reinstate was not presented on May 15, 2014.

7. On November 18, 2015, Petitioner's attorney filed a second Petition to Reinstate. This petition, set for hearing on December 8, 2015, was accompanied by a Notice of Motion and Order.

8. On December 8, 2015, counsel for both parties appeared before Arbitrator Flores to argue Petitioner's Petition to Reinstate. A record was made.

9. When Arbitrator Flores asked Petitioner's attorney to "explain the reasons why you are requesting the petition to reinstate under the circumstances in this case," Counsel responded as follows:

> Previously when our office was retained by Petitioner, she had been represented by counsel prior to us as well. During the pendency of that representation before we had appeared in the matter, the matter was dismissed, the exact date being February 13, 2014.
> I actually received a copy of that dismissal from my client on [March] 3, 2014.
> At that point I had brought a petition to reinstate based upon the fact that I did not personally have any knowledge that the matter was up at that time. Thus if I would have had knowledge that the matter was up at that time, I would have been present on February 13, that date. Learning about that after the fact. That's when I brought the petition to reinstate...T. 4.

10. Asked if there was anything else with regard to the petition to reinstate, Petitioner's attorney stated:

> With regard to the petition to reinstate, that's the reason that we're seeking to reinstate. Essentially don't want to have the Petitioner be compromised as far as her rights due to some logistics as far as the essentially the cross over in time between her previous attorney and when she retained us. T. 5.

11. Respondent objected to reinstatement and argued two points: 1) the petition to reinstate was timely filed but did not satisfy Rule 9020.90(b), and 2) Petitioner offered no explanation for the delay in prosecuting the petition, and that lack of diligence engendered significant prejudice to Respondent:

> The Petitioner's attorney did file a timely motion to reinstate as required by rules, however, what he didn't do which is also required by the rules, he did not file a notice of motion, he did not give notice to the Arbitrator, he did not give notice to Respondent's counsel. The rules are no less mandatory that he take those steps than

that he file the timely motion. So he's done one of the four things that he's required by the rules to do…
We've been denied the opportunity to get IMEs. We've been denied the opportunity doing utilization review. We've been denied an opportunity to bringing this Petitioner back to light duty if it is appropriate. If this case is reinstated if she's got injuries we're going to get hit with two years of additional TTD. Without any opportunity to defend that situation concurrently while it was all going on. T. 5-6, 9.

12. Arbitrator Flores denied reinstatement.

13. On March 18, 2016, Petitioner filed her Petition for Review of the Arbitrator's denial of reinstatement.

14. The Return Date on Review was set for July 29, 2016, but the authenticated transcript was not filed as of that date. Petitioner's Statement of Exceptions was similarly not filed by its due date. Thereafter, Respondent filed a Motion for Rule to Show Cause and Dismiss Review.

15. On December 21, 2016, a hearing was held before the Commission. By that time, the transcript had been filed; Petitioner was permitted to file her Statement of Exceptions *instanter* and the matter was taken under advisement.

16. On April 6, 2017, we entered an order denying Respondent's Motion for Rule to Show Cause and Dismiss Review, but denying oral arguments.

ANALYSIS

Rule 9020.90 governs reinstatement and provides, in pertinent part:

b) Petitions to Reinstate must be in writing. The Petition shall set forth the reason the cause was dismissed and the grounds relied upon for reinstatement. The Petition must also set forth the date on which the Petitioner will appear before the Arbitrator to present the Petition. A copy of the Petition must be served on the other side at the time of filing with the Commission in accordance with the requirements of Section 9020.70. The Respondent may file a response to the Petition.

c) Petitions to Reinstate shall be docketed and heard by the same Arbitrator to whom the case is assigned. Both parties must appear at the time and place set for hearing. Parties will be permitted to present evidence in support of, or in opposition to, the Petition. The Arbitrator shall apply standards of fairness and equity in ruling on the Petition to Reinstate and shall consider the grounds relied on by the Petitioner, the objections of the Respondent, and the precedents set forth in Commission decisions. A record shall be made of a hearing on any contested Petition. *50 Ill. Adm. Code 9020.90.*

On a petition to reinstate before the Commission, the burden is on the claimant to allege and prove facts justifying the relief sought. *Banks v. Industrial Commission*, 345 Ill. App. 3d 1138, 1140, 804 N.E.2d 629 (2004). The Commission finds Petitioner has not shown justification for reinstatement.

Initially, the Commission notes Respondent is certainly correct that the April 4, 2014 Petition to Reinstate failed to satisfy Rule 9020.90(b). The Appellate Court has held, however, that rather than being jurisdictional, the Rule 9020.90(b) requirements factor into the Commission's decision whether to reinstate: "Although the 60-day limit for filing a petition to reinstate a case after it has been dismissed by an arbitrator for want of prosecution is jurisdictional in nature, we do not believe that the same is true of the content requirements of such a petition as contained in section [9020.90(b)]." *TTC, Ill., Inc. v. Illinois Workers' Compensation Commission*, 396 Ill. App. 3d 344, 354, 918 N.E.2d 570 (2009). As such, while Petitioner's procedural failure weighs heavily against reinstatement, it is not dispositive.

Rather, what the Commission finds most compelling is Petitioner's lack of due diligence. "A party must exercise due diligence in pursuing his or her claim before the Commission." *Banks*, 345 Ill. App. 3d at 1143. Petitioner offered nothing to explain the 20-month delay between the filing of the timely-but-deficient Petition to Reinstate on April 4, 2014, and the December 8, 2015 hearing on the November 18, 2015 Petition to Reinstate. There was a statement at the hearing by Respondent's Counsel suggesting Petitioner's Counsel missed one date due to a death in the family (T. 13), but nothing from Petitioner's Counsel to otherwise attempt to justify the failure to prosecute the petition for over a year and a half. In Petitioner's Brief in Support of Petition for Review, Petitioner offers some additional information regarding what occurred on May 15, 2014. Under Factual Background, Counsel asserts:

3. ...filed a Petition to Reinstate the matter...on April 4, 2014, with hearing scheduled for April 13, 2014 (sic).
4. Initially, the date set for hearing on the Petition to Reinstate set for a date upon which Arbitrator Flores did not hear such matters.
5. Petitioner's counsel spoke with Arbitrator Flores on that date and received this information from Arbitrator Flores and was directed to reset the hearing date.
6. The hearing date was reset and oral arguments were heard on the Petition to Reinstate on December 8, 2015.

Such facts, though, provide no explanation as to why the significant delay in presenting the Petition to Reinstate.

The Commission finds Petitioner failed to present sufficient evidence to justify reinstatement. Petitioner failed to exercise due diligence in pursuing her claim, and the delay severely prejudiced Respondent.

18IWCC0114

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's order denying reinstatement is hereby affirmed.

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. Based upon the denial of reinstatement herein, no bond is set by the Commission.

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

DATED: FEB 27 2018

L. Elizabeth Coppoletti

LEC/mck

D: 1/17/18

43

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dennis Bennett,
Petitioner,

vs. ~~NO: 15 WC 02410~~

CHS Acquisition Corporation,
d/b/a/ Chicago Heights Steel,
Respondent.

18IWCC0115

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, medical, causal connection, notice, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 21, 2017, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $46,500.00. 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 27 2018
o021518
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BENNETT, DENNIS
Employee/Petitioner

Case# **15WC002410**

CHS ACQUISITION CORP DBA CHICAGO HEIGHTS STEEL
Employer/Respondent

18IWCC0115

On 7/21/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2152 FRANK CELANI ESQ
19065 HICKORY CREEK DR
SUITE 150
MOKENA, IL 60448

0560 WIEDNER & McAULIFFE LTD
JASON STELLMACH
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Dennis Bennett
Employee/Petitioner

Case # **15** WC **2410**

v.

Consolidated cases: _____

CHS Acquisition Corp. dba Chicago Heights Steel
Employer/Respondent

18IWCC0115

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **New Lenox**, on **6/7/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **9/14/14**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$42,578.64**; the average weekly wage was **$818.82**.

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

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

Respondent ***has 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 **$5,164.00** for ppd advances, for a total credit of **$5,164.00**.

Respondent is entitled to a credit of **$2,592.17** under Section 8(j) of the Act.

ORDER

RESPONDENT SHALL PAY PETITIONER THE REASONABLE, NECESSARY AND CAUSALLY RELATED MEDICAL EXPENSES INCURRED IN THE CARE AND TREATMENT OF HIS RIGHT WRIST PURSUANT TO SECTIONS 8 AND 8.2 OF THE ACT. RESPONDENT SHALL RECEIVE CREDIT FOR AMOUNTS PAID INCLUDING AMOUNTS PAID UNDER SECTION 8 (J) FOR WHICH RESPONDENT SHALL HOLD PETITIONER HARMLESS. ARB EX 1.

RESPONDENT SHALL PAY PETITIONER TTD OF $545.88 PER WEEK FOR A PERIOD OF 53 WEEKS COMMENCING 12/30/14 THROUGH 1/5/16.

RESPONDENT SHALL PAY PETITIONER $491.29 PER WEEK FOR A PERIOD OF 51.25 WEEKS IN THAT PETITIONER SUSTAINED 25% LOSS OF USE OF THE RIGHT HAND PURSUANT TO SECTION 8(E) OF THE ACT AND SUBJECT TO THE CREDIT FOR PPD ADVANCE.

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

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

Carolyn M. Doherty

Signature of Arbitrator

7/20/17
Date

JUL 21 2017

ICArbDec p. 2

FINDINGS OF FACT

Mr. Dennis Bennett, (hereinafter referred to as "Petitioner") is a 62-year-old former flange shearman for Chicago Heights Steel (hereinafter referred to as "Respondent"). Petitioner was a 44-year employee for the Respondent until he voluntarily retired in September 2016. Petitioner testified that he worked as a flange shearman for 33 years, during which time he operated the same shear machine. All flange shearman work in 30-minute shifts. Each 30-minute shift is followed by a 30-minute break. Petitioner acknowledged that while he was at the Respondent's plant an average of 45 hours per week, he was operating the flange machine between 20 to 22 hours per week.

Petitioner worked as a flange shearman operator which entailed operating the flange machine, guiding steel bars down a conveyer and pulling a lever to cut the bars into pieces. This required the Petitioner to operate a hand lever with his left hand and push buttons with his right hand. Petitioner also used the foot pedal to control the machine. Petitioner testified that a minimum of two employees are always working on the same flange machine. A flange shearman operator would never operate a machine without another employee present. Petitioner described the other employee as his "assistant."

Respondent's Exhibit No. 1 is a video which all parties agreed accurately depicts the flange shearman position. The machine shown on the video is the actual machine Petitioner had been operating for 33 years. The Arbitrator viewed the video in its entirety. The video depicts the steel bars coming down the conveyer 5 bars at a time side by side on the conveyer. The operator guides the bars with his right hand making sure the bars are flat on the machine surface as they are fed into the blade portion of the machine. Petitioner testified that the machine can accommodate five to eight bars at one time. The operator in the video constantly uses his right hand to guide the bars into the cutter. The guidance of the bars does not appear to require force applied to the bars. Once the bars are cut, the flange shearman operator then discards the scrap in a nearby bin using both hands. The bars can vary in height and weight. The average bar weighs two pounds per foot. The average discarded bar is two feet in length weighing four pounds.

Petitioner acknowledged that the video entered as Respondent's Exhibit No. 1, accurately depicts the flange machine and its proximity to the scrap bin. Petitioner also acknowledged that the video accurately depicts the flange machine when it is operating smoothly. However, Petitioner further testified that the video does not show everything he does while operating the line and specifically does not depict when there is trouble on the line. The Petitioner testified that when the machine is operating smoothly, he is not required to physically handle any of the bars until they are discarded into the nearby bin. Petitioner testified that there are entire 30-minutes shifts where the line runs smoothly. However, Petitioner testified that when the bars are twisted on the line they must be turned by hand with a wrench tool or taken off the line and cut with a torch. In addition, Petitioner testified that he uses both hands to level out the bars applying force and weight to the bars while guiding the bars. On occasion, Petitioner used a pipe to push on the bars in order to level the bars. Petitioner testified that he "pushes down all the time" while working the steel on the line in order to line up the steel bars. He testified that he applied some force and grip when picking up the scrap and throwing the scrap into the bin. Petitioner testified that he lifts up to 30 pounds of scrap bars at one time.

A four-page written job description with the heading "Physical Demands Analysis" was prepared by Genex on April 16, 2015. RX 2. The shearman operator is classified as a light physical demand level position based on the Dictionary of Occupational Titles Physical Demand Characteristics of Work. The description reads "As steel bars come down moving conveyor line, use right hand to guide into machine cutter. Using left hand, move lever back/forth to cut pieces. Toss scrap pieces into bin. Repeat with next set of steel bars. Work for 30 minutes continuously. Then break for 30 minutes. Start back up repeating process above. Always working

with another individual on opposite side of conveyor." The scrap pieces weigh on average between one to five pounds. Said objects are discarded on average one time every two minutes.

Jason Wagner is a 24-year employee for the Respondent. Mr. Wagner has been a superintendant for ten years. As superintendant, Mr. Wagner oversees approximately 75 employees, which included the Petitioner while he was an active employee. Mr. Wagner is familiar with the shearman operator position as he is around the flange machine on a daily basis. The flange machine has undergone no modifications since Mr. Wagner has worked for the Respondent, other than to address normal wear and tear. Mr. Wagner confirmed that the shearman operators work in 30-minute increments. Mr. Wagner verified that the flange machine shown in Respondent's Exhibit No. 1 is the same machine Petitioner had operated. Mr. Wagner agreed with the Petitioner that there are shifts where the shearman operator would not need to touch the bars until the scrap is discarded into the bin. According to Mr. Wagner, the line runs smoothly 95% of the time. During the remaining 5%, it is the responsibility of all employees operating that particular flange machine to free the bars. He agreed that Petitioner must use his right hand on the line to push buttons and pick up scrap after the cut. He further agreed that the shearman must also change the knife on the cutter using his right hand to screw nuts and bolts and may also turn a wrench or ratchet while working the line. He further agreed that some bars can be higher than others while on the conveyor and that Petitioner may have to apply pressure to the bar to push it down so that it is level with the other bars before feeding into the cutter. He also agreed that some force must be used to untwist the bars on the conveyor.

Petitioner testified that he did not experience any problems with either hand during the first 30 years he worked as a shearman operator until September 2014. In September 2014, Petitioner complained to Dr. Joshi bilateral wrist pain. Dr. Joshi ordered x-rays. PX 1. The x-rays of the left wrist were normal. X-ray of the right wrist was read to suggest that Mr. Bennett was suffering from mild to moderate degenerative osteoarthritis manifested by joint space narrowing between the distal radius and the proximal row of carpals with marginal osteophytes from the scaphoid carpal bone and dorsal aspect of the right wrist. There was no evidence of any acute fracture. Petitioner testified that on September 14, 2014, Dr. Joshi told the petitioner that his pain was worked related so Petitioner reported his right wrist pain to human resources. This testimony regarding notice was not rebutted.

On September 17, 2014, the petitioner underwent an EMG at South Suburban Hospital. The EMG history indicates Petitioner was seen for complaints of "pain and swelling in bilateral wrists for several years increasing over time…he has been doing repetitive work for the last 42 years as a shear operator… all of the fingers seem to be involved…he has positive Phalen sign bilaterally…he has a positive Tinel sign over the carpal tunnel region bilaterally." PX 6. The EMG results suggested that the petitioner was suffering from mild bilateral carpal tunnel syndrome. PX 6. Dr. Joshi referred Petitioner to Dr. Coates.

Petitioner first saw Dr. Coates on November 17, 2014. PX 3. Dr. Coates' records reflect that Dr. Coates reviewed x-rays and took a clinical history from Mr. Bennett. Petitioner reported 5 years of pain with the symptoms worsening 6 months prior to his visit. Petitioner described the pain as shooting and stabbing radiating on and off into the right arm. The pain was noted as severe and included numbness and tingling. PX 3. Exam revealed swelling and tenderness to palpation along the dorsal aspect of the radial scaphoid joint bilaterally with symptoms worse on the right than left. Dr. Coates noted multifocal areas of degenerative joint disease in petitioner's hands. Bilateral wrist x-rays indicated severe joint space loss of the radiocarpal joint and significant radiocarpal joint arthritis in the right wrist. Dr. Coates diagnosed bilateral wrist and hand pain and scapholunate advanced collapse of the right wrist and left wrist. He injected both the left and right radio-carpal wrist joints. PX 3. He prescribed medications and the use of splints at work and directed the petitioner to return to him in 4 to 6 weeks.

Petitioner was seen by Dr. Singh at Advocate on 12/3/14 and it was documented that he had been diagnosed with bilateral carpal tunnel syndrome. The notes indicate that Petitioner was a machinist and that he noticed a lot of numbness in his fingers at home at night. He used braces at night but could not use them at work as the work gloves did not fit over the braces. PX 1.

On December 15, 2014, Dr. Coates saw Mr. Bennett again and discussed surgery with him as the injections did not help. Petitioner reported that he had bilateral wrist pain but that he was not having pain at night. Dr. Coates noted that when he passively flexed both wrists Petitioner reported wrist pain and that "as soon as he begins working the pain is there." He noted that petitioner was suffering from bi-lateral SLAC wrist arthritis and that the pain was much greater on the right. Dr. Coates recommended that Petitioner would benefit from a proximal row carpectomy starting on the right. PX 3.

Petitioner followed up at Advocate through December 2014 complaining of bilateral wrist pain. PX 1. The records reflect that Petitioner had seen Dr. Coates, a hand surgeon, who recommended surgery. The records further reflect that Dr. Coates was leaving the area and that Petitioner was accordingly continuing his treatment at Advocate. PX 1. On 12/18/14, Dr. Singh recommended continued braces and Gabapentin and was referred to Dr. Labana for further care. PX 1. While waiting for approval to see Dr. Labana Petitioner followed up with Dr. Joshi. On 12/30/14, Dr. Joshi noted that Petitioner was off work and wearing the braces which helped his pain but that the pain returned with physical activity. He further noted that Petitioner had been doing the same job for 40 years which involves repetitive movement of the wrists. He noted that "clinically I don't think the patient should continue doing the same job much longer. He is not getting any younger and the arthritis and the carpal tunnel syndrome will keep bothering him even more. I feel he should either go on disability or at least change the job if his company allows." PX 1. He was again referred to Dr. Labana.

Dr. Labana testified via evidence deposition taken on August 14, 2015. PX 7. He is an orthopedic surgeon specializing in hand and upper extremity surgery. He testified that he first saw Petitioner on 1/12/15 when Petitioner reported bilateral pain and numbness. Petitioner offered that he worked pushing metal with his hands. Petitioner reported that his work was repetitive. He noted that Petitioner had failed prior conservative treatment and that surgery had been recommended by a prior treating doctor. He diagnosed Petitioner with right wrist arthritis and recommended that Petitioner undergo a four corner fusion of the right wrist. The surgery was performed on 2/10/15 using bone grafting screws and staples. Occupational therapy was prescribed on 3/5/15. X-rays on 4/23/15 showed good healing position and therapy was continued. He testified that based on his review of the job video Petitioner was unable to return to his job as of 4/23/15. At the last visit on 6/29/15, Dr. Labana recommended work conditioning. He opined that Petitioner's job duties aggravated and or worsened Petitioner's arthritis. PX 7, pp. 28-30. He testified that Petitioner was not at MMI at the time of the deposition as he was still to do work conditioning followed by an FCE. He anticipated Petitioner having permanent restrictions. Although he did not specifically treat Petitioner's carpal tunnel, he opined that his repetitive job duties likely aggravated the condition. PX 7, p. 33. He did not plan on removing the screws.

On cross exam he testified that his opinion is based on his review of the job video. PX 7, p. 39. His opinion is based on the fact that Petitioner had to apply force across the wrist joint which aggravated the arthritis. He was unable to assess the amount of force used or the weight of the steel bars depicted in the video. He agreed that if the bars were "feather weight" it may make a difference in his opinion. However, he testified, "but I think anything over that, when you're doing it a whole bunch of times a day and you're pushing on something hard, I think... anything over five pounds, ... it's still putting force across the wrist. And if it's an arthritic wrist, you're gonna worsen the condition." Px 7, p. 42. He was also unaware of the exact frequency of Petitioner's job duties. However, he opined that if Petitioner was at the job for 5- 10 years and performed that same function for the majority of his work day then he considered the job duties a contributing factor to the condition.

PX 7, pp. 43-44.

Petitioner was also seen for a Section 12 exam at Respondent's request by Dr. Vender on May 27, 2015. He testified via evidence deposition on October 5, 2015. RX 4. Dr. Vender testified that when he saw Petitioner he was status post right wrist fusion and that the treatment had been reasonable to treat Petitioner's diagnosed condition. RX 4, p. 10-11. Upon reviewing the job video, Dr. Vender opined Petitioner was capable of performing his normal duties. He did not believe Petitioner's job duties were an exacerbating factor for his arthritic condition and as such his job duties did not result in his need for the surgery. RX 4. P. 13. He did not perceive the job involved forceful activity with an impact necessary to constitute a repetitive trauma. He further testified that even if Petitioner performed forceful activity the activity was intermittent and not done on a regular and consistent basis. RX 4, p. 14, 25.

Petitioner was also sent for a Section 12 exam by Dr. Coe performed on July 14, 2015. Dr. Coe's evidence deposition was taken on 10/19/15. PX 9. Dr. Coe found his condition of bilateral hand and right wrist symptoms (right wrist radiocarpal arthritis aggravated by the repetitive and forceful nature of his work as a shearman operator and bilateral carpal tunnel) causally related to his job duties. PX 8. He testified that based on the history taken from Petitioner, the treatment and medical records and the video and job information, it was his opinion that the work activities Petitioner performed as a shearman operator were a factor causing the breakdown in his right wrist radiocarpal arthritis and the condition of bilateral carpal tunnel syndrome. Specifically, he opined that the work described by Petitioner including the "pushing parts, pushing levers, forceful extension and twisting of his wrist using both hands throughout his workday at a job he described as fast paced working up to six days per week occasionally 12 hours per day with parts that were by his description poorly finished that hung up in the machines with machine malfunctions that he had to clear that hose activities were factors that would accelerate breakdown in an arthritic wrist. They would place eccentric, unusual stresses on his arthritic right wrist and were a factor in its breakdown with onset of pain requiring medical and surgical treatment." PX 9, pp. 36-37.

On cross, Dr. Coe testified that if the line ran smoothly as it did in the video without difficulty in pulling or pushing levers it would be an unlikely cause of Petitioner's condition. PX 9, p. 47-48.

On 10/28/15, Respondent was offered his position as a shearman operator. On 11/13/15, Respondent advanced Petitioner $10,000 to undergo and pay for additional work conditioning and an FCE. RX 5,6.

Petitioner underwent an FCE on 12/14/15 which assessed his physical demand level at very heavy and indicated that repetitive motions that involve weight bearing through right hand/wrist and turning motion of that hand should be performed on an as tolerated basis. On 12/17/15 Petitioner attended his last visit with Dr. Labana. At that time he was placed at MMI with permanent restrictions of no lifting over 20 pounds with the right hand, no repetitive pushing/pulling, and splint/bracing as needed. PX 6.

At trial, Petitioner testified that he returned to full duty work for Respondent in January 2016. He was still unable to wear a splint on the job. Petitioner worked full duty until he retired in September 2016. Petitioner has not had any treatment since December 2015. Currently, he is unable to move his right wrist more than 75 degrees. He does not take any medication for his hand pain and still uses his right hand to write and to drive.

CONCLUSIONS OF LAW

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

C. E. F. Did an Accident Occur which Arose Out of and in the Course of Petitioner's Employment by Respondent? Was Timely Notice of the Accident Given to Respondent? Is Petitioner's Current Condition of Ill-Being Causally Related to the Injury?

The Arbitrator initially notes that although the initial treating medical records reflect bilateral hand complaints, Petitioner's testimony at trial was offered concerning the right hand/wrist only.

Petitioner credibly testified that he worked as a shearman operator at Respondent for approximately 33 years. All parties agree that the video depicts the machine Petitioner worked on for 33 years. The Arbitrator viewed the video and notes that it depicts a worker standing next to the machine with his left hand on a lever and his right hand guiding steel bars through a cutter at the end of the machine. Petitioner testified that the video depicts his general job performed every day for 33 years. Petitioner testified that he ran the machine for 30 minutes at a time and that he worked 45 hours per week.

Petitioner further testified that the video depicts the machine running without problems. However, Petitioner testified that the machine malfunctioned frequently. He testified that when the bars are twisted on the line they must be turned by hand with a wrench tool or taken off the line and cut with a torch. In addition, Petitioner testified that he uses both hands to level out the bars applying force and weight to the bars while guiding the bars. On occasion, Petitioner used a pipe to push on the bars in order to level the bars. Petitioner testified that he "pushes down all the time" while working the steel on the line in order to line up the steel bars. He further testified that he applied some force and grip when picking up the scrap and throwing the scrap into the bin. Petitioner testified that he lifts up to 30 pounds of scrap bars at one time. The Arbitrator notes that the bars can vary in height and weight. The average bar weighs two pounds per foot and on average between one to five pounds. The average discarded bar is two feet in length weighing four pounds and is discarded on average one time every two minutes. A four-page written job description of the shearman operator is consistent with the video and with Petitioner's testimony.

Jason Wagner agreed with the Petitioner that there are shifts where the shearman operator would not need to touch the bars until the scrap is discarded into the bin. According to Mr. Wagner, the line runs smoothly 95% of the time. During the remaining 5%, it is the responsibility of all employees operating that particular flange machine to free the bars. He agreed that Petitioner must use his right hand on the line to push buttons and pick up scrap after the cut. He further agreed that the shearman must also change the knife on the cutter using his right hand to screw nuts and bolts and may also turn a wrench or ratchet while working the line. He further agreed that some bars can be higher than others while on the conveyor and that Petitioner may have to apply pressure to the bar to push it down so that it is level with the other bars before feeding into the cutter. He also agreed that some force must be used to untwist the bars on the conveyor.

Petitioner further testified, and the treating records reflect, that he began having pain in his bilateral wrists 6 months prior to seeing Dr. Joshi in September 2014. At this initial visit with Dr. Joshi Petitioner was diagnosed with mild to moderate degenerative osteoarthritis manifested by joint space narrowing between the distal radius and the proximal row of carpals with marginal osteophytes from the scaphoid carpal bone and dorsal aspect of the right wrist. Petitioner testified that on September 14, 2014, Dr. Joshi told the petitioner that his pain was worked related so Petitioner reported his right wrist pain to human resources. This testimony regarding notice of accident was not rebutted.

Based on job video, Petitioner's credible testimony regarding the frequency and force of his job duties for 33 years and on the medical opinions discussed below, the Arbitrator finds Petitioner sustained repetitive trauma to his right wrist arising out of and in the course of his job for Respondent and manifesting on 9/14/14. The Arbitrator further finds that Petitioner provided timely notice to Respondent and that Petitioner's condition in his right wrist is causally related to his job duties for Respondent.

In so finding, the Arbitrator notes that Petitioner treated briefly with Drs. Joshi, Singh and Coates from September to December 2014 regarding his right hand and wrist complaints. The Arbitrator notes that the September 17, 2014 EMG history indicates Petitioner was seen for complaints of "pain and swelling in bilateral wrists for several years increasing over time…he has been doing repetitive work for the last 42 years as a shear operator…" In November and December 2014, Petitioner's treating physicians noted that Petitioner's pain would increase with activity and prescribed braces to be worn at work. On 12/30/14, Dr. Joshi noted that Petitioner had been doing the same job for 40 years which involves repetitive movement of the wrists. He noted that "clinically I don't think the patient should continue doing the same job much longer. He is not getting any younger and the arthritis and the carpal tunnel syndrome will keep bothering him even more. I feel he should either go on disability or at least change the job if his company allows."

Based on Petitioner's history and the job video, Dr. Lebana opined Petitioner's condition was causally related to his sufficiently repetitive and forceful job duties. He agreed that if the bars were "feather weight" it may make a difference in his opinion. However, he testified, "but I think anything over that, when you're doing it a whole bunch of times a day and you're pushing on something hard, I think… anything over five pounds, … it's still putting force across the wrist. And if it's an arthritic wrist, you're gonna worsen the condition." Px 7, p. 42. He opined that if Petitioner was at the job for 5- 10 years and performed that same function for the majority of his work day then he considered the job duties a contributing factor to the condition. PX 7, pp. 43-44. Dr. Coe also opined that Petitioner's condition was causally related. The Arbitrator places greater weight on the opinion of Dr. Lebana than on the opinion of Dr. Vender in finding causal connection for petitioner's condition. Based on a preponderance of the credible evidence at trial, the Arbitrator finds that Petitioner sustained a cumulative and repetitive trauma to his right wrist manifesting on September 14, 2014 causally related to his job duties for Respondent. The Arbitrator makes no findings on accident or causal connection pertaining to Petitioner's left wrist as no sufficient evidence was submitted at trial pertaining to Petitioner's left wrist.

J. Were the Medical Services That Were Provided to Petitioner Reasonable and Necessary?

Based on the Arbitrator's findings on the issues of accident and causal connection, the Arbitrator further finds that Respondent shall pay Petitioner the reasonable, necessary and causally related medical expenses incurred in the care and treatment of Petitioner's right wrist condition pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid including credit under Section 8(j) of the Act and shall hold Petitioner harmless for same. ARB EX 1.

K. Is Petitioner Entitled to Any TTD Benefits?

Based on the Arbitrator's findings on the issues of accident and causal connection, the Arbitrator further finds that Petitioner was temporarily and totally disabled for a period of 53 weeks commencing 12/30/14 through 1/5/16, the day Petitioner returned to work full duty for Respondent. Although Petitioner was offered his full duty job in October 2015, he underwent the FCE in December 2015 and returned to work full duty as of 1/5/16. Respondent shall receive credit for amounts paid, if any.

L. What is the Nature and Extent of Petitioner's Condition?

Again, the Arbitrator makes no findings and no award with regard to Petitioner's left wrist or hand.

Section 8.1b states that the determination of the level of permanent partial disability shall be based on five factors. No single enumerated factor shall be the sole determinant of disability. The first factor is the reported level of impairment pursuant to Section 8.1b (a). In this matter, no AMA impairment report was submitted and this factor is given no weight. The second factor is the occupation of the injured employee. The third factor is the age of the Petitioner. The forth factor is the employee's future earning capacity. With regard to these three factors, the Arbitrator notes that the 59 year old Petitioner was a shearman operator who returned to his regular duty job in January 2016. He retired later that year. As a result, the Arbitrator gives little weight to these factors.

The fifth factor is evidence of disability corroborated by the treating medical records. Petitioner sustained aggravation of his severe pre-existing arthritis in the right wrist necessitating a partial fusion of his right wrist. Petitioner testified and the medical records indicate that he has little motion in the right wrist. He is unable to move his right wrist more than 75 degrees. He does not take any medication for his hand pain and still uses his right hand to write and to drive. He was able to return to full duty work and worked for 8 months prior to retiring.

Based on the foregoing, the Arbitrator finds that Petitioner sustained 25% loss of use of the right hand pursuant to Section 8(e) of the Act. Respondent shall receive credit for the PPD advance made to Petitioner. ARB EX 1.

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rochele Roby,

Petitioner,

18IWCC0116

vs.

NO: 12 WC 35873

Solo Cup,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical, vocational rehabilitation 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 15, 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.

18IWCC0116

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 $50,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 27 2018
o2/8/18
DLS/rm
046

Deborah L. Simpson

Deborah L. Simpson

David L. Gore

David L. Gore

Stephen J. Mathis

Stephen J. Mathis

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

18IWCC0116

ROBY, ROCHELE
Employee/Petitioner

Case# **12WC035873**

SOLE CUP
Employer/Respondent

On 5/15/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0333 SHAY & ASSOCIATES
TIMOTHY M SHAY
260 E WOOD SR
DECATUR, IL 62523

1109 GAROFALO SCHREIBER HART ETAL
ANDREW RANE
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

18IWCC0116

STATE OF ILLINOIS)
)SS.
COUNTY OF Champaign)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Rochele Roby
Employee/Petitioner

v.

Solo Cup
Employer/Respondent

Case # 12 WC 035873

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 **Urbana**, on **March 10, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **9/24/2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$24,900.00**; the average weekly wage was **$592.89**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **1** dependent child.

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

Petitioner was temporarily totally disabled from **9/25/12 – 10/7/12** (1 6/7 weeks) and **5/13/13 – 7/17/15** (113 4/7 weeks) for a total period of **115 3/7 weeks**.

Petitioner is entitled to maintenance benefits from **7/18/15 – 3/10/17**, a period of **85 3/7 weeks**.

Respondent shall be given a credit of **$77,412.56** 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

Medical benefits

Respondent shall pay reasonable and necessary medical services as set forth in Petitioner's Exhibit 12, directly to the providers, if desired, and according to the fee schedule, as provided in Sections 8(a) and 8.2 of the Act.

Respondent is further ordered to reimburse Medicaid for payments made to medical providers for bills set forth in Petitioner's Exhibit 12.

Temporary Total Disability (TTD)

Respondent shall pay Petitioner temporary total disability benefits of **$395.26/week** for **115 3/7 weeks**, commencing **9/25/12 – 10/7/12, (1 4/7 weeks) and 5/13/13 – 7/17/15 (113 4/7 weeks)**, as provided in Section 8(b) of the Act. Per the stipulation of the parties, the only outstanding period of TTD due and owing is from 12/26/13 – 1/16/14 (3 1/7 weeks)

Vocational Rehabilitation and Maintenance

Petitioner is entitled to vocational rehabilitation services in the form of obtaining her B.A. from Eastern Illinoins University.

Respondent is ordered to pay to Petitioner the sum of **$12,037.43,** as set forth in Petitioner's Exhibit 22, representing past tuition and fees at Parkland College, as provided for in Section 8(a) of the Act.

Respondent shall pay the sum of **$9,964.75**, as set forth in Petitioner's Exhibit 26, representing past tuition and fees at Eastern Illinois University for the school year of 2016-2017, as provided in Section 8(a) of the Act.

Petitioner is entitled to ongoing vocational rehabilitation services in the form of payment of the cost of tuition, books, fees and all other costs associated with Petitioner's completion of her Bachelor's Degree at Eastern Illinois University, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner maintenance benefits of **$345.26 per week** for **85 3/7 weeks**, for the period **7/18/15 – 3/10/17**, as provided in Section 8(a) of the Act. The parties stipulated that this amount has been paid by Respondent.

Respondent is further ordered to pay maintenance in the sum of **$395.20 per week** through Petitioner's completion of her Bachelor's Degree at Eastern Illinois University provided Petitioner is enrolled and attending classes on a full-time basis.

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

May 9, 2017
Date

ICArbDec19(b)

MAY 15 2017

FINDINGS OF FACT and CONCLUSIONS OF LAW

Petitioner's case proceeded to arbitration pursuant to her 19(b) Petitioner on March 10, 2017. At the time of the hearing Respondent stipulated to accident and further stipulated that its only causation dispute was whether Petitioner's closed head injury was causally connected to the accident. The parties further stipulated that Petitioner's left shoulder condition was unrelated to the accident. The other disputed issues were medical bills, TTD (primarily the period from 12/26/13 – 1/16/14 as the attorneys agreed that all other TTD had been paid) and vocational rehabilitation. Petitioner and Bob Hammond were the only witnesses.

The Arbitrator finds:

Petitioner began working for Respondent in April of 2012 as a Machine Operator, and she operated machines on the lid line making lids. Petitioner would load round pieces of plastic onto a bar before setting the bar on rollers and feeding it through the machine. Petitioner testified she would place the loaded rolls on stands and then physically push them down a track to feed them into the machine. She would then catch the roll at the front of the machine so that she could hook it to the trim press, which would then press the lids.

Petitioner testified that on September 24, 2012, a roll was positioned too far over on a stand, and after placing the hook the roll flipped and the bar caught her left hand under her glove. She testified that, as the roll flipped, it "ripped everything out of her hand." While looking down at her hand after the initial injury she heard the hook come off the roll and looked up. The hook then hit her on the top of her head, on the right side, and spun her around. Petitioner testified she suffered a laceration above her hairline, and that she was bleeding from her left hand and head.

Petitioner presented to the Carle Foundation Hospital Emergency Department via EMS on September 24, 2012. PX 1. She was treated at Carle by Dr. Robert A. Gurtler, an orthopedic surgeon. PX 1. Dr. Gurtler noted full-thickness skin loss of the left thumb, and Petitioner was diagnosed with a degloving injury of her left hand, a tendon injury, and a scalp laceration. PX 1. Petitioner was kept overnight, discharged on September 25, 2012 and referred to a hand surgeon, Dr. Clifford Johnson. PX 1.

Petitioner presented to Dr. Johnson at the Carle Hand Surgery Clinic on September 25, 2012. PX 8. Dr. Johnson prescribed Keflex and Norco and advised Petitioner to remain off work and to keep the wound dressed until it could be re-evaluated. His concerns were three-fold: (1) prevent infection; (2)obtain coverage; and (3) obtain function. At the 9/27/12 appointment Petitioner was noted to be crying and very upset over the injury. On October 1, 2012 Petitioner denied any pain but would not speak with the doctor. She cried throughout the visit and nodded in response to questions. PX 8.

Petitioner signed her Application for Adjustment of Claim herein on October 2, 2012, alleging left hand and head injuries as a result of her accident on September 24, 2012. (AX 2)

Petitioner's scalp laceration was repaired with three staples, which were removed on October 3, 2012. PX 1, 2.

On October 4, 2012, Dr. Johnson's notes described Petitioner as a completely different person as she was happy and talkative and not appearing to be in pain. There was no crying. The doctor advised Petitioner that she could return to work on light duty with restrictions of office work only and no work with the left hand. He did not feel she should be returned to work on the floor near machinery. PX 8.

As of October 8, 2012 Dr. Johnson noted that Petitioner's improvement was "dramatic" and he was both "surprised and impressed" as to the degree of healing she had been able to achieve. PX 8.

Dr. Johnson re-examined Petitioner on October 12, 2012 noting she was doing well with improved pain control and her wound looked terrific as it was granulating nicely and filling in from the edges. He felt she was not going to need surgery. PX 8.

Dr. Johnson saw Petitioner again on October 15, 2012. Petitioner was reporting an increase in her pain and was noting concern about being able to keep it elevated at work. Her case manager was in attendance with her. Dr. Johnson wished for Petitioner to see a hand therapist. He also wanted a splint fabricated to be used at certain times. Work restrictions were noted as right hand only and she was to keep the wound clean, dry and covered while at work doing office work. PX 8.

Petitioner returned to work on a light duty basis on October 8, 2012. (AX 1)

Petitioner returned to see Dr. Johnson on October 18, 2012 noting some problems with her splint. Dr. Johnson was going to have another therapist look at the splint. While her wound was all but completely healed, he was concerned about stiffness of her first web space and thumb IP joint. She was to return in one week and restrictions remained in effect. PX 8.

As of October 25, 2012, when Petitioner returned to see Dr. Johnson she was doing well with marked diminishment in her pain. The only time she was experiencing pain was when doing her exercises or using her hand aggressively. She was to return in three weeks. PX 8.

Petitioner called Dr. Johnson's office on October 29, 2012 requesting a refill on her Norco. PX 8

Petitioner returned to the Carle Emergency Department on November 3, 2012 complaining of increasing left thumb pain. PX 3. She was evaluated by Physician's Assistant Nicole Alred, who assessed Petitioner with a wound infection. PX 3. Petitioner was prescribed antibiotics and discharged. PX 3.

Petitioner returned to see Dr. Johnson on November 6, 2012 and advised him of her recent visit to the ER. She was to continue with therapy and return in one week. PX 8.

On November 9, 2012, Petitioner presented to the Carle Emergency Department complaining of a headache on the side of her head where she was hit during the September 24, 2012 accident. PX 4. Petitioner testified that she started getting headaches after she stopped taking the Norco prescribed for her left hand pain. She testified she had stopped taking the Norco after returning to work on light duty, as she could not take narcotics at work. She described the headaches as moderate, constant, and described it as a banging pain. In the Comment section, it states, "For last 3 days, taking Vicodin and

pain not going away, was hit in head with a hook at work 1.5 months ago wants to know if it is associated." Petitioner was evaluated by emergency room physician Dr. Kristen Kent, who diagnosed Petitioner with a closed head injury and concussion, and advised her to return if her symptoms persisted. Under "Medical Decision Making" Dr. Kent wrote, " 46 yo with closed head injury in September with normal neuro exam, no fevers, no vomiting, no LOC with continued headaches along with irritability and increased tiredness...." The discussed the symptoms of a concussion and treatment plan with no further studies felt necessary at the time. Petitioner was discharged home in good condition.PX 4.

Petitioner returned to the Carle Emergency Department three days later, on November 12, 2012 complaining of a right-sided, throbbing headache. PX 5. Petitioner was evaluated by Physician Assistant Hoshang Irani, who ordered a CT scan of her head. PX 5. The CT scan was reviewed by radiologist Dr. Douglas W. Morton, who noted possible subtle hypodensity in the right cerebellar hemisphere. PX 5. Petitioner was diagnosed with a headache and post-concussion syndrome and referred to a neurologist. PX 5.

Petitioner returned to the ER on December 1, 2012 and again complained of a headache. PX 6. She was evaluated by emergency room physician Dr. Jose Ochoa, who opined that the etiology of her symptoms appeared to be post-concussive syndrome; however, he added that her work-up, physical exam and observation period did not indicate a serious cause to the symptoms. He wrote, "The current assessment has been explained to the patient including the fact that etiology cannot be ruled out with certainty." PX 6.

On December 6, 2012, Petitioner had an initial appointment with a new primary care physician, Dr. Robert Healy of Carle Clinic. Petitioner told the doctor she had been injured at work and was hit in the head by a hook and had a degloving injury to her left thumb. She had been seeing Dr. Johnson for the hand injury. He wrote, "Says she was told she had a concussion. Was told something showed up on the CT. Will be seeing Neuro in January. Received a call from her attorney and talked a lot with him. Her main issue was trouble sleeping, had headaches, and had hand pain." Her problem list included hypertension, a degloving injury of her hand, cellulitis and an abscess of her finger, and post-concussion syndrome. Dr. Healy diagnosed her with a head injury and thumb injury. PX 8.

On December 6-10, 2012, Dr. Healy's office documented numerous phone conversations regarding authorization for the recommended brain MRI. Workers' compensation was denying authorization for head because Petitioner had sustained a head laceration and "there was no contusion to the head." Petitioner telephoned back replying that she did injure her head at work when she injured her hand and she had staples in her head to prove it. Petitioner was going to have her lawyer fix the situation. PX 8

On December 7, 2012, Dr. Johnson referred Petitioner to Dr. Hyunchul Jung for pain management with respect to her left hand. PX 8.

Petitioner presented to Interventional Pain Management on December 10, 2012 and was evaluated by Dr. Jung. PX 8. Dr. Jung noted that Petitioner had pain with headaches and left thumb and finger pain. Dr. Jung noted that Petitioner was currently taking one to two tablets of Hydrocodone. PX 8. Dr. Jung prescribed Ultram and continued physical therapy. PX 8.

Petitioner returned to Dr. Johnson on January 8, 2013. PX 8. Dr. Johnson noted that her wound was healing well and opined that Petitioner could progress to a work conditioning program. PX 8.

Additionally, he placed her on work restrictions of no forceful grip, pinch, bend and torque with the involved hand. PX 8.

Petitioner completed her hand therapy on January 11, 2013. (PX 9)

Petitioner telephoned Dr. Jung's office on January 3, 2013 requesting more Tramadol as it helped a lot and she could get through therapy with very little pain.

Petitioner participated in work conditioning through Carle Therapy Services from February 22, 2013 through March 27, 2013. PX 10.

On January 15, 2013, Petitioner presented to the Department of Neurology (Dr. Chen) for an evaluation of her headaches. PX 8. She reported that she had experienced infrequent migraines in the past, but that since her accident she was having headaches almost every day. She described her work accident, including being hit in the head by a hook. She denied any loss of consciousness but had been having headaches almost every day since the accident. She was taking Vicodin, and later Ibuprofen and Aleve for awhile but then began having intermittent blurry vision that would come and go. She was working light duty. Petitioner was evaluated by Dr. Chen, who diagnosed her with "worsening migraine-like headaches with some blurry vision after a minor head injury." PX 8. He prescribed Gabapentin and advised her to return in three months following a brain MRI. PX 8.

Petitioner followed up with her primary care physician, Dr. Healy, regarding her headaches on January 17, 2013, and on January 24, 2013, she returned to the ER. PX 7, 8. She was evaluated by emergency room physician Dr. Jennifer Kent, and complained of ongoing headaches since her accident and reported that her headache that day was of the same character. PX 7. Petitioner followed up with Dr. Healy on January 28, 2013 after the emergency room visit. No changes in treatment were noted. He did note a detailed description of Petitioner's headaches. PX 8.

Thereafter, Petitioner telephoned DR. Healy's office as she needed some forms completed that would defer/reduce her student loan debt. At first the doctor thought it was disability paperwork and he preferred that Dr. Johnson complete it. He also documented a discussion with Petitioner regarding disability for her post-concussion syndrome. "I do not think she is disabled from this." The doctor did eventually help her complete the forms. PX 8.

On January 31, 2013, Petitioner presented to Carle Hospital for a brain MRI, which was reviewed by radiologist Dr. Momin Muzaffar. PX 8. Dr. Muzaffar noted scattered foci of Flair hyperintensity in the supratentorial white matter and a pituitary microadenoma versus intraseller Rathke's cleft cyst, but no acute intracranial abnormality. PX 8.

Petitioner was advised by telephone on February 5, 2013 that the brain MRI showed a possible tiny pituitary microadenoma. A repeat MRI in one year was recommended. PX 8

Petitioner's medication for headaches was changed on February 6, 2013 per Dr. Chen. She was going to try Percocet. Petitioner was very upset and frustrated trying to get an understandable explanation as to her MRI findings. PX 8

Petitioner followed up with Dr. Chen on February 12, 2013 after the MRI. PX 8. Dr. Chen opined that the CAT scan was inconclusive but the MRI showed some scattered foci of hyperintensity in the

supratentorial white matter which were likely nonspecific findings. He also noted a 2 mm. pituitary micradenoma or intrasellar Rathke's cleft cyst. He prescribed Lyrica. He again noted she seemed to be having worse headaches after a minor head injury. PX 8.

Petitioner was scheduled for some extensive dental work during February of 2013. Her dentist called Dr. Chen as he was concerned about proceeding after Petitioner had told him she had a benign pituitary tumor. Dr. Chen advised the dentist that a pituitary tumor had not be confirmed. PX 8

Petitioner continued to treat with Dr. Johnson for her left hand injury. As of February 19, 2013 she was doing very well but undergoing evaluation and treatment for her head injury. PX 8

Dr. Jung re-examined Petitioner on March 6, 2013. Petitioner was taking a 50 mg. tablet of Tramadol three times a day to help with her pain and it did so "significantly." Dr. Jung released her to return as needed but to continued using the Tramadol. PX 8

In late March Dr. Healy's office noted that Petitioner was only taking Amitriptyline on the weekend as she couldn't take it during the week. PX 8

Petitioner called Dr. Johnson's office on April 11, 2013 reporting that when she got home that day she was in pain from working eight hours and was having trouble with her current job duties. Petitioner was very concerned as she had been doing better and did not want to get worse. It was noted that workers' compensation would not authorize the FCE as she was currently attending work conditioning. The doctor changed her restrictions to right-handed work only. PX 8

Petitioner returned to see Dr. Johnson on April 19, 2013 (which was sooner than her previously scheduled appointment) as she was having trouble with her work restrictions. PX 8. Dr. Johnson kept the right hand only work restriction in effect. PX 8.

Petitioner returned to Dr. Chen on May 14, 2013, to follow up regarding her headaches. He noted that she was still having pretty frequent headaches of about 3 -4 per week. She couldn't tolerate the Amitriptyline and was taking Gabapentin which he increased in dosage. Petitioner was taken off work by Dr. Chen until further notice. PX 8.

Up through this time Petitioner had been working light duty.

Dr. Johnson re-examined Petitioner on May 28, 2013. She was being followed by Dr. Chen for her "head injury and heat." She stated that he had been taking her off work because of her head and she was not presently working. Petitioner had been discharged from the work conditioning program at SafeWorks due to noncompliance with the program. Petitioner reported she had not undergone a functional capacity evaluation. She denied having any pain but was having trouble with her thumb with its inability to function and reported numbness. Dr. Johnson noted that he could potentially complicate things if she didn't follow through with her therapy. He felt Petitioner should get a functional capacity evaluation (FCE) and assign restrictions thereafter. He also felt a second opinion could be helpful. She was to return after the FCE. Dr. Johnson noted that Petitioner was off work per Dr. Chen. PX 8

Petitioner had an appointment scheduled with Laura Wyncoop for June 25, 2013. Petitioner called and cancelled it stating she had the flu. PX 8

On June 25, 2013 Petitioner called Dr. Johnson's office and Dr. Chen's office requesting an appointment. She reported neck and bilateral arm pain she felt was stemming from her headaches. She had an appointment with the hand surgeon for the 25th but cancelled it. She reported being able to manage her headaches with Ultram but she wanted to see the doctor about her neck and bilateral arm pain. PX 8

Dr. Johnson examined Petitioner on July 11, 2013 at which point he felt the FCE demonstrated, for the most part, maximal effort. They reviewed the FCE with the doctor feeling she could return to work based upon the restrictions from the FCE dated June 5, 2013 performed at SafeWorks.. She was contemplating some additional therapy and continued treatment for her head injury. He told her to return as needed pending the foregoing. PX 8

Petitioner returned to Dr. Chen on July 23, 2013, and again reported suffering from headaches three to four time per week, but also stated that the Gabapentin was helping. PX 8.

Petitioner had a visit with Dr. Jung on August 5, 2013 to address treatment options. He released her from his care to return as needed. PX 8

On August 12, 2013 Dr. Chen revised Petitioner's work restrictions and allowed her to return to work for four hours a day for two weeks, after which time she could return to work full duty. PX 8.

On September 11, 2013, Petitioner presented to neurologist Dr. Russell Glantz of Parkview Orthopaedic Group for an Independent Medical Examination at the request of Respondent. RX 4. Dr. Glantz diagnosed Petitioner with subjective headaches, and agreed with Dr. Chen that the MRI findings were not responsible for her symptoms. RX 4. Dr. Glantz opined that Petitioner's headaches were not related to the September 24, 2012 accident, but were instead a continuation of pre-existing migraines. RX 4. Dr. Glantz stated that, from a neurological point of view, there were no objective findings, however he also testified that headaches are subjective and that he is unable to objectify them. RX 4. Dr. Glantz further stated that, while in his opinion Petitioner's treatment for headaches was not related to the September 24, 2012 accident, her treatment may have been reasonable and necessary for the headaches she subjectively experienced. RX 4.

Additionally, an IME was conducted with respect to Petitioner's left hand on September 25, 2013 by Dr. Nabil Barakat at Midwest Hand Surgery. RX 1. Dr. Barakat opined that Petitioner's treatment for her left hand injury to that point had been reasonable and necessary, that her findings correlated to her subjective complaints, and that Petitioner had not reached MMI. RX 1. Dr. Barakat further stated that the next step in Petitioner's treatment might be surgical intervention. RX 1.

Petitioner returned to see Dr. Jung on October 4, 2013 reporting left-sided finger web pain for which she was taking Ultram which helped keep the pain under a controllable level. She ws to continue on the Ultram. He also noted Petitioner was going to be discussing surgical options with Dr. Johnson. PX 8a

On October 15, 2013, Petitioner returned to Dr. Chen for a follow up regarding her headaches. PX 8. She reported she was still taking Gabapentin, and that her headaches were acceptable. PX 8. Dr. Chen ordered a repeat brain MRI. PX 8.

Petitioner called Dr. Chen's office on October 31, 2013 and reported a bad headache, which she rated at 8/10. PX 8. She stated she was unable to get out of bed due to the pain. PX 8.

Petitioner followed up with Dr. Johnson on November 19, 2013 regarding the September 25, 2013 IME. PX 8. Petitioner indicated she would like to proceed with surgery, but that Dr. Chen had ordered a repeat brain MRI, which would need to occur first. PX 8. Petitioner was released to work without restrictions with respect to her left hand. PX 8.

Petitioner called Dr. Chen's office on December 3, 2013 stating that her attorney had told her that none of Dr. Chen's records state that her headaches were due to her concussion at work. She wished to know why because she never had the headaches before the head injury. Dr. Chen replied on December 4, 2013 that his first consultation report states the headache started after a head injury. PX 8

Petitioner had an appointment with Dr. Jung on December 4, 2013. Her pain was reportedly "relatively under control" and surgery with Dr. Johnson was pending. PX 8

Petitioner called Dr. Chen's office on December 27, 2013 stating she needed a note from the doctor stating her headaches were from her work-related injury. Dr. Chen responded "ok to write the letter." PX 8

On January 10, 2014, Petitioner returned to Dr. Johnson to sort out paperwork issues from her November 19, 2013 visit. PX 8. Dr. Johnson stated that he released Petitioner to work without restrictions at that time based upon a misunderstanding. PX 8. He mistook Petitioner to have said she was able to work without restrictions, when in fact she had stated that Respondent was not letting her work due to her restrictions. PX 8. He noted that his restrictions were based upon what work she was able to perform without pain. PX 8. Petitioner reported that she experienced pain with forceful gripping, bending, pinching and torqueing with her left hand and fingers. PX 8. Dr. Johnson placed Petitioner on work restrictions of no forceful gripping, bending, pinching, or torqueing with the hands and fingers on the left until her planned surgery. PX 8.

On January 14, 2014, Petitioner presented to Carle Hospital for a repeat brain MRI. PX 8. The MRI was reviewed by Dr. Muzafar, who found no changes from the prior MRI. PX 8.

Petitioner called Dr. Chen's office on January 15, 2014 reporting she had been cleared by Neurology for surgery. PX 8.

Petitioner returned to Dr. Chen on January 17, 2014 following the MRI, and he noted the findings were unchanged. Petitioner reported "Overall her headache is doing fine." The repeat MRI showed she didn't have a tumor; rather, it was more likely a Rathke's cleft cyst. She was told to go see an eye doctor regarding her blurry vision and to return in six months. PX 8.

On January 29, 2014, Petitioner presented to Carle Hospital for surgery, which was performed by Dr. Johnson. PX 8. Specifically, Dr. Johnson performed: a left first web space 4 flap z-plasty; tenolysis of the left FPL; external neurolysis of the left thumb radial digital nerve; repair of the left thumb radial digital nerve; and external neurolysis of the left thumb ulnar digital nerve procedures. PX 8. There were no complications. PX 8.

Petitioner underwent an eye exam on February 10, 2014 and low power reading glasses were recommended. PX 8

Petitioner began hand therapy on an outpatient basis on February 11, 2014 after being examined by Dr. Johnson who felt she was ready to do so. Regarding work, she was limited to right hand work only. PX 8

Petitioner underwent another eye exam on February 18, 2014 and was given a prescription for eyeglasses. PX 8

Dr. Johnson noted good progress in his February 21, 2014 office note. Petitioner was advised to perform her therapy diligently. PX 8

Dr. Johnson re-examined Petitioner on March 4, 2014 noting Petitioner was having a lot of pain, undergoing therapy three times a week and doing her home exercises. She remained off work by one of her treaters and was using Hydrocodone and Gabapentin for pain relief. Noting they "had been down this road before" Petitioner was encouraged to not give up on therapy and to try her best. She could return to work with mostly right-handed work and no forceful grip, pinch, bending or torqueing of the left hand. Another order for therapy was given. PX 8

Petitioner began taking classes at Parkland College during the 2014 Spring Semester. PX 16.

Dr. Glantz also testified via his evidence deposition taken on March 13, 2014, and entered into evidence as Respondent's Exhibit 3. Dr. Glantz diagnosed Petitioner with subjective headaches, and agreed with Dr. Chen that the MRI findings were not responsible for her symptoms. RX 4. Dr. Glantz opined that Petitioner's headaches were not related to the September 24, 2012 accident, but were instead a continuation of pre-existing migraines. RX 4. Dr. Glantz testified Petitioner did not suffer a concussion because of the gap between the injury and when the headaches became apparent to her, and because she did not lose consciousness. RX 3, p. 22, 25, 28-29. In his analysis of causation Dr. Glantz did not discuss the frequency or character of Petitioner's previous headaches, nor did he reference the records from Dr. Chen in which Petitioner stated her prior migraines were infrequent and that they were much worse after the accident. RX 4. Dr. Glantz testified he had not reviewed any medical records from prior to the accident. RX 3, p. 31.

Dr. Glantz stated that, from a neurological point of view, there were no objective findings; however he also testified that headaches are subjective and that he is unable to objectify them. RX 4, RX 3, p. 42-43. He testified he had no reason to dispute that Petitioner experienced headaches. RX 3, p. 42-43. Dr. Glantz further stated that, while in his opinion Petitioner's treatment for headaches was not related to the September 24, 2012 accident, her treatment may have been reasonable and necessary for the headaches she subjectively experienced. RX 4.

Dr. Glantz also testified that ninety-nine percent of his medical-legal work is for insurance companies, defendants, respondents, or law firms representing defendants or respondents. RX 3, p. 58. He testified that in the last five years he has earned between $175,000.00 and $234,000.00 per year for his medical-legal work. RX 3, p. 57.

As of April 21, 2014, Dr. Jung felt Petitioner could return on an as-needed basis in the future. Some hypersensitivity was noted around her scar area with some slight numbness on her thumb web area. Medication was discussed and changed. PX 8

Dr. Johnson re-examined Petitioner on April 22, 2014 noting she was doing well. Workability was currently based on her restrictions from "her concussion which has her off work due to her head injury. From his perspective, Petitioner could do light duty when released from the head injury. He stressed that she needed to push herself to use her hand given the length of time she has been protecting it. PX 8

Petitioner had a visit with Dr. Healy on April 24, 2014. He noted that she had pain in her left hand but it was better. She also reported some left shoulder pain. She was off work but taking class on line from Parkland in Kinesiology. Dr. Healy also noted "Still active with law suit for injury that happened sept. 2012." PX 8

Petitioner was discharged from therapy on April 28, 2014. Petitioner had attended seventeen sessions and only missed one. She was still unable to open jars, jewelry clasps or lift heavy or large objects with her left hand. PX 8

Dr. Healy saw Petitioner on April 29, 2014 for her annual exam. PX 8

Petitioner continued to undergo therapy for her hand in May, June, and July of 2014. PX 8

In May of 2014 Petitioner called Dr. Jung's office regarding a lot of left shoulder pain she was experiencing and for which pain medication wasn't helping. As of June 4, 2014, Petitioner was still having lots of pain in her left shoulder but she was undecided as to what kind of referral she wanted. Ultimately Dr. Jung suggested left shoulder therapy. Workers' compensation was noted to be denying coverage for any left shoulder problems. PX 8

On July 22, 2014 Dr. Johnson noted that Petitioner was making excellent progress, but also that she remained off work per Neurology. PX 8.

Petitioner underwent a left shoulder steroid injection on July 22, 2014 (per Dr. Jung) for an unrelated shoulder condition. PX 8.

Petitioner called in to Neurology on August 4, 2014 regarding an upcoming appointment. She also mentioned she would be starting school in September. PX 8

On August 7, 2014 Petitioner called Dr. Jung's office regarding her left shoulder injection. Motion was better but she was having terrible pain and tightness down her left side. She also reported having bad headaches that her Gabapentin was not helping. PX 8

Petitioner saw Dr. Jung on August 11, 2014 in follow-up for the shoulder injection. She also had some cervical complaints noted at the time. Slight limitation of Petitioner's left thumb was documented. PX 8

Petitioner returned to Dr. Chen on August 15, 2014. PX 8. She reported that her headaches were getting better ("stable") with her current medication, and that she was getting them once a week or once a month. PX 8. She stated that overall she was happy with her situation, but she felt stressed and feared

that physical activity might make the headache worse. PX 8. She did not feel comfortable going back to work which, Dr. Chen, opined was reasonable. PX 8.

Dr. Healy examined Petitioner on August 18, 2014 for an ear problem. PX 8

Petitioner underwent therapy for her neck beginning on August 25, 2014. PX 8

Petitioner saw P.A. Shroyer on August 29, 2014 regarding bilateral shoulder complaints. She was diagnosed with a left shoulder contusion. PX 8

On September 3, 2014, Petitioner returned to Midwest Hand Surgery for a second IME with respect to her left hand. RX 2. Dr. Barakat opined that Petitioner had reached MMI with respect to her left hand and that she did not need further surgical treatment. RX 2. She also stated that, due to her persistent hypersensitivity and loss of range of motion, Petitioner was not able to return to her job as a machine operator. RX 2. Dr. Barakat stated she believed this restriction to be permanent and she recommended a functional capacity evaluation (FCE). RX 2.

Petitioner was examined by Dr. Bane, an orthopedist, on September 22, 2014. Petitioner wanted her left shoulder looked at. Dr. Bane noted her degloving injury and that something came down and hit her in the head at the time of the accident. He did not feel the work accident was causally related to her left shoulder complaints. Petitioner told the doctor that her work accident had occurred two years earlier. He wrote, "She had been on pain medicine for a long time. Said she completely got off of that by like May/June of this year and then she started noticing her shoulder giving her more trouble." He felt she had an arthritic AC joint. PX 8

On November 10, 2014, Petitioner followed up with Dr. Johnson regarding the IME, and he agreed with Dr. Barakat that Petitioner should undergo a FCE. They also discussed Petitioner's attorney's concerns regarding the FCE, especially concerning the hypersensitivity in her hand that could affect the results. Dr. Johnson agreed that she might have different abilities on different days; however, the FCE was the best way to get an objective idea of what she could do. At the present, he felt the restrictions could be based from the 9/3/14 IME. PX 8.

Petitioner called Dr. Jung's office on January 21, 2015 regarding worsening headaches. They were more frequent and pretty bad and don't go away but get better when she lies down and stays quiet. She reported being sensitive to light but no nausea or vomiting. She had begun weaning herself off the Gabapentin in August when the headaches went away but in the past month they had returned. Her dosage was increased. PX 8

Petitioner underwent a left shoulder injection on January 28, 2015. PX 8 Per the order of Dr. Jung, Petitioner underwent a left hand x-ray on January 28, 2015. Mild narrowing between the distal pole of the scaphoid and the base of the trapezium was noted. Additionally, small subchondral cysts were noted in the head of the first metacarpal as part of an early degenerative process. PX 8

Petitioner called in on February 2, 2015 regarding worse hand complaints. It was suggested that she get in to see Dr. Johnson. PX 8

Petitioner met with Dr. Johnson on February 6, 2015. She reported some aching in her palm ("5/10"). She originally thought it might have been related to her left shoulder but her shoulder improved

after a recent injection but the aching is still present. She denied using her hand for any heavy activities. Dr. Johnson noted that her left hand "really looks terrific" and was the least swollen and most mobile he had seen it since her accident. Her scars remodeled nicely. He did not some limited motion of the first web space compared to the opposite side. He assured Petitioner that it was common for patients with a significant injury to have aches and pains in the area of the injury over time but he couldn't see anything causing her discomfort. He still felt restrictions from either an FCE or the last IME would be appropriate. PX 8.

Petitioner returned to Dr. Chen on February 18, 2015, and again stated she was uncomfortable returning to work due to her headaches. PX 8. Dr. Chen adjusted her Gabapentin dosage. PX 8.

Petitioner returned to see Dr. Jung for her headaches on February 18, 2015. She reported that overall she had been stable and when she reduced the Gabapentin, the headaches became worse so she was back on it. The most recent MRI of her brain showed a Rathe's cyst so further brain MRIs would not be warranted. Petitioner reported she still didn't feel comfortable going back to work and "the stress can make her headache worse." He kept her off work. PX 8

On March 17, 2015 Petitioner called in wishing to have the FCE scheduled. PX 8

Petitioner presented to WorkWell Systems, Inc. on March 31, 2015 for a FCE. The primary diagnosis was left hand degloving injury and the secondary diagnosis was listed as closed head injury with post-concussion syndrome. Petitioner was noted to be attending school to further her education. The evaluation was conducted by Physical Therapist Tiffany DeLaCruz, who noted that Petitioner put forth her full effort throughout testing. She was able to safely lift twenty pounds floor to waist, fifteen pounds waist to crown, and twenty pounds front carry, each on a rare basis. There were five job attributes of a machine operator which she was unable to perform, and PT DeLaCruz noted that she was functioning at a light physical demand level. Petitioner returned to Dr. Johnson for a follow up on April 10, 2015, and he placed her on work restrictions per the FCE. PX 8; PX 11.

Petitioner was examined by PA-C Tom McCall on April 6, 2015 regarding bilateral hand pain. Petitioner denied any recent trauma or injury. She was having increased pain in her left hand and mild pain with her right hand and felt her left hand was a little swollen. She denied any overuse or unusual activity with her hands. Mr. McCall saw no signs of an acute injury. He noticed slightly limited range of motion of her fingers. She was given a script for Norco and Anaprox to help with her symptoms untl she could be seen by her hand specialist. PX 8

Dr. Johnson re-examined Petitioner on April 10, 2015. At that time they reviewed her March 31, 2015 FCE. He noted he would impose restrictions based upon that FCE. He also addressed Petitioner's concerns about the swelling in her left hand which, by history, had gotten so bad she had to go to the emergency room. He did not see any swelling on exam. He believed her regarding pain complaints. He also offered to have her get a second opinion which she declined. They did agree to proceed with an x-ray and MRI if approved by workers' compensation. PX8

Petitioner and Dr. Johnson met on May 5, 2015 and they reviewed her x-ray. The doctor explained to her that it showed some very early STT joint arthritis and a small cyst within the thumb metacarpal head. They were unchanged from previous x-rays. The MRI had not been approved. Dr. Johnson again suggested a second opinion. PX 8

Petitioner underwent a right shoulder injection on May 6, 2015. PX 8

Petitioner followed up with Dr. Jung on May 8, 2015. Petitioner was waiting for an MRI of her left hand and wished to only use over-the-counter medications. PX 8

Petitioner underwent the MRI of her left hand and saw Dr. Johnson thereafter. She had some increased T2 signal about the flexor tendons of the middle and ring fingers consistent with her areas she found most swollen. She had some notable stiffness in flexion of those two digits. He recommended an injection of the flexor sheath of those fingers which was done that same day (June 5, 2015). PX 8

Petitioner last saw Dr. Johnson regarding her left hand injury on July 17, 2015. PX 8. She reported no pain in her left hand. Dr. Johnson described her fingers as having excellent range of motion. The webspace was unchanged. The injection had helped greatly. Dr. Johnson released her from his care on modified duty pursuant to the March 31, 2015 FCE. PX 8.

On July 29, 2015 Petitioner presented to Dr. James Barkmeier regarding right hand and wrist pain that had begun about a month earlier. She was prescribed pain medication. PX 8

Petitioner underwent bilateral shoulder injections on August 11, 2015. PX 8

On August 19, 2015 Petitioner returned to Dr. Chen and reported that her headaches were stable; however, she felt unable to return to work as the "stress is too much for the headache." Most of the time, her headaches were stable but when she reduced the medication the headaches became worse. She was to return in six months. PX 8.

On August 25, 2015 Petitioner's attorney sent correspondence to Respondent's attorney requesting verification of whether Respondent was willing to provide work within Petitioner's restrictions. PX 14.

Petitioner saw Julie Swartz, P.A., on August 26, 2015 regarding her right hand pain. Petitioner had recently undergone blood work and had a high rheumatoid factor. Petitioner wondered if it was due to her work injury and was told it wasn't. PX 8

On September 1, 2015 Petitioner underwent a rheumatology consultation with Dr. Russell. Petitioner told Dr. Russell that she had an industrial accident about three years earlier "which resulted in trauma to the left hand and degloving injury that involved the thumb. She had blunt trauma to both shoulders in connection with that injury but none to the right hand." Since then Petitioner had recovered most of the use of her left thumb but had been relying on her right hand for most activities. In April of 2015 she noticed the onset of swelling and pain in her left wrist and palm and she was unable to make a fist because of the pain. She underwent a left hand MRI which revealed tendinitis of the left third and fifth flexor tendons. By the time the MRI had been performed most of her wrist symptoms had resolved. The fingers responded to subsequent injections but in July of 2015 she began having problems with her right wrist. A right wrist x-ray revealed a probably justa-articular osteopenia and lab work showed a positive rheumatoid factor. Petitioner had also been noticing increasing bilateral shoulder pain for which she received bilateral injections. Petitioner was taking Indocin and having no current joint pain. A

history of migraines was also noted. Petitioner reported being able to do most of her activities of daily living. She was using her right hand largely to decompensate for some residual dysfunction of the left thumb. The doctor felt Petitioner had some early rheumatoid arthritis and maybe a transient carpal tunnel syndrome but it had resolved. Medications were discussed. PX 8

Petitioner called Dr. Chen's office on September 15, 2015 regarding worse headaches un-helped by Imitrex. They appeared to be worse when outside and she was unable to sleep.

Petitioner looked for work between September 18, 2015 and September 29, 2015. During that time she looked for six jobs. PX 15

On September 29, 2015 Petitioner saw her family doctor, Dr. Hussain, regarding a three month history of right wrist pain intermittent in nature and brought on by writing, working on a computer, or any activity with wrist movements. She was given medication and told to follow up with rheumatology and to avoid heavy lifting. PX 8

On October 2, 2015 Petitioner looked for 3 jobs. PX 14 On October 4, 2015 she looked for another three jobs. PX 15

Petitioner looked for four jobs on October 11, 2015 and two jobs on October 16, 2015. PX 15

Petitioner returned to see Dr. Chen on October 26, 2015 regarding her headaches. They "went through a lot of the common triggers for the headache. Again, she is not sure and I give her a long list of the common triggers, hoping she can find out over time." She had tried to reduce her Gabapentin and the doctor thought that might have triggered the headaches. No further brain MRIs were going to be needed due to the findings on the second one. PX 8

According to Petitioner's job search forms, she looked for six jobs on October 26, 2015. PX 15

On October 30, 2015 Petitioner's attorney sent correspondence indicating that Respondent had not made an offer of employment to date, and stating Petitioner was actively pursuing a self-directed job search. He also acknowledged that as of that date no offer of employment had been made by Respondent to Petitioner. PX 14.

Petitioner looked for three jobs on November 3, 2015 and two jobs on November 4, 2015. PX 15

On November 5, 2015 Petitioner underwent bilateral shoulder injections. PX 8

Petitioner looked for on job on November 5, 2015 and four jobs on November 15, 2015. PX 15

Petitioner had numerous conversations with Dr. Jung's office in January of 2016 regarding her bilateral shoulder pain. She was wanting Dr. Jung to proceed with bilateral shoulder injections. Any sort of ambulation aggravated her pain. PX 8

Dr. Chen testified via his evidence deposition taken on January 28, 2016, and entered into evidence as Petitioner's Exhibit 13. Dr. Chen testified he had reviewed the Emergency Department records and the diagnosis of post-concussion syndrome. PX 13, p. 12-13. He testified that, after reviewing Petitioner's history of present illness and CT scan, and performing an examination, her symptoms were consistent with post-concussion syndrome. PX 13, p. 16. He testified that her headache got significantly worse after the injury, and that a diagnosis of post-concussion syndrome could be made based on that time sequence. PX 13, p. 16-17. He further testified that, while some doctors may apply a stricter criteria, many, including neurologists, would not require loss of consciousness in order to diagnose a concussion. PX 13, p. 17. Dr. Chen also testified that he couldn't say for certain if the trauma Petitioner experienced on September 24, 2012 was sufficient to cause a concussion but her story "sounded credible." PX 13, p. 18He testified that concussions are the mildest brain injury, and minor injuries can cause concussions. PX 13, p. 57-59. If symptoms, such as headache or dizziness, develop after an injury, he would diagnose post-concussion syndrome. PX 13, p. 59. Dr. Chen testified that, within a reasonable degree of medical certainty, Petitioner's headaches were causally related to the September 24, 2012 accident. PX 13, p. 18.

When discussing the initial September 24, 2012 ER visit, he also testified that it is common for one injury to be overwhelming, and for people to not realize they have another injury until after going home from the hospital. PX 13, p. 67.

Dr. Chen testified that, as far as his care and treatment, Petitioiner would likely continue with Gabapentin, but would potentially adjust the dosage or try other medication. PX 13, p. 36.

Additionally, Dr. Chen testified that the MRI findings were not related to the September 24, 2012 accident, and that the MRI findings were not likely the cause of Petitioner's headaches. PX 13, p. 20, 79-80.

Dr. Chen testified, within a reasonable degree of medical certainty, that the trauma of September 24, 2012 was likely a cause of the headaches Petitioner was experiencing at that time. PX 13, p. 33. Dr. Chen testified that Petitioner did not report any other possible reasons for the headaches, such as stress, new injury or new medications. PX 13, p. 34. He testified that without a new cause, it was still his opinion that the headaches were caused by the September 24, 2012 trauma. PX 13, p. 33-34. Dr. Chen testified he did not change her work restrictions at that time, and that she would still be off work. PX 13, p. 36-37.

On cross-examination Dr. Chen acknowledged that he didn't recall Petitioner mentioning any headaches before November 9, 2012. (PX 13, p. 73) He also agreed that she lacked any common symptoms associated with a concussion except for a headache. He also agreed that he was speculating as to what happened when Petitioner originally presented to the ER on September 24, 2012. (PX 13, p. 70)

After the deposition, Petitioner returned to see Dr. Chen on February 18, 2016. He noted "She had a minor head injury then started having pain after that." She still has some intermittent headache, some good days, some bad days, some good weeks, some bad weeks. She is taking more Gabapentin when the headache is worse and cutting down when better which was fine with the doctor. Overall, Petitioner was

doing fine and there were no changes made to the current treatment plan. She was to return in six months. PX 8

On February 19, 2016 Petitioner underwent bilateral shoulder injections. PX 8

Petitioner called Dr. Jung's office on February 23, 2016 regarding her shoulder pain. The injections did not help. Dr. Jung recommended a shoulder specialist. Petitioner replied that she had seen Dr. Bane in the past and "he wants to do surgery; however, she doesn't want him to cut on her." PX 8

By letter dated March 17, 2016 Petitioner's attorney wrote, "It is my understanding that [Respondent] continues to take the position that there is no employment available for my client within her restrictions for her hand." He also referenced a letter from Respondent's attorney advising him that Respondent was still performing an ADA search in an effort to determine whether or not [it] could make reasonable accommodations for [Petitioner's] restrictions." He wrote, "I am assuming that since four months have elapsed since your letter, the personnel department [at Respondent] has been dismantled and in fact, no one has made an ADA evaluation." PX 14

Petitioner looked for nine jobs between March 17 and March 19, 2016. PX 15

Petitioner looked for eleven jobs in April of 2016. PX 15

At Parkland College, Petitioner majored in general studies and graduated with an Associate's Degree on May 13, 2016. PX 17.

Petitioner looked for nine jobs in May of 2016 after graduating. PX 15

On June 2, 2016, Petitioner's attorney sent correspondence stating that she had completed her Associate's Degree and would be seeking her Bachelor's Degree. PX 14. That correspondence also stated Petitioner would be setting the matter for a 19(b) hearing to request vocational rehabilitation, specifically, her college education. PX 14.

By letter dated June 2, 2016 Petitioner's attorney advised Respondent's attorney that a completed Request for Disability Accommodation had been sent to the ADA specialist at Dart Container. There had been no efforts, to date, to return Petitioner to work within her restrictions. His demand for vocational rehabilitation had also gone without response and Petitioner was continuing to perform a job search on her own. PX 14

In June of 2016 Petitioner looked for 21 jobs. PX 15

By letter dated June 22, 2016 Petitioner's attorney forward job search forms to Respondent's attorney and asked if Respondent was willing to return Petitioner to work within her restrictions. PX 14

On/about July 13, 2016 Petitioner's attorney scheduled a 19(b) hearing in this matter for August 17, 2016. (RX 5)

18IWCC0116

Petitioner looked for four jobs on July 19, 2016. PX 15

On July 21, 2016 Petitioner was seen at the Department of Orthopedics/Section of Podiatry. The visit is labeled "workers' compensation." Petitioner was there in "follow-up" for a left fifth toe fracture. According to the note, "[Petitioner]'s injury occurred June 27, 2016. She stubbed her toe at work." Petitioner was given a shoe to use as needed as she was reporting quite a bit of pain using her regular shoe. Petitioner was to return in four weeks. (RX 8)

On November 6, 2016, Vocational Consultant Bob Hammond completed an Initial Vocational Report for Petitioner. PX 25. Mr. Hammond recommended that Petitioner continue her pursuit of a Bachelor's Degree, and opined that positions in social services would allow for accommodations regarding her restrictions. PX 25. Additionally, while Petitioner was fifty years old, Mr. Hammond testified that, with her Degree, she would be able to work well into her sixties and beyond. With a Bachelor's Degree, Petitioner would be able to recoup her lost wages over time. PX 25.

By letter dated February 16, 2017 Petitioner's ADA request with "Dart Container" was denied. PX 28

Petitioner's case proceeded to arbitration on March 10, 2017.

Petitioner testified that she is currently 50 years old and unemployed.

Petitioner addressed RX 8, the office note dated July 21, 2016, pertaining to a foot injury. Petitioner acknowledged injuring her foot but denied that it occurred at work as stated in the record. Petitioner testified that she wasn't working at that time; rather, she was volunteering for her church where she injured her foot.

Petitioner testified that she graduated from high school in 1984. Petitioner testified she had attended community college in the past, but that she did not complete any degree although she was certified as a CNA in 1998. Petitioner testified that she didn't do well in college because she was unmotivated and immature. She failed some courses and withdrew from others.

Petitioner did find work as a CNA in Springfield Illinois and she worked at a nursing home. She lived in Springfield from around 2002 through 2008. Petitioner testified, at length, regarding her prior employment opportunities.

She testified that she began working for Respondent in April of 2012 as a Machine Operator, and that she operated machines on the lid line making lids. Petitioner testified she would load round pieces of plastic onto a bar before setting the bar on rollers and feeding it through the machine. Petitioner testified she would place the loaded rolls on stands and then physically push them down a track to feed them into the machine. She would then catch the roll at the front of the machine so that she could hook it to the trim press, which would then press the lids. Petitioner was asked about the list of job demands included in the report from her March 31, 2015 functional capacity evaluation, and agreed that the listed demands were accurate.

Petitioner testified that on September 24, 2012, a roll was positioned too far over on a stand, and as a result after placing the hook the roll flipped and the bar caught her left hand under her glove. She testified that, as the roll flipped it "ripped everything out of her hand." While looking down at her hand after the initial injury she heard the hook come off the roll and looked up. The hook then hit her on the top of her head, on the right side, and spun her around. Petitioner testified she suffered a laceration above her hairline, and that she was bleeding from her left hand and head. She did not lose consciousness.

Petitioner was taken to the emergency room. She had sustained a laceration to her head. She was kept overnight and then discharged to follow up with Dr. Johnson. Petitioner testified to her care and treatment with Dr. Johnson as reflected in the medical records. Petitioner testified that eventually Dr. Johnson performed surgery and she was eventually allowed to return to light duty work for Respondent; however, she couldn't take all her medication while working and she began to get headaches. Petitioner testified that they became so bad she had to go to the emergency room in November of 2012. She then sought treatment with her family doctor and was referred to Dr. Jung for pain management.

Petitioner testified to her ongoing treatment as set forth in the medical records, including the surgery performed by Dr. Johnson to her left hand in January of 2014.She also treated with Dr. Chen for her ongoing headaches. After the surgery she underwent a great deal of work conditioning. She also went to an optometrist to check her vision complaints. Finally, Petitioner underwent an FCE in late March of 2015. Based upon it, permanent restrictions were given to Petitioner for her left hand injury. Petitioner testified that she never returned to work for Respondent after the permanent restrictions were issued. Petitioner testified she has never been provided vocational training or assistance by Respondent.

Petitioner testified that she would apply for jobs online, and that if the employer was local, she would call. She testified she called several potential employers to make sure they received her online application. Petitioner testified she attempted to find work within her restrictions. She testified she was unable to find any work

Petitioner testified she returned to college because she had always been able to count on an industrial job previously, but that she was no longer able to due to her work restrictions for her left hand injury. At Parkland College, Petitioner majored in general studies and graduated with an Associate's Degree on May 13, 2016. PX 17. She testified she was successful in completing her degree this time because she knows what she wants, and because she is older and more stable.

Petitioner testified that many of the jobs she was interested in required a Bachelor's Degree, which is why Petitioner decided to continue her education after receiving her Associate's Degree. She testified that she began attending Eastern Illinois University, and that she is currently working towards her Bachelor's Degree in general studies with minors in psychology and sociology. She testified that in her first semester she received four B's and one C, and that she is currently taking Psychology for Adolescents, Theories of Personality, Diversity, Ethical Behavior in Business, and Critical Thinking. She is currently receiving A's and B's. Petitioner testified she will return to classes in the Fall of 2017, and that she expects to graduate in December of 2017.

Petitioner testified she has been asked to apply for the Honor Society and Eastern Illinois University, and that she speaks to children as part of the Lincoln Challenge, a program to help reach troubled children before they are put into the system. She testified she has been asked to speak at two

workshops in Philadelphia as well. She speaks to children about the challenges she has faced and about not letting a few bad decisions define you.

Petitioner testified that after completing her Degree she wants to help people and, in particular, she would like to work in a transition center for women and young girls. She testified that the contacts she is making speaking as part of the Lincoln Challenge are helping her to find work once she completes her education.

Respondent has not helped pay for any of Petitioner's educational expenses she has incurred while attending school and obtaining her degree in May of 2016. Petitioner testified to the expenses she has incurred as reflected in the exhibits.

Petitioner testified to ongoing pain in her left hand and trigger fingers. She feels an achiness in her palm and hand and tightness in the web space. Petitioner testified to a tendency to drop things in her left hand. She also has to change the manner in which she types at the computer which she has to do while taking classes. She gets a cramp when typing. She also testified that she cannot bend her left thumb. Petitioner takes extra strength Tylenol for her daily pain complaints.

Petitioner testified that she still gets periodic headaches, maybe four to five times per month. She continues to take Gabapentin for them and continues to see Dr. Chen. She testified to having an appointment very soon.

Petitioner testified that she would like to finish and get her degree. She has a son in college and bills to pay. She has found her passion within her studies and wishes to pursue it and have something she truly enjoys doing for the rest of her life.

On cross-examination Petitioner agreed that she wasn't really having headaches prior to November 12, 2012 because she was on Vicodin. The Vicodin helped her with the headaches. Lyrica did not. The Gabapentin has really helped with the headaches, depending upon the dosage.

Petitioner denied having any headaches prior to the accident other than the regular kind people have. She acknowledged that when she saw one of Respondent's doctors she may have told him that she had migraine headaches when living in Springfield and that she was prescribe Imitrex. She did not recall what other medications, if any, she might have tried when living in Springfield. She denied having migraine headaches since going to work for Respondent in April of 2012.

On further cross-examination Petitioner was asked about her MRIs with Dr. Chen and her lackluster performance the first time around in college when she was much younger. She agreed that she didn't pursue any higher education between 2005 and 2014. Petitioner testified that when she enrolled in Parkland College in 2014 she wanted to start her own business and work with people. She took classes in grant writing. She agreed that she did that before the FCE was done in March of 2015.

Petitioner started school at Parkland on her own in 2014 and she took two classes. She withdrew from one. In the summer of 2014 she took three classes. In the fall of 2014 she took four classes and withdrew from one of them. In the spring of 2015 she took four classes and got a "D" in one and an "F" in one. She took two classes during the summer and four classes in the fall of 2015 but had to withdraw from one of them. She took three classes in the spring of 2016 and graduated with an Associate's Degree in May. Petitioner testified that she doesn't plan on taking classes during the summer of 2017 because

her son would be home from college and after three semesters of college summer school would seem a bit much.

Petitioner agreed that many of her job searches were on-line. She hasn't applied for any jobs she cannot do because of her restrictions. Petitioner agreed that she didn't apply for any jobs after May of 2016 that involved an Associate's Degree. Petitioner agreed that most of her jobs before going to work for Respondent paid minimum wage. She further testified that many prospective employers wanted her to have a B.A.

On further cross-examination Petitioner agreed that she told Mr. Hammond that she had computer skills but her speed is very low due to problems with achiness in her left hand.

On redirect examination Petitioner was asked about her statement to Dr. Glantz about working for Respondent and having some headaches. Petitioner explained that she probably wasn't getting enough sleep and so the stress bothered her. The headaches were stress related.

Mr. Hammond testified on behalf of Petitioner. Mr. Hammond has a Master's Degree from the University of Illinois-Springfield in human development counseling, and is certified by the American Board of Vocational Experts to provide vocational services and activities.

Mr. Hammond testified that, while Petitioner's job search was at times sporadic, Petitioner applied to some of the places he would have advised, and that she did a good job when she was looking. He further testified that it is common for people conducting a self-directed job search to have gaps in their search, as they do not understand how to look appropriately. He further testified that lots of job applications are now handled on-line.

Mr. Hammond testified a Bachelor's Degree is appropriate because Petitioner has an interest in the field, which increases her chances of completing the program; because she is seeking a position that would allow her to self-accommodate; and because in the social service field she is more likely to find employers willing to accommodate her restrictions. He testified she has an excellent chance of completing her course work, and that the only reason her grade point average is low is that it includes classes from her previous failed attempts at community college.

Mr. Hammond stated that Petitioner was unable to return to her previous job, and without completing her education, she would most likely be limited to minimum wage jobs with little opportunity for advancement. PX 25. He also testified that she would be unable to perform significant clerical work because of the limitations of her left hand, including typing limitations. Without vocational rehabilitation, Mr. Hammond testified Petitioner could expect to make $8.35 to $8.75 per hour, with an outside possibility of earning $9.00 per hour. He testified that this took into account her Associate's Degree, and stated that he does not advise individuals to pursue an Associate's Degree unless it is in a technical field. However, in Petitioner's case, he believed it had been an excellent idea as it led her to pursue a Bachelor's Degree.

Mr. Hammond stated that after completing her education Petitioner would be able to secure a pay rate more in line with her past earnings and would not have a major wage loss. PX 25. Mr. Hammond testified that while Petitioner would start out at entry level wages with a Bachelor's Degree, she would be able to earn median wages of around $28,000.00 to $30,000.00 after five years.

Mr. Hammond testified that Petitioner would be able to find work after receiving her Bachelor's Degree. He testified the field she is interested in is appropriate for her age. He testified that her participation in the Lincoln Challenge program would improve her chances of finding employment. Mr. Hammond also testified that Eastern Illinois University offers job placement assistance for graduates.

The Arbitrator concludes:

Initial Comment.

Respondent introduced into evidence RX 8, a copy of an office note dated July 21, 2016 wherein Petitioner was being seen for an alleged work-related foot injury. The Arbitrator presumes this was introduced for the purpose of showing Petitioner was working in July of 2016. Petitioner testified that the history regarding her being at work was wrong. She testified, without rebuttal, that she was a volunteer at her church when she hurt her foot. The Arbitrator further notes that the note of July 21, 2016 was a follow-up visit. No prior records regarding this injury were admitted into evidence. Respondent produced no other evidence to suggest that Petitioner was working somewhere at the time of the accident. The Arbitrator gives RX 8 very little weight in the overall scheme of things.

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

Respondent agrees that on September 24, 2012 Petitioner sustained an accidental injury arising out of and in the course of her employment. Respondent further agrees that Petitioner's current condition of ill-being, as it relates to her left hand, is causally related to her work place injury. Respondent only disputes whether Petitioner's current condition of ill-being, with respect to her head injury, is causally related to the accident.

After a review of the totality of the evidence, the Arbitrator finds that Petitioner's current condition of ill-being in her left hand is causally related to her undisputed work-related accident. Petitioner has also suffered with headaches and the Arbitrator finds Petitioner's undisputed accident was a cause of Petitioner's headaches. While the parties stipulated that Petitioner's let shoulder condition was unrelated to the accident the Arbitrator notes that the medical records in evidence show Petitioner has also treated for right shoulder, neck, bilateral arm, and right hand complaints. The Arbitrator finds that Petitioner has failed to prove that any symptoms or complaints to the foregoing body parts are causally related to her work accident herein. No doctor provided a causation opinion in support thereof and a chain of events analysis won't support such a finding due to gaps in treatment since the accident and inconsistent histories to doctors regarding the onset of the symptoms (for ex., Petitioner presented for her shoulders she related injuring them in the accident but prior to that visit there had been no indication in any of the records (or Petitioner's testimony) that her shoulders were injured in the accident.)

Respondent primarily disputes whether Petitioner sustained a concussion or closed head injury as a result of her undisputed work injury. The Arbitrator finds that Petitioner failed to prove she sustained a concussion at the time of the accident. Petitioner did get hit in the head and suffered a laceration. She has proven that the headaches she has experienced since early November of 2012 are causally related to the accident. This finding is based upon a chain of events and the testimony of Dr. Chen who opined the headaches were related to the accident.

Petitioner has a pre-existing history of migraine headaches but, she said it best – they were/are stress-related. She had them when she moved to Springfield and was trying to juggle work and family. She had them again while working for Respondent earlier in 2012 and not getting enough sleep. The Arbitrator finds that, while Petitioner had a pre-existing history of migraines, her testimony and medical records indicate that they had been infrequent and less painful prior to the September 24, 2012 accident. Furthermore, she had no headaches after the accident as it was not until November 9, 2012 that Petitioner presented to the Emergency Department complaining of a headache on the side of her head where she was hit during the accident. PX 4. She testified that she started getting headaches after she stopped taking the Norco prescribed for her left hand pain. It is also apparent that the headaches came on after she returned to work light duty but was unable to take some of her pain medications. This testimony was unrebutted. Her left hand injury, her restrictions, and her ability to try to return to work without pain medication would be an understandably stressful time/situation. Petitioner's headaches have a temporal relationship with events post-accident and Petitioner's ongoing recovery. The headaches appear to be triggered at different times by various situations and stages of Petitioner's treatment and recovery for her undisputed left hand injury.

The Arbitrator has considered the emergency room records from November of 2012. She was diagnosed with a closed-head injury/concussion during those visits (11/9, 11/12, and 12/1) At the December 1st visit, she told personnel that she had been to the hospital and previously diagnosed with a concussion. While these records indicate diagnoses of "concussion" and "closed head injury" the doctors also noted in their records, especially that of Dr. Ochoa, that these diagnoses were not certain. These were emergency room physicians and not neurologists.

The Arbitrator has carefully considered the depositions of Dr. Chen and Dr. Glantz, both neurologists.

Dr. Chen testified that Petitioner's symptoms were consistent with post-concussion syndrome, and noted that while she had experienced infrequent migraines in the past, she was having headaches almost every day since her headaches began following the accident. PX 8, 13, p. 16. That was not correct. Petitioner testified that the headaches began in November of 2012. He testified that because her headaches got worse after the accident, he was able to diagnose post-concussion syndrome. PX 13, p. 16-17. Again, that history was not correct. Petitioner testified that the headaches began in November of 2012, not immediately after the accident. However, Dr. Chen did testify that, within a reasonable degree of medical certainty, Petitioner's headaches were causally related to the September 24, 2012 accident. PX 13, p. 18, 33-34. The Arbitrator finds his testimony and opinions regarding Petitioner's headaches persuasive.

At the same time the Arbitrator was not entirely persuaded by Dr. Glantz either. While Dr. Glantz opined that Petitioner's headaches were a continuation of pre-existing migraines, he failed to discuss the frequency or character of Petitioner's previous headaches, and admitted that he had not reviewed any medical records from prior to the accident. RX 3, p. 31. He further failed to note that Petitioner stated that her prior migraines were infrequent, and that they were much worse and more frequent after the accident. While Dr. Glantz diagnosed Petitioner with subjective headaches, and testified that headaches are subjective and not able to be objectified, he appears to have disregarded Petitioner's subjective reports regarding the frequency and intensity of her headaches. In his analysis of causation Dr. Glantz did not discuss the frequency or character of Petitioner's previous headaches, nor did he reference the records from Dr. Chen in which Petitioner stated her prior migraines were

infrequent and that they were much worse after the accident. Dr. Glantz also failed to address the inter-relationship, if any, between a significant injury, stress while recovering and attempting to return to work after such an injury, and headaches.

Dr. Glantz based his opinion that Petitioner did not have a concussion upon the fact that she did not lose consciousness following the injury. The Arbitrator finds Dr. Glantz's testimony regarding whether or not Petitioner sustained a concussion at the time of the accident more persuasive than that of Dr. Chen. Dr. Chen testified that, while some doctors may apply a stricter criteria, many neurologists would not require loss of consciousness in order to diagnose a concussion. But, again, Dr. Chen did not have the correct timeline for the onset of Petitioner's headaches post-accident. In the end, the Arbitrator felt Dr. Chen made enough concessions on cross-examination to undermine his causation opinion regarding whether Petitioner sustained a concussion.

For the reasons set forth above, the Arbitrator finds Petitioner's current condition of ill-being, as it relates to her headaches and left hand, is causally related to her work accident.

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

Respondent disputes liability for payment of Petitioner's medical bills for treatment of her headaches. For the reasons set forth above, Petitioner's current condition of ill-being, as it relates to her headaches is causally related to her work place accident. Additionally, Dr. Glantz agreed that Petitioner's medical treatment for her headaches was reasonable and necessary. RX 4.

The Arbitrator finds that Petitioner's medical treatment to date, as set forth in Petitioner's Exhibits 1 through 8, has been reasonable, necessary, and causally related to the September 24, 2012 accident. Petitioner's medical bills were presented into evidence as Petitioners Exhibit 12. Respondent shall pay reasonable and necessary medical services as set forth in Petitioner's Exhibit 12, directly to the providers if it so wishes, and according to the fee schedule, as provided in Sections 8(a) and 8.2 of the Act.

Issue L: Is Petitioner entitled to temporary total disability benefits?

Respondent only disputes liability for temporary total disability benefits for the period of December 26, 2013 through January 16, 2014. After a review of the totality of the evidence, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits for the period of December 26, 2013 through January 16, 2014. On November 19, 2013, Dr. Johnson released Petitioner to work without restrictions; however, on January 1, 2014 Dr. Johnson stated he had misunderstood Petitioner during her November 19, 2013 visit. PX 8. Dr. Johnson provided work restrictions at that time of no forceful gripping, bending, pinching, or torqueing with the hands and fingers on the left until her left hand surgery, which took place on January 19, 2014. PX 8. As such, Petitioner was placed on work restrictions during the disputed period of January 10, 2014 through January 16, 2014.

It is also clear that Petitioner should have been on restrictions from November 19, 2013 through January 10, 2014, as Dr. Johnson acknowledged that he had released Petitioner to work without restrictions in error. As such, Petitioner was also restricted during the disputed period of December 26, 2013 through January 10, 2014.

For the reasons set forth above, the Arbitrator finds that Petitioner is entitled to temporary total

disability benefits for the period of December 26, 2013 through January 16, 2014.

Issue O: Is Petitioner entitled to Vocational Rehabilitation?

There appears to be no dispute that Petitioner has permanent work restrictions caused by her undisputed left hand injury. She has been unable to return to work for Respondent. No job has been offered to her within her restrictions. Quite succinctly, Respondent has done absolutely nothing to assist Petitioner with moving forward in her life and work after sustaining a significant injury to her left hand which left her with permanent restrictions and the inability to return to work for Respondent.

Pursuant to the Illinois Worker's Compensation Commission's Administrative Rules, an employer's vocational rehabilitation counselor shall prepare, in consultation with the injured employee, a written assessment of the vocational rehabilitation required to return the injured worker to employment. *50 Ill.Admin. Code Section 9110.10(a).* A vocational rehabilitation assessment is required when the injured employee is unable to resume their regular duties as a result of the injury. *50 Ill.Admin. Code Section 9110.10(a).*

There is no rule prohibiting self-directed vocational rehabilitation programs. *Roper Contracting v. Indus. Commn.*, 812 N.E.2d 65, 70–71 (Ill. App. 5th Dist. 2004). In *Roper*, the employer did not offer vocational rehabilitation until after the injured employee had initiated a self-directed job search. *Id.*, at 68. The Court upheld the Commission's award of maintenance for the self-directed rehabilitation program. *Id.*, at 71.

In this case, Petitioner has requested vocational rehabilitation from Respondent, but no rehabilitation program has been offered. Petitioner's attorney sent correspondence to Respondent's attorney requesting work within her restrictions, requesting vocational rehabilitation, and informing Respondent that Petitioner had completed her Associate's Degree and would seek a Bachelor's Degree. PX 14. On February 16, 2017 Petitioner received correspondence from "Dart Container" stating that it was unable to provide her with an ADA accommodation in order to perform her job duties. PX 28. Petitioner testified she has never been provided vocational training or assistance by Respondent. Additionally, Respondent has failed to present any evidence demonstrating it prepared a written assessment of the vocational rehabilitation needed to return Petitioner to employment as required by Section 9110.10(a) of IWCC Rules.

A claimant is generally entitled to vocational rehabilitation where she sustains a work-related injury which causes a reduction in her earning power and there is evidence that rehabilitation will increase her earning capacity. *Roper,* citing *National Tea Co. v. Industrial Comm'n,* 97 Ill.2d 424, 432, 73 Ill.Dec. 575, 454 N.E.2d 672 (1983). After a review of the totality of the evidence, the Arbitrator finds that Petitioner is entitled to vocational rehabilitation, and finds that Petitioner is entitled to reimbursement for the costs associated with her self-directed vocational rehabilitation program, which consists of her pursuit of a college education. The Arbitrator bases this finding on the testimony of Petitioner and of Mr. Hammond, on the documents entered into evidence by Petitioner, and on the application of the facts pursuant to *National Tea.*

There is no question Petitioner has suffered a reduction in earning power. Dr. Barakat, in her September 3, 2014 IME report, stated that Petitioner was unable to return to her job as a machine operator, and that her work restrictions with respect to her left hand were permanent. RX 2. Further, in her March 31, 2015 FCE, Petitioner was unable to perform five job attributes of a machine operator and

was functioning at a light physical demand level. PX 11. Additionally, in his Vocational Report, Mr. Hammond stated that Petitioner was unable to return to her previous job and, at best, she would be reduced to one-handed work at minimum wage. PX 25. He also testified that she would be unable to perform significant clerical work because of the limitations of her left hand, including typing limitations. Without vocational rehabilitation, Mr. Hammond testified Petitioner could expect to make between $8.35 and $8.75 per hour, with an outside possibility of earning $9.00 per hour.

Completing her Bachelor's Degree would increase Petitioner's earning power. In his Vocational Report Mr. Hammond stated that Petitioner would be able to secure a pay rate more in line with her past earnings and would not have a major wage loss. PX 25 He also noted that minimum wage jobs offer little opportunity for advancement. PX 25. Mr. Hammond testified that while Petitioner would start out at entry level wages with her Degree, she would be able to earn median wages of around $28,000.00 to $30,000.00 after five years. Additionally, Mr. Hammond testified that, with her Degree, she would be able to work well into her sixties and beyond. With a Bachelor's Degree, Petitioner would be able to recoup her lost wages over time. PX 25.

Petitioner testified in detail regarding her job search, and has provided evidence documenting her search, PX 15. Further, she testified that she sought employment within her restrictions. Petitioner testified she began her job search in September 2015, and that through the date of Arbitration, she had been unable to secure work. Mr. Hammond testified that, while her job search was at times sporadic, Petitioner applied to some of the places he would have advised, and that she did a good job when she was looking. He further testified that it is common for people conducting a self-directed job search to have gaps as they do not understand how to look appropriately. Additionally, a respondent should not criticize a petitioner's job search when it has refused to provide any vocational assistance of its own. *Walker v. Village of Bolingbrook*, 08 IL. W.C. 44350, 12 I.W.C.C. 00533, 2012 WL 2131270.

Petitioner attended Parkland College and graduated with an Associate's Degree in General Studies on May 13, 2016. PX 16, 17. Petitioner testified that many of the jobs she is interested in required a Bachelor's Degree, which is why she continued her education at Eastern Illinois University after receiving her Associate's Degree. Mr. Hammond testified that Petitioner could only expect to make between $8.25 and $9.00 an hour with her Associate's Degree, and that he does not advise individuals to pursue an Associate's Degree unless it is in a technical field. However, in Petitioner's case, he believed it had been an excellent idea as it led her to pursue a Bachelor's Degree.

Petitioner testified she is working on her Bachelor's Degree in general studies with minors in psychology and sociology. She testified she would be returning to classes in the fall and is projected to graduate in December 2017. Mr. Hammond noted that Petitioner would like to go into business or social services. PX 25. He testified a Bachelor's Degree is appropriate because she has an interest in the field, which increases her chances of completing the program, because she is seeking a position that would allow her to self-accommodate, and because in the social service field she is more likely to find employers willing to accommodate her restrictions. Mr. Hammond recommended Ms. Roby continue to pursue her degree, and testified she has an excellent chance of completing her course work. PX 25. While Petitioner is fifty years old, she is seeking to enter a field which would allow her to work into her sixties and beyond, extending her work-life expectancy.

Petitioner testified she has been asked to apply for the Honor Society and Eastern Illinois University, and that she speaks to children as part of the Lincoln Challenge, a program to help reach troubled children before they are put into the system. She testified she has been asked to speak at two

workshops in Philadelphia as well. Mr. Hammond testified that the only reason her grade point average is low is that in includes classes from her previous failed attempts at community college.

Mr. Hammond testified that Petitioner would be able to find work after receiving her Bachelor's Degree. He testified the field she is interested in is appropriate for her age. He testified that her participation in the Lincoln Challenge program would improve her chances of finding employment. Mr. Hammond also testified that Eastern Illinois University offers job placement assistance for graduates.

Petitioner presented herself at the arbitration hearing in a very positive light. While she had little, if any, success in college when much younger, that should not be used to defeat her forward movement at this time. We were all young once and, with age, comes wisdom, experience, and growth. Petitioner came across as highly motivated and positive.

For the reasons set forth above, the Arbitrator finds both that Petitioner is entitled to vocational rehabilitation and that a college education as outlined by Mr. Hammond is an appropriate vocational rehabilitation program. Petitioner has sustained a work-related injury that has caused a reduction in her earning capacity and the proposed educational program and college degree will increase her earning capacity. Respondent is ordered to pay to Petitioner the sum of $12,037.43, as set forth in Petitioner's Exhibit 22, representing past tuition and fees at Parkland College, and the sum of $9,964.75, as set forth in Petitioner's Exhibit 26, representing past tuition and fees at Eastern Illinois University for the school year of 2016-2017.

The Arbitrator further awards Petitioner vocational rehabilitation services in the form of completing her educational requirements for a B.A. degree at Eastern Illinois University, at Respondent's expense, so long as Petitioner is enrolled, attending classes and moving forward towards her degree. The Arbitrator does not feel she can award a specific dollar amount regarding the cost of the future educational expenses (tuition and related fees) as the costs cannot be determined precisely as they may change, especially in this economy. However, what has been presented in PX 27 (estimated cost of $9,597.00) can certainly serve as a guide. Respondent is further ordered to pay maintenance benefits in the sum of $395.20 per week through Petitioner's completion of her Bachelor's Degree so long as Petitioner is enrolled in, and attending, college on a full-time basis. Petitioner testified that she does not wish to attend summer school this summer for personal reasons. That is her choice but if she doesn't she should not be receiving maintenance. By comparison, a parent may choose to take family time/leave from work. Again, that is a choice but it is, generally, unpaid. As such, should Petitioner choose not to enroll and attend classes she should not receive maintenance. Respondent is ordered to pay the tuition and fees at Eastern Illinois University as they are incurred by Petitioner and including books and related fees.

****

STATE OF ILLINOIS)
) SS.
COUNTY OFCHAMPAIGN)

☒ 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 Murphy,
Petitioner,

18IWCC0117

vs.

NO: 12 WC 26572

Rowe Foundry, Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 7, 2016, is hereby affirmed and adopted.

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

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

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 2018
o2/8/18
DLS/rm
046

Deborah L. Simpson

Deborah L. Simpson

David L. Gore

David L. Gore

Stephen J. Mathis

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0117

MURPHY, JACOB
Employee/Petitioner

Case# **12WC026572**

ROVE FOUNDRY INC
Employer/Respondent

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

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

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

1824 STRONG LAW OFFICES
MICHAEL BRANDOW
3100 N KNOXVILLE AVE
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2250 STEPHEN H LARSON LAW OFFICE
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ST LOUIS, MO 63146

18IWCC0117

STATE OF ILLINOIS)
)SS.
COUNTY OF Champaign)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jacob Murphy
Employee/Petitioner

v.

Rowe Foundry, Inc.
Employer/Respondent

Case # **12** WC **26572**

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 **D. Douglas McCarthy**, Arbitrator of the Commission, in the city of **Urbana**, on **August 9, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **11/2/11**, 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 not*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$24,729.12** the average weekly wage was **$475.56**.

On the date of accident, Petitioner was **23** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

The petitioner failed to prove that he sustained an accident arising out of and in the course of his employment. Therefore, all benefits under the Illinois Workers' Compensation Act are denied. All other issues become 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. Dyas McCarty

Signature of Arbitrator

8/30/2016

Date

SEP - 7 2016

THE ARBITRATOR FINDS THE FOLLOWING FACTS

The Petitioner began his employment with the Respondent on June 3, 2011. He testified that he was assigned to the molding area where he made cores. The Petitioner stated that his job required him to take a shovel, collect hot sand out of a machine and pour into a mold. When this would harden, the Petitioner would take the molds off and stack the cores. These cores would be stacked on a table. The Petitioner would then place them on shelves and pallets.

The Petitioner testified that his immediate supervisor at the foundry was Troy Sansenbaugher. Mr. Sansenbaugher was the person to whom the Petitioner would report for job assignments or anything else that might take place at work.

At the time of the Petitioner's commencement of employment, he was provided with a copy of the company handbook (Res.Ex.4). The Petitioner agreed that he had signed the document acknowledging that he had reviewed the handbook. The Petitioner also testified that since he had read the handbook he was familiar with the company's policy that he was to report any work injury, no matter how small, immediately to his supervisor.

The Petitioner testified that he had been involved with two work related incidents prior to November of 2011. The Petitioner sustained an injury to his hands and also had some sand get into his eye. The Petitioner did not file any workers compensation claims for those prior injuries. The Petitioner testified that he had reported those two prior incidents on the day that they happened. He reported them to Bill Toner, the safety director. The Petitioner acknowledged that he was familiar with how the accident reporting process worked at the foundry. The accident reports were admitted into evidence. In each case, the report was completed on the day of the alleged accident. (RX 5)

Upon direct examination, the Petitioner testified that he had suffered earlier from leg pain which aggravated his sciatica but he had not suffered from low back pain. On April 4, 2010, the Petitioner sought emergency medical attention at Crawford Memorial Hospital. At that time it was recorded that he had suffered from back pain for two weeks and had been seen by a chiropractor. The hospital records go on to note that the Petitioner had gone to sit in a chair the prior day after playing basketball and was unable to get back out of the chair. He arrived at the hospital by ambulance. The admission records record further that the Petitioner reported that his symptoms came on gradually in the left lumbar area radiating into the left buttock. He also reported a history of similar problems in the past. The Petitioner underwent a CT scan which suggested there were findings of broad based disc bulging at L5-S1. The CT scan report indicated that the Petitioner had suffered from low back pain and had been seeing a chiropractor since November of 2009. (Res.Ex.6)

When the Petitioner was questioned regarding the admission to Crawford Memorial Hospital on April 4, 2010, the Petitioner stated that he did not remember reporting that he had suffered from back pain for weeks and had seen a chiropractor. He did recall arriving by ambulance and he also recalled that he had been given Morphine.

The Petitioner also treated for low back complaints with Chiropractor William King starting on or about March 23, 2010. According to the chiropractic records from that date, the Petitioner complained of low back pain that had been present since the prior November. (Res.Ex.8) The Petitioner agreed that he had been having trouble with his legs and his back. The Petitioner treated with the chiropractor through April 23, 2010. (Res.Ex.8)

The Petitioner testified that he was working for the Respondent on November 2, 2011. He stated that on that date he hurt his back picking up one of the heavier cores off of the ground. According to the Petitioner's recollection, this occurred about 7:00 in the morning. He testified that he felt pain in the lower right side of his back and into his buttocks. The Petitioner testified that after noticing this pain he called his mother and asked her to bring him some Tylenol. He then continued to work for another two hours. The Petitioner then testified that he told his boss, Troy, that he hurt his back and had to go home. The Petitioner could not recall Troy's last name. When asked exactly what he told to Troy, the Petitioner stated that he reported that he had hurt his back and had to go home. The Petitioner admitted that he did not tell Troy how he hurt his back. The Petitioner denied telling Troy that he had hurt his back playing flag football.

The Petitioner testified that after he spoke to Troy on November 2, 2011, he went home. He took Tylenol and rested. He then returned to work on November 3, 2011. He claimed that his low back was sore and painful. When asked why he didn't tell Troy on November 2, 2011 that he had hurt his back at work, the Petitioner stated that "in the moment I was in pain. " He testified to holding another conversation with Troy on November 3, 2011. When asked to relate that conversation, the Petitioner testified that he reported that his back still hurt and that he couldn't work the rest of the day. The Petitioner again admitted that he did not tell Troy how he had hurt his back. The Petitioner stated that Troy mentioned that he should talk to "the HR lady." The Petitioner did not talk to this individual but instead went to Dr. Turner, his primary care physician.

The Petitioner's supervisor, identified as "Troy" by the Petitioner, was Troy Sansenbaugher. Mr. Sansenbaugher testified by deposition which was recorded on a DVD. (Res.Ex.1) Mr. Sansenbaugher testified that he began his job with the foundry on October 6, 2010 and at that time became a supervisor. His duties include hiring of personnel in his department, making molds and teaching his workers how to do the job. He testified that he supervised between 6 to 9 people in the molding department. He testified that the employees under his supervision were required to report to him any work related accidents or incidents. Mr. Sansenbaugher testified that any accident or injury, no matter how small it was, was to be reported to him initially. He would then go to the safety director, Bill Toner so that reports could be prepared and filed. Mr. Sansenbaugher testified that the employees are informed of the company reporting requirements regarding work injuries on the day they start work. At that time they are provided with a copy of the foundry handbook which includes details regarding injury or accident reporting. He also testified that the safety director also goes over reporting issues when the safety training is performed and he emphasizes the reporting of injuries. (Res.Ex.2 at 6-7)

Mr. Sansenbaugher testified that the workers were instructed that they were to report to him any accidents or injuries at work. He testified that they know they were to come to him. He

also testified that if he was not in the immediate area or was not able to be found, the workers were instructed to go directly to Bill Toner, the safety director. (Res. Ex.7)

Mr. Sansenbaugher testified that he was working as the molding department supervisor on November 2, 2011. He was familiar with Jacob Murphy. He noted that the Petitioner had only worked for them a short time. He confirmed that the Petitioner's job was to make cores and also to help on the molding end by finishing molds. Mr. Sansenbaugher testified that he was the Petitioner's direct supervisor in November of 2011. (Res.Ex.9) Mr. Sansenbaugher noted that the Petitioner's job status was shaky at that time and he was getting close to "pointing out." The Petitioner's attendance record had been poor and he had incurred many points for failing to arrive or arrive late. Mr. Sansenbaugher testified that since they were shorthanded he had given the Petitioner the benefit of the doubt and kept him working even though he had been given many verbal warnings on how he was "messing up." The Petitioner was close to being terminated from his employment. (Res.Ex. 2 at 9)

Mr. Sansenbaugher testified that the Petitioner was at work on November 2, 2011. He noted that after the Petitioner arrived at work on November 2, 2011 he was "sitting down a lot." He noted the Petitioner would get into the skid loader which could be driven around. He sat on the skid loader for a long period of time. He noted that the Petitioner was "moping around" and it looked as if he was "just feeling sorry for himself." (Res.Ex.2 at 10) Mr. Sansenbaugher testified that on November 2, 2011 he was standing beside the core bench or between the mixer control and the mixer. He testified that the Petitioner approached him holding his back, bent over. The Petitioner told Mr. Sansenbaugher that he hurt his back either in West Union or West York while playing flag football the previous weekend. He also reported that he had taken either muscle relaxers or some type of prescription pill that his mother had brought to him. The pills were not working and he needed to go home. Mr. Sansenbaugher stated that he told the Petitioner "well you got to do what you got to do." (Resp.Ex.2 at 11) Mr. Sansenbaugher also testified that the Petitioner began to tell him about having back injuries, sciatic nerve damage or something from years prior and that he specifically told him that he had injured his back playing flag football the previous weekend. He noted that the Petitioner was holding his lower back at the time. (Res.Ex.2 at 11)

Troy Sansenbaugher testified that at no point did the Petitioner report to him that he had injured his back while working at the foundry. (Res.Ex.2 at 11-12) Mr. Sansenbaugher was aware that the Petitioner was involved with flag football prior to November 2, 2011, as the Petitioner had approached him and asked him to either go down and join in or go down and watch Travis Spracker with him. Mr. Sansenbaugher testified that he was aware that the Petitioner was playing flag football on the weekend. (Res.Ex.2 at 12) Mr. Sansenbaugher testified that absolutely was not mistaken with regard to what the Petitioner reported to him on November 2, 2011. (Res.Ex.2 at 12) Mr. Sansenbaugher also noted that the Petitioner did not report a back injury occurring at work to him at any time after November 2, 2011. He noted the Petitioner specifically told him that he hurt his back playing flag football. (Res.Ex.2 at 12)

Mr. Sansenbaugher testified he did not prepare an accident report on November 2, 2011 because the Petitioner did not report to him that he hurt his back at work. He noted the Petitioner left the foundry and "that was pretty much it." He then noted that the next day the Petitioner

showed up for a very short time and reported that he couldn't do the job. He stated that he just had to go. Mr. Sansenbaugher noted that this was the last time he ever saw the Petitioner or heard from him. He stated that it was later that he heard that the Petitioner was trying to file a workers' compensation claim. (Res.Ex.2 at 13) Mr. Sansenbaugher noted that if the Petitioner had reported to him on November 2, 2011 that he injured his back while performing the job at Rowe Foundry, he would have taken him up to talk to Bill Toner and file an accident report. He stated that "everyone knows that if they even cut their fingers and stuff, Bill will find out about it." He noted that everyone knows the procedure for reporting injuries. (Res.Ex.2 at 13)

On direct examination, the Petitioner admitted that he had not told Troy Sansenbaugher how he hurt his back. He denied telling him that he had injured it playing flag football. He again denied that upon cross-examination. The Petitioner did agree that he had been involved with flag football the previous weekend whereas the team was being organized and the players met to review the rule and practice their formations. The Petitioner acted as the quarterback. One of the participants in the flag football practice, Jared Lindley, recalled that this practice took a couple of hours to complete. He noted that all of the players, including the Petitioner, were on their feet, running routes and he was throwing the football to the people. He testified that everyone was being very active.

The former safety director for the Respondent, Bill Toner, testified at Arbitration. He testified that while he was the safety director he was in charge of new hire training, safety, enforcing safety rules, policies and procedures. He also was in charge of handling all work related injuries that occurred in the Respondent's facility. Mr. Toner testified that he was familiar with the Petitioner and noted that he worked in the West molding department as a core maker. Mr. Toner performed safety training with the Petitioner at the time he started his employment. Mr. Toner testified that during the training he reviewed with the Petitioner the requirement for reporting injuries that take place on the job. He testified that the company policy required that all work related injuries be reported immediately. The policy mandated that the purportedly injured worker must report the claimed injury to the supervisor. If the supervisor was not available, they were to report to him. He noted that the policy was located in article 9, page 7 of the employee handbook. (Res.Ex.4)

Mr. Toner testified that the Petitioner was familiar with the company policy regarding the reporting of alleged work related injuries as in fact he had reported two injuries occurring prior to November 2, 2011. Mr. Toner testified that the Petitioner reported those incidents to him and incident reports were prepared. Mr. Toner reviewed Respondent's Exhibit 5 and testified that it consisted of three accident reports that he had prepared with regard to events reported by the Petitioner. Mr. Toner noted that the Petitioner reported the claimed June 15, 2011 and July 14, 2011 accidents to him on the day that they took place. They were reported on the date that they were claimed to have occurred. (Res. Ex.5)

Mr. Toner testified that the third accident report, which regarded the incident at the center of the dispute, was not prepared on the day of the alleged accident but was instead prepared on November 21, 2011. Mr. Toner testified that the report was prepared on that particular date because that was the day the Petitioner came in and asked to file an accident report. Mr. Toner noted that if the Petitioner had reported injuring himself at work in the plant on November 2,

2011, he would have been informed on the day of the reporting. He testified that he was not informed on that date of an actual report of a claim for a related accident. Mr. Toner had spoken with the Petitioner's supervisor, Troy Sansenbaugher, on November 2 or November 3, 2011. He testified that Mr. Sansenbaugher told him that the Petitioner had reported that he hurt his back playing football. Mr. Toner made a note of it on that date. He confirmed that Troy Sansenbaugher was the Petitioner's direct supervisor in November of 2011. He also affirmed that Mr. Sansenbaugher was familiar with the injury reporting policies of the Respondent and at no time during his employment did he ever fail to follow the requirements of section 9 of the employee handbook. Mr. Toner also noted that the Petitioner was aware that he was the safety director during the period of the Petitioner's employment.

Mr. Toner testified that the Petitioner did not report to him on either November 2 or November 3 of 2011 that he had sustained an injury while working in the plant. He did not find out that the Petitioner was claiming this injury until November 21, 2011. On that date a report was prepared which can be found within Respondent's Exhibit 5. Mr. Toner noted that the Petitioner would not sign the accident report. That report reflects that the employee told his supervisor that he had injured his back playing football. (Res.Ex.5)

Mr. Toner testified that the Petitioner never returned to the foundry after November 21, 2011. He was never again contacted by the Petitioner regarding his claimed injury. He also did not contact him regarding returning to work on light duty.

The Petitioner consulted with his primary care physician, Dr. James Turner, on November 3, 2011. According to the doctor's note, the Petitioner complained of low back pain which radiated down the right buttock and posterior thigh to the knee. He reported that he was shoveling sand and lifting 100 pounds at work yesterday. He complained of back pain and stiffness along with right paresthesia. Dr. Turner noted the petitioner might need physical therapy and place the Petitioner on essentially sedentary duty. (Pet.Ex.4)

The Petitioner continued to treat with Dr. Turner and underwent physical therapy at Kinetic Rehabilitation. The Petitioner then was referred to Dr. Pradeep Narotam. The Petitioner was first evaluated by Dr. Narotam on December 14, 2011. At that time the Petitioner reported that he had suffered from low back pain for one month after lifting a tractor weight and developed back pain. The history records that the Petitioner had no back pain prior to injury. Further details were provided where the Petitioner stated that he was lifting a very heavy object weighing approximately 80 to 100 pounds off the floor and noted his back began to tighten up and the pain began to get worse. Dr. Narotam examined the Petitioner and reviewed the patient's MRI which he noted to reveal an L5-S1 herniated lumbar disc. The diagnosis was lumbar instability, lumbar herniated disc with radiculopathy. The doctor recommended an L5-S1 discectomy with possible inter-body fusion. (Pet.Ex.3)

The Petitioner underwent surgery at Union Hospital in Terra Haute, Indiana on December 29, 2011. At that time Dr. Narotam performed surgery which included an L5-S1 laminotomy, L5-S1 foraminotomies, a discectomy and inter-body fusion. He also underwent an intra-laminar fixation. (Pet.Ex.2)

The Petitioner followed up with Dr. Narotam post-operatively beginning on January 12, 2012. At that time the doctor noted that the petitioner was doing better and his weakness in the legs had improved. He no longer had leg pain and had mild bilateral lower back pain. (Pet.Ex.3)

By February 9, 2012, Dr. Narotam recorded that the Petitioner no longer had any leg pain. He still complained of some small areas of numbness laterally and behind the left knee. He was told to increase activity as tolerated and was noted to be functioning much better since surgery. Pain was noted to be very mild and the treatment was overall as excellent. (Pet.Ex.3)

By April 4, 2012, Dr. Narotam noted the Petitioner manifested a steady gait without any limping. He complained of some occasional low back pain and some left calf pain and tightness but there was no longer any claudication. Straight leg raising was found to be negative. The Petitioner displayed no motor or sensory deficits. The spinal hardware was found to be intact. Dr. Narotam recommended gradual weight loss. He noted he was functioning much better and the Petitioner had a greater improvement in his quality of life. The pain was again noted to be very mild. (Pet.Ex.3)

The Petitioner was examined at the Respondent's request by Dr. John Hammerstein on May 14, 2012. At the time of this visit, the Petitioner's chief complaint was that of low back pain with pain radiating out into the left leg. The Petitioner reported to the doctor that after lifting what he called a tractor weight at work he noted a fairly immediate onset of low back pain which radiated into the right leg. He further reported that the left leg began to bother him after his lumbar fusion. (RX 2 at 7) The Petitioner did not relay any history of pain leading up to that injury. The doctor reviewed the records and noted that the Petitioner had treated with this primary care physician and then was evaluated by the neurosurgeon, Dr. Narotam. He noted that the Petitioner underwent surgery in the earlier part of December. Dr. Hammerstein also reviewed the medical records from Dr. James Turner and Dr. Narotam as part of his evaluation. (Res.Ex.3 at 6-7)

Dr. Hammerstein noted that his only positive finding on that date was that the Petitioner had a positive straight leg raising on the left. Otherwise he had a relatively normal examination. The surgical incision was healed. The neurological status was normal. The doctor felt that the finding of the positive straight leg raising test indicated a little bit of irritation to the sciatic nerve. Otherwise, everything was within normal limits. (Res.Ex.3 at 8) Dr. Hammerstein also reviewed pre-operative imaging which included an MRI. He felt that the MRI showed degenerative changes in the L5-S1 disc levels. He noted that the disc was bulging slightly to the left and that the foramen were moderately stenotic. He felt that the post-operative x-rays showed a presence of an inter-spinous fixation device between the L5 and S1 disc spaces. He also noted the presence of what looked like bone graft material in that same space. The doctor noted that for the type of device that it was it was in an appropriate position. (Res.Ex.3 at 9)

Dr. Hammerstein felt that the Petitioner had suffered from degenerative disc disease. The doctor also felt that based upon the condition of the fusion the Petitioner should be able to resume his current occupation. The doctor was aware that the Petitioner performed heavy labor. (Res.Ex.3 at 10-11)

Dr. Hammerstein felt that the surgery had been rather aggressive, especially that the Petitioner was only four weeks past his supposed accident. He noted that the Petitioner was fairly young to undergo such aggressive surgery, especially based on the pathology that he had noted. He noted that it was a little surprising to him that the Petitioner had undergone a fusion. The doctor testified that if the Petitioner had been his patient he would have suggested stronger physical therapy and at least one or two rounds of epidural injections. (Res.Ex.3 at 12)

Dr. Hammerstein testified that it was his opinion, within a reasonable degree of medical certainty, that the Petitioner could have caused or aggravated his lumbar condition while playing flag football. He noted that those activities were strenuous enough that they could exacerbate symptoms. He noted that it comes down to word of mouth in terms of timing as to when the pain started and when the activity was done. (Res.Ex.3 at 15-16)

Dr. Hammerstein testified that he is trained to calculate ratings of impairment using the AMA guidelines, 6th Addition, for rating impairment. He testified that this was standard practice for workers' compensation injuries in Indiana. Dr. Hammerstein testified that he handles workers' compensation cases in the State of Indiana. He is quite familiar with the use of the 6th Addition of the AMA guidelines. It was Dr. Hammerstein's opinion that based upon the guidelines, the Petitioner would have a 10% impairment. (Res.Ex.3 at 17)

The Petitioner returned to Dr. Narotam on August 8, 2012. At that time the doctor noted that he had a steady gait and no limp. Again he had some mild low back discomfort but no leg pain or claudication. He found the straight leg raising to be normal. There was no motor weakness or sensory deficit. X-rays were taken and revealed good fusion mass and no instability. Dr. Narotam released the Petitioner to return to work with restrictions that included no lifting 15 to 30 pounds or less, avoiding repeated bending, avoiding repeated carrying of objects and pushing or pulling. He also noted the Petitioner should sit or stand alternatively and avoid long periods of driving. (Pet.Ex.3)

On February 6, 2013, Dr. Narotam again noted the Petitioner had a steady gait or no limp. He displayed no neurological deficits. The Petitioner was released to return to work at that time as a "class 2 worker". (Pet.Ex.3)

The Petitioner returned to Dr. Narotam on September 25, 2013. At that time the doctor noted that the Petitioner's pain was very mild. He again recommended that he lose weight. The report notes that the Petitioner was employed at normal duty for TRW. (Pet.Ex.3)

Dr. Narotam last examined the Petitioner on March 12, 2014. The Petitioner demonstrated a steady gait. He noted that the Petitioner was employed at normal duty working for Pretium Packing. He noted the Petitioner was able to work 12 hour shifts. He found that the Petitioner's spinal hardware was intact. (Pet.Ex.3)

Dr. Narotam testified that he last saw the Petitioner on March 12, 2014. (Pet.Ex.5 at 19) The doctor also testified that the Petitioner was totally disabled from work between the dates of December 14, 2011 and August 8, 2012. (Pet.Ex.5 at 21)

Dr. Narotam testified that the Petitioner reported to him that he had suffered from no back pain prior to his injury and no prior back injuries. The doctor testified that he obtained those statements directly from the Petitioner. He stated that the Petitioner reported that he had had no back symptoms and had no prior back injuries before he lifted that heavy weight. (Pet.Ex.5 at 23) Dr. Narotam testified that he was not aware that the Petitioner had suffered from low back pain with radiation into the left buttock in April of 2010. He knew nothing about the visit to the Crawford Memorial Hospital Emergency Room on April 4, 2010 nor did he review the CT scan that was performed on April 4, 2010 which revealed findings suspicious of a broad base disc bulge at L5-S1. (Pet.Ex.5 at 24)

Dr. Narotam agreed that the Petitioner was obese, as he was 6 feet tall and weighed 316 pounds. He agreed that such obesity greatly advances the degeneration of the discs of the spine because of the increased stress. Dr. Narotam also agreed that the Petitioner's spinal degenerative changes were well in excess of what he would have expected for someone who was 23 years of age. (Pet.Ex.5 at 25) Dr. Narotam testified that in reaching his opinions on causal connection with regard to the accident at work contributing to the injury, he agreed that he relied upon the history that was related to him by the Petitioner at that initial visit. (Pet.Ex.5 at 26) The doctor agreed that in order for his opinion to be correct he would have to reply upon the accuracy of the history that was provided by the Petitioner. (Pet.Ex.5 at 27)

Dr. Narotam agreed that the Petitioner showed rapid recovery post-operatively. His back pain and leg pain symptoms recovered. Weakness eventually did resolve. Motor function returned to normal. The doctor agreed that post-operatively the Petitioner was neurologically intact. (Pet.Ex.5 at 36)

At the last visit of March 12, 2014, Dr. Narotam noted that he took x-rays of the lumbar spine which revealed that all of the fixation hardware was solid and in good position. There was no sign of instability or slippage. (Pet.Ex.5 at 44) At the final visit the Petitioner was neurologically intact. The Petitioner was officially discharged at that time and was determined to have reached maximum medical improvement. (Pet.Ex.5 at 45-46)

The Petitioner testified that he returned to work on February 12, 2013 and began employment with a company called TRW. He testified that his job involved sitting down and putting plastic pieces into a machine. The Petitioner then worked for Pretium Packaging. He began working there in December of 2014 and was employed for 7 or 8 months. His job involved placing plastic bottles into a box.

After the Petitioner left the packaging company, he obtained work for ATS. At that company he made plastic doors for vehicles. He worked for 6 or 7 months. The Petitioner stated that he had held a few other jobs but he could not remember where else he had worked. He could not recall how many different jobs he had held. He did eventually obtain a job at North American Lighting in Paris. He worked for them for 4 months working with lenses for headlights on automobiles and trucks. The Petitioner testified that his jobs have all been in factories involving light manufacturing. At the time of the arbitration, the Petitioner was collecting unemployment.

When questioned as to what if anything the Petitioner noticed about his low back, he noted that it was easily aggravated but for the most part it is fine on a day to day basis. The Petitioner has not returned for any further medical care either with Dr.Narotam or his primary care physician.

THE ARBITRATOR CONCLUDES

In regard to disputed issues C and D, the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that the Petitioner failed to prove with credible and convincing evidence that he sustained an accident arising out of and in the course of his employment.

In support of this conclusion, the Arbitrator notes the following:

The Respondent had a clearly defined policy regarding the reporting of work related injuries. The employee handbook (Res.Ex.2) contains article 9 which states the following: "In case of an injury while working, an Employee must report the injury to his supervisor immediately. The company is insured for all expenses caused by an injury incurred while working if it is necessary to go to the doctor. Any injury which the Employee is aware, or should have been aware of, and which is not reported on the day of injury will result in the Employee being assessed two penalty points as set forth in section 6."

Mr. Bill Toner, the safety director, and Troy Sansenbaugher, the Petitioner's immediate supervisor, both testified that the Petitioner had been informed with this policy when he commenced his employment with the foundry. The Petitioner also signed a document headed, "Acknowledgement of Receipt of the Rowe Foundry, Inc., Personnel Manual." This document acknowledged his receipt of the employee manual and his obligation to read and become familiar with its contents. The Petitioner testified, after being shown Respondent's Exhibit 4 at the Arbitration, that he had acknowledged receipt of that handbook. He admitted that his signature was present on the acknowledgement page. He also testified that he was familiar with the accident reporting requirements as outlined in article 9.

The evidence shows that the Petitioner was in fact familiar with and complied with the accident reporting requirements of article 9 of the employee handbook concerning two earlier alleged accidents. The Petitioner previously reported an incident occurring on June 15, 2011, when he suffered from sand in his right eye. This incident was reported on June 15, 2011, to the safety director, Bill Toner. (Res.Ex.5) The Petitioner also previously reported an incident which took place on July 14, 2011, involving his left hand. This event was also reported to the safety director, Bill Toner, on July 14, 2011. (Res.Ex.5) There is thus evidence revealing that the Petitioner had no difficulty reporting the June 15, 2011 and July 14, 2011 incidents in line with the reporting requirements. The incidents were reported on the date that they purportedly occurred and were reported to Bill Toner as the supervisor, Troy Sansenbaugher, was not available.

The incident that is the center of this dispute was not reported in a manner consistent with the employee handbook or the Petitioner's actions regarding his prior incidents. The Petitioner did not report to Bill Toner regarding the alleged November 2, 2011 incident until November 21, 2011. (Res.Ex.5) This meeting did not take place until after Mr. Toner had told the Petitioner's mother, who had called him, that the Petitioner must address the claim himself. The November 21, 2011 accident report was prepared when the Petitioner met with Mr. Toner in person at the foundry. That report records that the Petitioner had reported to his supervisor that he injured his back playing flag football. (Res.Ex.5) The Petitioner refused to sign this accident report. Mr. Toner testified that the Petitioner's direct supervisor, Troy Sansenbaugher, had reported to him on November 2 or 3, 2011 that the Petitioner had injured his back playing football. This was documented in the accident report contained within Respondent's exhibit 5. The Arbitrator has carefully reviewed the testimony of Troy Sansenbaugher, which is documented both on a digital video disc and in a written transcript. Mr. Sansenbaugher very clearly testified that he had observed the Petitioner, upon his arrival at work on November 2, 2011 and that he was "sitting down a lot" and was also "feeling sorry for himself." Mr. Sansenbaugher testified that when the Petitioner spoke to him, he related that he had injured his back playing flag football and that he needed to go home. Mr. Sansenbaugher testified that the Petitioner did not report to him at any point that he had injured his back while working in the foundry on November 2, 2011. (Res.Ex.1 and Res.Ex.2)

At Arbitration, the Petitioner testified during direct examination that while he had told Troy Sansenbaugher that his back was painful, he did not tell him how he had injured himself. The Petitioner, on both direct and cross-examination, stated that he only told Troy Sansenbaugher that his back hurt and he did not describe an injury occurring at work. The Petitioner had the opportunity to report the alleged lifting incident of November 2, 2011 to Troy Sansenbaugher on November 3, 2011, when the Petitioner returned to the foundry for that day's work. The Petitioner again only told Mr. Sansenbaugher that his back hurt and that he had to go home. When the Petitioner's attorney questioned the Petitioner as to why he did not report a work injury to Troy Sansenbaugher, the Petitioner only responded that, "In the moment I was in pain." Later he said that he thought his report was sufficient when he told his supervisor that his back hurt. (TR at 46,47) The Arbitrator notes that the Petitioner had two direct opportunities to report the alleged November 2, 2011 lifting incident to his immediate supervisor in accordance with the requirements of article 9 of the employee handbook. The Petitioner failed to do so on both occasions. The supervisor, Mr. Sansenbaugher, clearly recalled that the Petitioner reported that he had injured his back playing football.

It is the Petitioner's burden of proof to provide credible and convincing evidence to support his allegation with regard to accidental injury taking place at work. The Petitioner in this case was clearly cognizant of the requirement that injuries be reported immediately when they purportedly occur. He was able to follow the reporting requirements for the earlier claimed incidents of June and July 2011. He failed to do so on November 2, 2011. He spoke with his direct supervisor, who had noticed his behavior, and admitted that he did not tell him at that time that he had hurt his back at work. He merely told him that his back was sore and painful and that he needed to go home. Mr. Sansenbaugher very clearly testified that the Petitioner told him that he had hurt his back while playing flag football. The Petitioner denied that he made that statement, but he did not testify that he had reported a work related injury.

The accident reports from the insured (Res.Ex.5) clearly show that the incident was not reported until November 21, 2011, and then the record reflects that the supervisor reported the football incident. There is no evidence to show that the Petitioner reported the lifting incident when it purportedly occurred.

The other more glaring problem with the Petitioner's credibility involves his failure to tell Dr. Narotam, his surgeon, that he'd had a prior back injury. The doctor testified very clearly that the Petitioner told him that he had neither prior back pain nor prior back injuries. (PX 2 at 23) The medical records referenced above show that in fact he had prior back pain and treatment. He was taken from his home by ambulance with back pain radiating down his left leg in April 2010. He had been and continued to see his chiropractor for back complaints for about three weeks thereafter. Surely he would have recalled this treatment when asked directly about it by his surgeon some twenty months later. The Petitioner explained in his testimony that his prior pain was more in his leg. Accordingly, he didn't tell the doctor about his back problems.

The Petitioner was unable to provide a convincing explanation for why he did not report this claimed injury on the date that it occurred. He also was unable to provide a convincing explanation as to why he didn't tell Dr. Narotam about his prior back treatment. He has failed to prove by a preponderance of the evidence that he was injured at work as alleged. Accordingly his claim is denied.

All of the other issues become moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Patrick McCormick,
Petitioner,

18IWCC0118

vs.

NO: 16 WC 2494

Jennings Electric 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 accident, temporary disability, medical, causal connection and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 20, 2017, is hereby affirmed and adopted.

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

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

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

DATED: FEB 27 2018
o2/15/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

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

18IWCC0118

McCORMICK, PATRICK
Employee/Petitioner

Case# 16WC002494

JENNINGS ELECTRIC LLC
Employer/Respondent

On 6/20/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2431 CUTLER & SILVERGLADE
JACOB D SILVERGLADE
POB 665 372 INDIAN BOUNDARY RD
CHESTERTON, IN 46304

2542 BRYCE DOWNEY & LENKOV LLC
JESSICA M RIMKUS
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

18IWCC0118

STATE OF ILLINOIS)
) SS
COUNTY OF LA SALLE)

☐ 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)

Patrick McCormick
Employee/Petitioner
v.
Jennings Electric, LLC
Employer/Respondent

Case # 16 WC 2494

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine Ory**, Arbitrator of the Commission, in the city of **Ottawa**, on **September 26, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident **September 3, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$65,280.80;** the average weekly wage was **$1,255.40**

On the date of accident, Petitioner was **49** years of age, **married** with **one** dependent child.

Respondent ***does not owe*** for all reasonable and necessary medical services.

Respondent shall be given a credit of $ for TTD, **$2,510.79** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$2,520.79**

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

ORDER

Petitioner failed to prove he sustained an accident on September 3, 2015 that arose out of and in the course of his employment with respondent.

Petitioner's claim is hereby denied and case is dismissed.

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

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

Christine Moy

Signature of Arbitrator

IC ArbDec19(b) p. 2

June 14, 2016

Date

JUN 20 2017

18IWCC0118

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Patrick McCormick	)
Petitioner,	)
vs.	) **No. 16 WC 2494**
Jennings Electric, LLC	)
Respondent.	)
	)

ADDENDUM TO ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing under the provisions of §19b/§8a in Ottawa on September 26, 2016. The parties agree that on September 3, 2015 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's wage in the year pre-dating the claimed accident was $65,280.80 and his average weekly wage calculated pursuant to §10 was $1,255.40.

At issue in this hearing is as follows:

1. Whether the petitioner sustained accidental injuries that arose out of and in the course of his employment;
2. Whether petitioner gave respondent notice of the accident within the time limits set in the Act.
3. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
4. Whether respondent is liable for the unpaid medical bills
5. Whether petitioner is entitled to payment for prospective medical treatment.
6. Whether petitioner is due TTD.

STATEMENT OF FACTS

Patrick McCormick Testimony

Petitioner, age 50 had been employed as an electrician for more than 25 years. Petitioner worked for a variety of employers before he began working for respondent in October, 2011. Petitioner confirmed Jeff Jennings is respondent's owner. Petitioner got to know Jeff Jennings when they both work at RJ Erickson Electric as electricians approximately 18 years before.

Petitioner got to know Jeff's wife, Leslie, about three or four years before. Leslie works in respondent's office in Crete, Illinois. Petitioner understood Leslie did billing, payroll and respondent's general office operations.

Petitioner went to respondent's office a few times a week to either pick up a check, speak to Jeff, drop off money and things such as that. Petitioner described his relationship with Leslie as friendly.

Petitioner was hired by Jeff when petitioner ran into Jeff at a supply. Jeff advised he was busy and needed help. Petitioner first worked part time. After Jeff had a cancer scare, Jeff went full time. Jeff began referring to petitioner as foreman. Jeff expressed confidence in petitioner.

There were three employees; petitioner, Chris Wheeler and Craig Hutch. Petitioner regularly worked with Chris; he did not regularly work with Jeff. Petitioner described the working relationship with Chris as friendly. Petitioner was responsible for the work performed. Chris had worked for respondent before petitioner. Chris left respondent's employ over a dispute and was then hired back.

Petitioner received his daily work assignment by either talking with Jeff, via a text or by stopping by Jeff's house. They would meet daily at respondent's shop. On September 3, 2015, petitioner met Jeff at the shop. Petitioner and Chris then followed Jeff in the van to the road where the job was located. Jeff was not at the Queens Estate job site when the work was being done.

On September 3, 2015, petitioner was working a job at Queens Estate Trailer Court off Route 1 in Crete, Illinois. Jeff, petitioner and Chris met at respondent's shop at about 7. They left for Queens Estate at 7:30 or 8. Petitioner and Chris rode in the van together and Jeff drove his own truck. Respondent was hired by Queens Estate to re-establish power that had been lost.

They needed to put a pipe in the ground from the module where the meters were located to the disconnect on the trailer up into the trailer service. This required them to dig a trench of 60 to 70 feet in length and eight to ten inches deep. They had a problem arcing around a tree with the pipe as the pipe was rigid. They chose to assemble the pipe before feeding it into the trench. They also had to work around a gas pipe.

Petitioner was in the trench and Chris was pushing the pipe from the cat module. The pipe flattened out as it came out of the arc digging it into the side wall. Petitioner was on all fours trying to pull the pipe when he felt a pain. The pain was located between the shoulder blades at the middle of his neck and left shoulder. He was able to finish the job. He took Aleve and went to bed.

The next morning, he awoke with a stiff neck. He went to work. Jeff asked petitioner what was wrong as he was carrying himself differently. Petitioner told Jeff he must have slept wrong or something. The day after the Queens Estate job, petitioner went to work at a job on Wood Street in Crete to do some upgrades. As petitioner went to hoist himself up into the attic with both arms, his left arm gave out and he landed back down on his feet. He was not able to get up in the attic after that. He had done this type of activity thousands of times before and never had any problems doing it.

On September 4, 2015, petitioner had the opportunity to speak with Jeff. The conversation took place at the shop. Chris Wheeler was present. Jeff asked how petitioner was doing and petitioner replied: "terrible". At that time petitioner advised Jeff that he thought he had actually hurt himself the day before at the Queens Estate job. No paperwork was provided to petitioner.

Petitioner continued to work for the next six weeks. He had pain between the shoulder blades, sore neck radiating down his shoulder and the back of the [left] arm. His condition got worse. He was having trouble climbing ladders, working with hands above head, or arms out in front of him. Chris picked up the work load.

Petitioner did not often work directly with Jeff. However, worked together on the Steger State Fire Department retrofit lighting job. Jeff did the high job and petitioner stayed on the ground and put fixtures together. Petitioner believed this job was done in late October. Petitioner believed he worked with Jeff only a few times between September 3rd and Christmas.

Petitioner picked up his paycheck from the office about half the time; sometimes directly from Leslie, sometimes it was in the mailbox. Petitioner recalled that in late September Jeff was on vacation or out fishing and petitioner went to pick up his check from Leslie. Leslie was walking out of the garage as petitioner was walking up the driveway. Petitioner was carrying self with left

shoulder as neck was sore. Leslie asked petitioner what was wrong. Petitioner told Leslie he hurt himself. She said, "oh yes, Jeff told me about hurting yourself at the Queens Estate job". She then said to petitioner: "you have done that before haven't you?" He testified: "I don't know." He took his check and left.

Petitioner first sought treatment at Franciscan Point Urgent Care on Sunday, October 18, 2015 after he had sleepless nights and slept in his chair. He complained of pain radiating down his arm, neck and pain between his shoulder blades. He received a shot and prescriptions. Petitioner advised Jeff he was hurting but he should be able to work through it.

Petitioner continued to work with Chris; having Chris do the heavier stuff. Petitioner and Chris were doing a job at a granite shop; doing outside lighting with a lift. As it was hard for petitioner to get in and out of the lift basket, Chris was in the lift. It was getting colder; petitioner thought it was about November. Chris brought it to Jeff's attention that he had to do all the work. At the Lincolnshire golf course job petitioner could not get in the crawl space to pipe; therefore, Chris went in and petitioner handed him things.

The next time petitioner received treatment was on November 18, 2015; again at Franciscan Urgent Care. Petitioner complained of pain radiating down his arm, shoulder, neck and between the shoulder blades. It was worse than in October. He was given prescriptions; an MRI was ordered. After successfully obtaining a MRI, he was referred by the doctors at Franciscan Point Urgent Care to Dr. Randolph Chang. Petitioner first opted for pain management rather than surgery.

Petitioner advised Jeff that Dr. Chang told him to take it easy. Petitioner continued to receive medical treatment using his own insurance. Jeff told petitioner he had workers' compensation insurance, if needed. When it got too expenses and petitioner needed time off, petitioner called Jeff [about filing a workers' compensation claim]. Jeff had petitioner call his insurance broker, Jay Biesterfield.

After not receiving relief from an injection, Dr. Randolph Chang referred petitioner to surgeon, Dr. Mark Chang. Petitioner had previously had a neck fusion by Dr. Mark Chang 15 to 17 years ago. The neck fusion was the result of a work-related injury he suffered while working for RJ Erickson Electric. After the fusion, petitioner was doing fine. He has not seen an orthopedic doctor, or receive physical therapy, and has been able to work for 16 or 17 years.

Petitioner underwent surgery on July 29, 2016. He was taken off work by Dr. Randolph Chang as of January 4, 2016 and remains off work. Surgery was paid though Indiana Medicaid. In May, at respondent's request, petitioner was examined by Dr. Bernstein.

On cross examination petitioner agreed he received a settlement for his prior workers' compensation claim. He thought his memory six weeks after the occurrence was about the same as it was during the arbitration hearing. He didn't remember telling the doctor when he was first seen on October 18, 2015 that the pain started about three weeks before. Although he could not state definitively the date of the accident, he confirmed it was the Queens Estate job. He asked respondent for the payroll records so he could determine exactly when he was working at Queens Estate.

Petitioner testified that on October 18, 2015, the doctor did not ask petitioner how he got hurt. He only advised the doctor he was hurt.

Jeff left the Queens Estate job before petitioner and Chris started the work.

Jeffrey Jennings Testimony

Jeff Jennings, owner of respondent, testified in behalf of respondent. As owner, Jeff meets his employees at the shop most mornings to pick up materials and to go over who is going where. He works alongside the employees about two days a week. The other time he was estimating, laying out jobs and doing paperwork. He usually would see his employees daily.

Jeff testified that if an employee is hurt, the employee reports the injury to him. If an employee reports an injury, Jeff reports the claim to his agent, Jay Biesterfield.

Jeff got to know petitioner when he worked with him about 18 years before at R J Erickson Electric. Petitioner has worked with respondent for about four years.

Jeff remembered doing the Queens Estate job on September 3, 2015. Jeff did not recall petitioner reporting that he was hurt on that day. Jeff did not recall petitioner reporting an injury the following day. Jeff testified petitioner did not report any injury the following weeks or months. Petitioner continued to do his work with respondent. Specifically, he remembers petitioner did a remodeling job in Olympia Fields. It involved roughing; installing new piping in a new home. It was pretty labor intensive.

Jeff remember petitioner calling him before work on Friday, November 13. Petitioner advised Jeff he was nauseous. Petitioner advised he got dizzy every time he sat up. Jeff told him to take the day off. Up to that point in time, petitioner did not relate his condition to work.

It was not until the next day, when Jeff and petitioner were working at the Crete Fire Department job, that petitioner advised Jeff his shoulder was bothering him really bad and that he had hurt himself on the job. Jeff told petitioner to take it easy and to work on the ground stuff. Jeff noted it on his paperwork at home and called Jay Biesterfield. Jeff advised petitioner he had workers' comp and if he needed to make a claim, let him know. This took place on Monday, November 16th. Jeff testified he was not aware of a work injury until that date.

Jeff referred petitioner to Jay Biesterfield. It was at this time also that petitioner advised Jeff that he (petitioner) remembered it was the Queens Estate job where he got hurt. Sometime later, petitioner asked to look at the job log to determine when the Queens Estate job was done. Jeff mentioned that the job was some time ago; petitioner got upset. Jeff then checked his records to determine when the job was done. Jeff was surprised to hear for the first time, on November 16th, that petitioner was hurt on September 3rd.

On cross examination, Jeff agreed he possibly noticed petitioner carried himself in a stiff manner. Petitioner and Jeff were friendly; participating in outside family activities. Jeff trusted petitioner with business money.

Jeff indicated he called his wife, Leslie, from the fire department job on November 16th and advised petitioner had told him that he hurt himself. Jeff indicated that despite petitioner's November 18th medical record indicating he was stiff, had unbearable burning and pain down his left arm, weakness and numbness, decreased range of motion and strength in his left arm and in the cervical spine, Jeff did not notice problems with the petitioner. Jeff indicated it was never brought to his attention.

Jeff agreed that worker Chris complained to Jeff that petitioner was assigning more work to Chris, but this was after November 16th. After that date, petitioner was assigned light duty work. Petitioner brought in a note indicated he could work without restrictions and then the following week brought in a note indicating he could not work.

Leslie Jennings Testimony

Leslie Jennings, who was married to Jeff Jennings, worked as respondent's secretary for as long as the Jennings had owned respondent's business. Usually, if an employee has a work injury, it would be reported to Jeff initially. Leslie did not recall petitioner reporting a work injury directly to her. She heard of petitioner's injury through Jeff. Leslie denied hearing about a work injury involving petitioner's right shoulder until Jeff told her in November.

Although Leslie would see petitioner about once a week, when he picked up his check, she denied ever noticing petitioner walking in an awkward position with his neck.

Patrick McCormick Rebuttal Testimony

On rebuttal, petitioner testified that he carried himself awkwardly every day since he hurt himself at the Queens Estate job.

Franciscan Physician Network Crown Point Clinic Records (PX.1)

Petitioner's history on November 18, 2015 was: "Patient here with c/o left sided neck pain and numbness/tingling down left arm. Symptoms started about 2 months ago. Patient denies actual injury. States that about 2 months ago, he was laying a pipe at work and bent down to lift something and felt a "pinch" in his middle neck. Started having pain in between shoulder blades next day and the pain has gradually worsened and is now radiating down the left arm with numbness and tingling. He is also c/o increased weakness to left arm and left hand…He states that the pain in his neck and left arm are becoming unbearable which is why he decided to come in today."

The diagnosis was cervical radiculopathy. A MRI was ordered.

Dr. Randolph Chang Records (PX.2)

Petitioner was first seen by Dr. Randolph Chang on December 8, 2015. Dr. Chang reported the November 25, 2015 MRI showed a bulky posterior central and left paramedian disc protrusion causing impingement on the left C7 nerve root in the foramen. A cervical/thoracic epidural steroid injection was recommended.

Petitioner returned on December 15, 2015. He was awaiting authorization for the injection.

His condition remained the same when seen again on January 5, 2016. He was kept off work by Dr. Chang. Dr. Chang reported petitioner's symptoms were caused by petitioner pulling a pipe on September 3, 2015.

On March 29, 2016 petitioner was referred to Dr. Mark Chang and was to call if he wished to have another cervical epidural injection.

Midwest Spine Care/Dr. Mark K. Chang Records (PX.3)

He was first seen by Dr. Mark Chang on March 31, 2016. Petitioner related his cervical condition to the work accident of September 3, 2015 when he was pulling on a pipe. Dr. Mark Chang diagnosed chronic progressive left C7 radiculopathy secondary to C6-7 large herniation. Dr. Mark Chang recommended discectomy and fusion at the C6-7 level.

Dr. Mark K. Chang May 13, 2016 Report (PX.4)

Dr. Mark Chang authored a report to Attorney Silverglade dated May 13, 2016. Dr. Chang confirmed petitioner's neck condition was caused by the September 3, 2015 work accident. Dr.

Mark Chang confirmed petitioner required a cervical fusion at the C6-7 level due to the work injury of September 3, 2015.

Vertical Plus MRI report of November 25, 2015 (PX.5)

The November 25, 2015 cervical MRI showed the large paramedian disc protrusion at the C6-C7 level.

Franciscan Physician Network/Dr. G. Babchuk Note of June 22, 2016 (PX.6)

Dr. Babchuk's June 22, 2016 note confirmed petitioner was to be off work until cleared by orthopedic spine surgeon, Dr. Mark Chang.

CVS Pharmacy Receipts (RX.7)

The charges are $189.99 for Gabapentin and $19.29 for Tramadol. The other receipt totaling $25.36 does not indicate the name of the medications.

Advance Pain & Anesthesia Bills (PX.8).

The original bills are $4,180.00, with a balance of $727.41 for Dr. Randolph Chang, and $400 for the APAC Surgical Center.

Registration of Jennings Electric, LLC (PX.9)

Registration with the Secretary of State confirms Leslie Jennings is the registered agent for respondent's corporation.

July 29, 2016 Operative report by Dr. Mark K. Chang (PX.10)

The operative report confirms petitioner underwent a C6-7 anterior discectomy, and fusion by Dr. Mark Chang on July 29, 2016 for a C6-7 disc herniation.

Franciscan Express Care (RX.1)

Petitioner reported to Franciscan Express Care on October 18, 2015 due to neck pain. The history was reported as: "Patrick J. McCormick is a 49-year-old male with chief complaint of neck pain. Symptoms began 3 weeks ago. Patient denies injury. Pain is rated 9/10. Diagnosis was cervical strain."

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

C. With respect to the issue of whether an accident occurred that arose out of and in the course of petitioner's employment by respondent, the Arbitrator finds the following facts:

The Arbitrator finds petitioner failed to prove by a preponderance of the evidence that he sustained accidental injuries that arose out of and in the course of his employment with respondent on September 3, 2015.

In reaching this conclusion, the Arbitrator took into consideration petitioner's own inconsistent testimony in reaching this conclusion. Specifically, petitioner testified that on the day after the purported accident, when Jeff noticed petitioner was carrying himself differently, he told Jeff he must have slept wrong or something. By his own admission he did not relate to Jeff that he had injured himself the day before.

Although petitioner claimed that later in the day after the purported accident he told Jeff he was feeling terrible and that he actually hurt himself the day the day before on the Queens Estate job, petitioner did not pursue any paperwork at that time, or any time, until November 16, 2015.

In addition, petitioner testified, that in an exchange with Leslie which purportedly took place at the end of September, he told Leslie he hurt himself. She said, "oh yes, Jeff told me about hurting yourself at the Queens Estate job". She then said to petitioner: "you have done that before haven't you?" He testified: "I don't know." Again, petitioner himself did not specifically relate the condition to the Queens Estate job. Furthermore, Leslie testified that she did not know about petitioner's claimed injury until November.

Another factor considered by the Arbitrator were the medical records of petitioner's visit at Franciscan Express Care on October 18, 2015, which were introduced by respondent and not petitioner. The history contained in these records was that petitioner's pain come on three weeks before and petitioner denied any injury.

Also, the fact that petitioner continued to do his usual work until November 13, 2015 does not support that he was injured on September 3, 2015.

Finally, if petitioner legitimately believed he had injured himself at work on September 3, 2015, there would be no reason for him to continue using his personal insurance to receive treatment, or not to pursue the claim earlier.

For all of these reasons, the Arbitrator finds petitioner did not sustained accidental injuries that arose out of and in the course of his employment with respondent on September 3, 2015.

As the Arbitrator determined petitioner did not sustain accidental injuries from a work accident on September 3, 2015, all other issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF McHENRY)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Carol Sellner,

Petitioner,

vs.

NO: 16WC019947

18IWCC0119

Village of Palatine,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of permanent 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 25, 2017 is hereby affirmed and adopted.

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

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

18IWCC0119

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 28 2018

Stephen J. Mathis

SJM/sj
o-2/15/2018
44

David L. Gore

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SELLNER, CAROL
Employee/Petitioner

Case# **16WC019947**

VILLAGE OF PALATINE
Employer/Respondent

18IWCC0119

On 5/25/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2489 BLACK & JONES
JASON ESMOND
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

0075 POWER & CRONIN LTD
DANIEL ARTMAN
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

STATE OF ILLINOIS

COUNTY OF McHenry)

18IWCC0119

☐ 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

Carol Sellner
Employee/Petitioner

v.

Village of Palatine
Employer/Respondent

Case # **16 WC 19947**

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 **Waukegan, Illinois**, on **April 25, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident 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, **June 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* causally related to the accident.

In the year preceding the injury, Petitioner's average weekly wage was **$1,307.69**.

On the date of accident, Petitioner was **53** years of age, ***single*** with **0** dependent children.

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

ORDER

- Respondent shall pay petitioner the sum of **$721.66** per week for a further period of **22-1/2** weeks, as provided in Section 8(c) of the Act, due to the disfigurement sustained by Petitioner as a result of her injury.

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

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

5/24/17
Date

ICArbDec

MAY 25 2017

STATEMENT OF FACTS

Petitioner worked for the Respondent as a Customer Service Representative and as a Meter Reader. She performed meter reading approximately 3 times a month. She worked full time in Customer Service. On June 4, 2014, Petitioner was performing meter reading. She knocked on the gate of a fenced yard. When she didn't hear any pets, she opened the gate and entered. While in the yard, 2 pitbulls came around the corner. Petitioner grabbed the gate and attempted to escape the yard when her left leg was bit.

Petitioner was seen at Northwest Community Hospital on the day of her injury. Her wound was cleaned and irrigated. X-rays were taken and dressings were applied. X-rays did not reveal any fractures. Petitioner was treated at the Wound Clinic at Northwest Community Hospital where she was provided antibiotic ointment and medication to prevent infection. She was restricted to standing and walking as tolerated. It was noted that she had soft tissue injuries, but that there was not much more to do other than apply silver gel and to observe the wound. On July 11, 2014, Petitioner was discharged from care and advised to continue using the Silver Gel. (Px. 1)

Petitioner testified that she had been evaluated by a plastic surgeon after July 1, 2015, but no procedures were scheduled.

The Arbitrator observed an obvious, discolored scar on Petitioner's left calf. It was a circular scar, consistent with a dog bit, measuring approximately 2.5 inches in diameter.

Petitioner testified that she called in a sick day after her injury and missed one (1) meter reader route while on restrictions. She was paid Temporary Partial Disability for that missed day of work. Petitioner testified that she has occasional pain in her leg. If she sits on her leg, she will have pain. She will take over the counter medication, such as Tylenol, to alleviate her pain. She does not know if the scarring is sensitive to sunlight as she rarely wears shorts as a result of the scarring.

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

The Arbitrator finds that Petitioner's current condition of ill-being is causally related to his work injury of June 4, 2014. The Arbitrator relies upon the records of the treating physicians and Petitioner's testimony regarding her ongoing symptoms following her injury.

Petitioner sustained an accepted injury on June 4, 2014. She underwent treatment consistent with the dog bite she suffered. Petitioner testified to occasional ongoing pain in the area of the scarring. No records or evidence was presented suggesting that Petitioner had sustained any other injury to her left leg that would be the source of the current occasional pain.

The Arbitrator finds that Petitioner's present condition of ill-being is causally related to her work injury of June 4, 2014. Petitioner testified to ongoing symptoms in the area of the scarring on her left calf consistent with her injury. The scarring demonstrated at hearing is consistent with Petitioner's testimony and the medical records from Northwest Community Hospital that described her injury. Therefore, the Arbitrator finds that Petitioner's present condition of ill-being is causally related to her June 4, 2014 injury.

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

The Arbitrator adopts the findings of fact and conclusions of law contained above with respect to the issues of accident and causal connection and incorporates them herein by this reference. The Arbitrator observed the scarring on Petitioner's left calf. The Arbitrator observed a circular, discolored scar on Petitioner's left calf measuring approximately 2.5 inches in diameter. The Arbitrator finds that Petitioner has suffered 22-1/2 weeks of disfigurement as a result of the June 4, 2014 work injury. As such, Petitioner is awarded $721.66 (the max PPD rate on Petitioner's date of injury) per week for a period of 22-1/2 weeks, as provided in Section 8(c) of the Act, because the injuries sustained caused disfigurement to the left leg.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ashley Broderick,

Petitioner,

vs. NO: 15WC038279

Menards,

18IWCC0120

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, causal connection, prospective medical care, 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 26, 2017 is hereby affirmed and adopted.

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

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

18IWCC0120

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $17,100.00. 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 2 8 2018
SJM/sj
o-2/8/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRODERICK, ASHLEY
Employee/Petitioner

Case# **15WC038279**

MENARDS
Employer/Respondent

18IWCC0120

On 6/26/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0874 FREDERICK & HAGLE
JEFFREY J COCAGNE
129 W MAIN ST
URBANA, IL 61801

0358 QUINN JOHNSTON
CHRISTOPHER CRAWFORD
227 N E JEFFERSON AVE
PEORIA, IL 61602

18IWCC0120

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Ashley Broderick
Employee/Petitioner

v.

Menards
Employer/Respondent

Case # **15** WC **038279**

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 **Urbana**, on **May 10, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What 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 **10/19/15**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**19,448.00**; the average weekly wage was $**244.44**.

On the date of accident, Petitioner was **26** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**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 TTD benefits for 17 days or 2 and 3/7 weeks, at a rate of $220.00/week, for the periods of 11/10/15 through 11/26/15; said amount of time being stipulated to by Petitioner's and Respondent's attorneys;

Respondent shall pay the following unpaid medical bills according to the fee schedule:

Carle Hospital:	$7,167.00
Carle Physician Group:	$1,283.00
Christie Clinic:	$2,538.00

Respondent shall pay to the Petitioner the sum of $220.00/week for a period of 25 weeks, representing 5 % Person As A Whole pursuant to Section 8 (d) (2) of the Act.

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

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

18IWCC0120

D. Douglas McEnerty

6/22/17

Signature of Arbitrator

Date

JUN 26 2017

In support of the Arbitrator's decision relating to disputed issues C, F, J, and L the Arbitrator finds as follows:

The Petitioner testified that she was employed with the Respondent starting in February of 2015. The Petitioner testified that on October 19, 2015, she was working as a cashier at the Menards in Champaign, Illinois. Petitioner testified that her job duties included assisting clients, heavy lifting of objects onto a conveyer belt, and heavy lifting in general. Petitioner also testified that she made $9.35 an hour as a cashier.

The Petitioner testified that while working on October 19, 2015, a gust of wind blew a heavy, hinged, wooden gate, slamming the gate into the Petitioner, striking her in the interior chest, left shoulder and ribs with such force that it pushed her into a wooden podium behind her. She testified that the gate was made from heavy plywood. The Petitioner testified that on said date she weighed 102 pounds and was 4 foot 10 ½ inches tall. She testified that she was pushed into the podium by the wooden gate with such force that a resulting bruise formed on her hip thereafter. Respondent called as a witness Menard's General Manager, Dan Ahart. On cross-examination, Mr. Ahart agreed that the door weighed 25 pounds.

The Petitioner testified that after the wooden gate struck her, the Petitioner finished checking out the customer that was at her register, and immediately turned on her flashing light. The Petitioner testified that the flashing light signals to her supervisor that she is in need of immediate assistance. The Petitioner testified that after turning on her flashing light, she spoke with a supervisor named Zach, and explained what had just occurred. Petitioner testified that she also asked to be transferred to a different cash register to avoid the dangerous situation and was indeed transferred. The Petitioner testified that she then spoke with a supervisor named Jessica and explained that she was in pain and was unable to work. She testified that Jessica told her she would not be allowed to go to the hospital. The Petitioner testified that she next spoke with supervisor Chris McKenzie in Human Resources who drove the Petitioner to Carle Occupational Medicine at Carle Foundation Hospital.

The accident was filmed on one of the store's security cameras. (RX 1) The Petitioner testified that it was not a true and accurate representation of what happened on the date of the accident. The Petitioner explained, and it is clear from viewing the Exhibit, that there are portions of frames of video missing due to the low quality of the video. The Petitioner maintained that there was a four second time lag between each frame shown on the video. Mr. Ahart agreed that there was a time lag, but estimated that it was less than one second.

Petitioner further testified that besides the aforementioned missing frames, the frames showing the gate striking her were also not recorded due to the poor quality. The Petitioner explained that the gate struck her in the chest, ribs, and shoulder, and she testified that what is viewable on the video are the frames showing her reaction directly after being struck, and her pushing the gate away from her after it struck her. Furthermore, the Petitioner testified, and it is clear from Respondent's exhibit #1, that the Petitioner clearly favored her left side immediately after the gate struck her, and thereafter on the video.

Furthermore, the Petitioner's doctor's note from Carle Foundation Hospital on October 19, 2015 is consistent with the Petitioner's testimony and what the Petitioner told her supervisors regarding being struck by a wooden gate. *See Petitioner's Exhibit 1 P. 6.* Petitioner further testified that she was given restrictions that day regarding the amount of weight she was to lift after said appointment. Petitioner was taken off of work that day and given restrictions of no lifting, pushing or pulling over 10 lbs., no overhead lifting, and no repetitive work with the left shoulder. *Id.*

Petitioner also testified that she returned to Carle Hospital emergency room two days later for pain in her left shoulder on October 21, 2015. Petitioner testified, and the exhibits exemplify, that she was x-rayed at Carle emergency room on October 21, 2015 and she was told to follow-up at Carle orthopedics. Again, the Petitioner's medical note from October 21, 2015 is consistent with her testimony. *Id* at pgs. 11-13. Petitioner's records also indicate that she was placed on right hand work only on October 26, 2015. *Id* at 32.

The Petitioner testified that per her referral, she followed up with Dr. Zeman at Carle orthopedics for suspicion of a torn rotator cuff. Petitioner testified that her symptoms included pain, swelling of the arm, and limited range of motion. Petitioner testified that Dr. Zeman recommended a MRI and physical therapy.

The MRI was performed on November 10, 2015. It showed no evidence of a full thickness rotator cuff tear but did show mild bone marrow edema in the acromion and distal clavicle which could suggest bone bruising or reactive changes. (RX 3)

The Petitioner further testified that she was placed off of work for a seventeen day period in November, and the respondent stipulated to the amount of lost time.

The Petitioner testified that she attended physical therapy at Carle Occupational Medicine up until January 2016. She testified that Carle Occupational Medicine referred her to Dr. Bane's office for evaluation and treatment of her left subject shoulder, and for possible shoulder steroid injections. Petitioner's records exhibit that as of December 28, 2015, Petitioner still had restrictions of no lifting, pulling, or pushing with the left arm, right-handed work mostly, and to wear her splint as needed. *Id* at 70-71. On January 13, 2016 her restrictions were right hand work mostly, avoid overhead work and overhead lifting, and to wear her sling at work. *Id* at 78-79.

The Petitioner further testified that she did not follow-up with Dr. Bane nor did she continue physical therapy after her January 13, 2016 appointment because the workers' compensation carrier would not approve any of the prescribed treatment, and was not currently paying any of the past medical bills. Petitioner testified that she was told at Carle that she either had to pay for the examinations up front, or they would be unable to treat her.

The Petitioner further testified that she was told if treatment related to her workers' compensation injury were put on her state medial card, she would lose coverage for her and her minor son.

The Petitioner testified that she would have continued treatment for her shoulder had the workers' compensation company paid for the treatment. Petitioner further testified that she was never actually taken off of her aforementioned restrictions of January 13, 2016. Moreover, Petitioner's records show that at an unrelated follow up appointment at Carle Foundation Hospital on March 7, 2016, it was noted that Petitioner still had pain in her left shoulder. *Id* at 87.

The Petitioner testified that prior to October 19, 2015 she had never seriously injured her shoulder. Petitioner further testified that she was in a vehicle accident prior to the October 19, 2015 injury, but did not suffer any injuries to her left shoulder, and did not seek treatment other than her initial emergency room evaluation during which she had an examination of her neck. Petitioner further explained that due to her small stature, her seat belt sits on her neck, not her shoulder, and she suffered no injury whatsoever to her left shoulder during the aforementioned accident.

The Petitioner testified that she still has stiffness and loss of mobility in her left shoulder due to her work related injury. She testified that she continues to have pain and difficulty with certain activities. Petitioner further testified that she has difficulty with overhead lifting, and exemplified her limited range of motion to the Arbitrator on the date of the trial. Petitioner testified that she has a pain level of 4 out of 5 with activity, and she cannot complete activities with her left arm such as cleaning, or lifting of heavy objects.

Mr. Ahart also testified regarding alternate theories as to why the Petitioner may have an alternative motive to seek a workers' compensation claim. Mr. Ahart first testified to the Respondent's termination point system and testified that under said system when an employee gets to 9 points they are suspended, and when they get to 10 points they are terminated. He testified that the Petitioner was close to termination at her job with the

Respondent. However, Mr. Ahart could not testify as to exactly how many points the Petitioner had accumulated at the time of her injury. Moreover, Mr. Ahart offered no proof or physical documentation of said point system at trial. When asked why he did not bring any proof of the point system, or how many points Petitioner had, he testified he did not know he was going to be asked to testify regarding the point system. Mr. Ahart was then asked if he was aware he would be testifying to Respondent's theory that Petitioner had alternative motives for her workers' compensation claim prior to trial, and admitted that he knew he would be testifying to these alternative theories, but still could not offer an explanation as to why he brought no physical proof of Petitioner's points totals. Nor could Mr. Ahart testify as to exactly how many points the Petitioner had accumulated.

Moreover, Mr. Ahart testified that he was directly in charge of investigating workers' compensation claims at Menards, but testified that he could not recall if he ever spoke to the Petitioner directly regarding her claim. When asked to clarify why he never spoke to her directly, Mr. Ahart responded that he did not know.

Mr. Ahart also testified explicitly that there was no evidence of any injury suffered by the Petitioner on the video. When asked if he noticed that she favored her left arm and shoulder in the video, Mr. Ahart testified no. He also testified that it would be impossible for the impact from the gate not to be on the video despite admitting to a lag in the video.

Given the totality of the evidence and testimony, the Arbitrator finds the Petitioner more credible than the Respondent's witness. Mr. Ahart refused to acknowledge the poor quality of the Respondent's Exhibit #1. In reviewing the video, it is clear that multiple frames were not on the video, and the swinging gate clearly disappears in the video due to the low frame rate. It is also noticeable that people in the video appear in one spot, and reappear in the next frame in a different spot. Despite this, Mr. Ahart testified it would be impossible for the exact second of impact not to be depicted in the video. Moreover, Mr. Ahart denied that the Petitioner had any reaction at all, and the video clearly shows the Petitioner favoring her left side at multiple points in the video. Such testimony on the part of Mr. Ahart clearly puts his credibility in doubt.

The Arbitrator further finds that the extent of the time lag on the video has really no impact on the issues at hand. The Petitioner had no history or medical documentation of any prior treatment of the left shoulder, save for some shoulder issues when she was in high school and being involved in a motor vehicle accident about one month prior to the accident. She explained that she did have some swelling in the areas under her shoulder belt but nothing that required any treatment. The accident occurred when a swinging door weighing 25 pounds swung into her left side unexpectedly as she performed her normal work duties. She was, it should be noted, less than 5 feet in height, weighing just over 100 pounds. She was sent by her employer that day to the occupational medical facility where she was found to be in moderate pain with tenderness to palpation of the anterior aspect of the left shoulder joint. She was given medication and told to return to work with restrictions. From that point forward until her treatment ended on January 3, 2016, she exhibited symptoms and examination findings consistent with a left shoulder injury. She got some relief from physical therapy and medication but when she was last seen by Dr. Cohen on the above date she had a limited range of motion, grinding with abduction and pain and popping with elevation. (PX 1-1/13/16) Dr. Cohen felt she had a left rotator cuff tendinopathy with worsening symptoms. He recommended she be seen by Dr. Bane, an orthopedic surgeon.

After having carefully viewed all the testimony in the case and exhibits introduced into evidence, this Arbitrator finds that per the aforementioned facts, the Petitioner's injury arose out of and in the course her employment with Menards. Her injury was causally related to said accident based upon the chain of events noted above.

Accordingly, this Arbitrator has reviewed the medical bills as well as evidence in this matter, and determines that Petitioner's exhibits 2 and 3, the bills from Carle and Christie Clinic, were bills casually related to the Petitioner's injury that occurred on October 19, 2015.

In terms of permanent partial disability, the Arbitrator notes that the Petitioner testified that she has ongoing issues with her shoulder including a limited range of motion, and pain with activity.

No AMA report was offered into evidence, so this factor is waived.

With regard to age and occupation, the Arbitrator notes that Petitioner was 26 years old at the time of her injury. She has a work life expectancy of 39 more years. Her job as a clerk/cashier requires her to lift on a regular basis. Because of the length of time that the Petitioner is expected to experience symptoms in her left shoulder as a result of her job duties, the Arbitrator gives greater weight to this factor.

There is no evidence indicating a future wage loss.

The objective medical evidence referenced above shows injuries consistent with rotator cuff tendinopathy. The symptoms she reported to all of her treating doctors and her testimony at trail concerning her limitations are consistent with said diagnosis.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that the Petitioner sustained permanent partial disability to the extent of 5% loss of a person as a whole pursuant to Section 8(d) 2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF McLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Julie Lemons,

Petitioner,

vs. NO: 14WC 24101

Advocate Bromenn Medical Center,

Respondent.

18IWCC0121

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, causal connection, 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 1, 2017 is hereby affirmed and adopted.

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

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

18IWCC0121

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $23,200.00. 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 2 8 2018
SJM/sj
o-2/8/2018
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LEMONS, JULIE
Employee/Petitioner

Case# **14WC024101**

18IWCC0121

ADVOCATE BROMENN MEDICAL CENTER
Employer/Respondent

On 5/1/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0564 WILLIAMS & SWEE LTD
STEVEN R WILLIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

2461 NYHAN BAMBRICK KINZIE & LOWRY
KAREN HAARSGARD
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

18IWCC0121

STATE OF ILLINOIS)
)SS.
COUNTY OF MC LEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Julie Lemons
Employee/Petitioner

v.

Advocate Bromenn Medical Center
Employer/Respondent

Case # 14 WC 24101

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Bloomington, on March 29, 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On February 22, 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 $46,384.00; the average weekly wage was $963.08.

On the date of accident, Petitioner was 31 years of age, single with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $2,201.28 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $2,201.28. At trial, the parties stipulated TTD benefits had been paid in full.

Respondent is entitled to a credit of $33,346.31 under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 10, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of $33,346.31 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner $577.85 per week for 40 weeks because the injuries sustained caused the eight percent (8%) loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

William R. Gallagher, Arbitrator

April 27, 2017
Date

ICArbDec p. 2

MAY 1 - 2017

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment for Respondent on February 22, 2013. According to the Application, Petitioner was lifting and sustained an injury to the back and other parts of the body (Arbitrator's Exhibit 2). Respondent agreed Petitioner sustained a work-related injury, but disputed liability on the basis of causal relationship. In regard to temporary total disability benefits, at trial, Petitioner and Respondent agreed that temporary total disability benefits had been paid in full (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a nurse in the intensive care unit. On February 22, 2013, Petitioner and another employee were attempting to roll a patient in intensive care. At that time, Petitioner experienced an onset of low back pain.

Petitioner testified she had two prior low back surgeries, a two level fusion in 2004 and a micro-discectomy at L3 in October, 2012. Subsequent to the prior back surgeries, Petitioner was able to return to work without restrictions. Petitioner was working in a full unrestricted capacity when she sustained the accident on February 22, 2013.

Petitioner went to Respondent's ER on February 22, 2013, approximately three hours after the accident. According to the ER record, Petitioner advised of her prior back surgeries. At that time, Petitioner complained of low back pain and a feeling her legs were going to give out; however, Petitioner denied any radiation/discomfort in her legs. Petitioner was directed to follow-up with Dr. Emilio Nardone, the physician who performed the October, 2012, surgery (Petitioner's Exhibit 2).

Petitioner was again seen in Respondent's ER on February 26, 2013. Petitioner continued to have low back pain with occasional numbness down both legs. An MRI was performed which revealed a small left paracentral disc herniation at L3-L4 and a moderate right lateral disc herniation at L2-L3. The radiologist opined that the herniation at L3-L4 was new and the herniation at L2-L3 was not new (Petitioner's Exhibit 3).

Petitioner was seen by Dr. Nardone on March 4, 2013. At that time, Petitioner advised Dr. Nardone she had been lifting patients the prior week and had back and leg pain. Dr. Nardone noted he had performed back surgery three to four months ago and Petitioner had done well until she attempted to lift a patient and subsequently developed severe left sided back and hip/leg pain. Dr. Nardone reviewed the MRI and opined Petitioner had left sacroiliac joint pain and L3 radiculopathy. He ordered physical therapy (Petitioner's Exhibit 4).

Petitioner subsequently sought medical treatment from Dr. Craig Carmichael, a physiatrist, on June 6, 2013. In his record of that date, Dr. Carmichael noted Petitioner's prior back surgeries and the accident of February, 2013. At that time, Petitioner complained of low back pain, greater on the left than right. Dr. Carmichael recommended Petitioner undergo some epidural injections (Petitioner's Exhibit 8).

Dr. Carmichael performed a series of epidural injections from June through August, 2013. When Dr. Carmichael saw Petitioner on August 30, 2013, he noted Petitioner had experienced a significant increase of pain in February, 2013, and that there was a right foraminal herniation at L2-L3 (Petitioner's Exhibits 8 and 9).

Dr. Nardone saw Petitioner on January 27, 2014. At that time, Petitioner complained of low back and coccyx pain after "falling." His record did not contain any details about Petitioner having sustained a fall. Dr. Nardone diagnosed Petitioner with nonspecific back pain and recommended Petitioner exercise, lose weight and try acupuncture (Petitioner's Exhibit 4).

At the direction of Respondent, Petitioner was examined by Dr. Stanford Tack, an orthopedic surgeon, on April 18, 2014. In connection with his examination of Petitioner, Dr. Tack reviewed medical records provided to him by Respondent. When seen by Dr. Tack, Petitioner complained of low back pain, a sense of restless legs, left buttock pain, burning in her hips and occasional parasthesias in the right leg (Respondent's Exhibit 1; Deposition Exhibit 2).

Dr. Tack opined Petitioner had sustained a lumbar strain superimposed on her pre-existing lumbar spine conditions. He stated that the injury exacerbated Petitioner's pre-existing symptoms; however, this was temporary and the symptoms related to the accident had resolved. He opined Petitioner's current symptoms were related to her pre-existing back conditions. He also stated Petitioner would have reached MMI by May 22, 2013, or approximately three months after the accident (Respondent's Exhibit 1; Deposition Exhibit 2).

Dr. Carmichael saw Petitioner on June 4, 2014. At that time, Petitioner had complaints of pain at the lumbosacral junction and into both hips. Dr. Carmichael noted Petitioner had done well following the prior back surgeries until she sustained the injury in the beginning of 2013. On July 28 and September 30, 2014, Dr. Carmichael performed epidural injections to Petitioner's low back (Petitioner's Exhibit 8).

Dr. Carmichael again saw Petitioner on November 10, 2015. At that time, Petitioner complained of periodic flareups of her back pain and had right greater than left back and leg pain. Petitioner noted an increase in her symptoms with prolonged sitting, bending forward and transferring patients. Dr. Carmichael made some changes in Petitioner's prescribed medications. Dr. Carmichael subsequently saw Petitioner on May 2, 2016. At that time, Petitioner still had right greater than left back and leg pain as well as bilateral hip pain. Dr. Carmichael continued to treat Petitioner with prescribed medications (Petitioner's Exhibit 8).

Dr. Carmichael was deposed on October 15, 2015, and his deposition testimony was received into evidence at trial. Dr. Carmichael testified that his diagnosis was L2-L3 herniation and L3-L4 discogenic pain. In regard to causality, Dr. Carmichael stated that the accident of February, 2013, caused a permanent aggravation of Petitioner's pre-existing conditions. While he agreed Petitioner has significant back abnormalities that predated the accident, he noted that Petitioner consistently related the work injury as causing a major change in her condition (Petitioner's Exhibit 1; pp 14-15, 19).

In regard to Dr. Carmichael's examination of Petitioner of August 30, 2013, he noted that Petitioner was attempting to change jobs from the ICU to recovery. The reason for this was that working in the ICU was much more physically demanding than the work in recovery (Petitioner's Exhibit 1; pp 10-11).

Dr. Tack was deposed on January 18, 2017, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Tack's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. He testified Petitioner had sustained an exacerbation of her pre-existing symptoms, that the symptoms had "regressed," but that Petitioner continued to have low grade symptoms that were not unlike those she had prior to the accident (Respondent's Exhibit 1; p 21).

On cross-examination, Dr. Tack agreed that the accident could have aggravated a pre-existing condition and that following both of the prior back surgeries, Petitioner was able to return to work in a full duty capacity (Respondent's Exhibit 1; pp 29, 33-34).

At trial, Petitioner testified that her back symptoms had now improved and she had returned to work as a nurse. However, Petitioner changed jobs and was no longer working as an intensive care nurse but worked as a nurse in a physician's office. Petitioner stated that her back condition was the primary reason she changed jobs as well as the fact that when she worked as an intensive care nurse, she was required to work 12 hour shifts.

Conclusions of Law

In regard to disputed issue (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner's current condition of ill-being is causally related to the accident of February 22, 2013.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner sustained a work-related injury to her low back on February 22, 2013, when she and another employee were attempting to roll a patient in intensive care.

Prior to the accident of February 22, 2013, Petitioner had undergone two back surgeries, a fusion in 2004 and a microdiscectomy in October, 2012; however, Petitioner had recovered from both of those procedures and worked in a full unrestricted capacity. At the time of the accident of February 22, 2013, Petitioner worked as an intensive care nurse.

Subsequent to the accident of February 22, 2013, Petitioner continued to have back, leg and hip symptoms and was periodically treated by Dr. Craig Carmichael.

The Arbitrator found Petitioner to be a credible witness and noted that while she was being treated by Dr. Carmichael, Petitioner consistently related her increased symptoms to the accident of February 22, 2013.

Dr. Carmichael's opinion that Petitioner sustained a permanent aggravation of her pre-existing conditions was consistent with Petitioner's ongoing symptoms and the fact that Petitioner subsequently obtained a less physically demanding job.

Dr. Tack's opinion that Petitioner sustained a temporary exacerbation of her pre-existing back conditions was not consistent with Petitioner's ongoing post-accident symptoms and the treatment she obtained thereafter.

Based upon the preceding, the Arbitrator finds the opinion of Dr. Carmichael to be more persuasive than that of Dr. Tack.

In regard to disputed issue (K) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and that Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 10, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of $33,346.31 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In regard to disputed issue (L) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of eight percent (8%) loss of use of the person as a whole.

In support of this conclusion the Arbitrator notes the following:

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

At the time of the accident, Petitioner was a nurse in Respondent's intensive care unit. This was a job that was physically demanding which required, among other things, lifting/moving patients. While Petitioner was able to return to work to that job after the accident, she subsequently obtained a job as a nurse in a physician's office which was less physically demanding. Although the change in her job was not mandated by her treating physician, Petitioner credibly testified that her need to obtain a less physically demanding job was because of her symptoms. The Arbitrator gives this factor moderate weight.

Petitioner was 31 years old at the time of the accident. She will have to deal with the effects of this injury for the remainder of her working and natural life. The Arbitrator gives this factor moderate weight.

There was no evidence tendered that Petitioner's future earning capacity was affected by this injury. The Arbitrator gives this factor no weight.

Subsequent to the accident of February 22, 2013, Petitioner had increased low back, leg and hip symptoms and received multiple epidural injections and prescribed medications. The Arbitrator gives this factor significant weight.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dale Riggen,

Petitioner,

vs.

NO: 16WC 16501

Caterpillar, Inc.,

18IWCC0122

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(s) of accident, medical expenses, causal connection, 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 May 30, 2017 is hereby affirmed and adopted.

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

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

DATED: FEB 28 2018

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

SJM/sj
o-2/8/2018
44

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RIGGEN, DALE
Employee/Petitioner

Case# **16WC016501**

CATERPILLAR INC
Employer/Respondent

18IWCC0122

On 5/30/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4707 LAW OFFICE OF CHRIS DOSCOTCH
2708 N KNOXVILLE AVE
PEORIA, IL 61604

2851 CATERPILLAR INC
ELIZABETH C LeBARON
PO BOX 348
AURORA, IL 60507

18IWCC0122

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

Dale Riggen
Employee/Petitioner

v.

Caterpillar, Inc.
Employer/Respondent

Case # 16 WC 16501

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Peoria, on April 11, 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On February 10, 2016, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $47,987.16; the average weekly wage was $922.83.

~~On the date of accident, Petitioner was 42 years of age, single with 1 dependent child(ren).~~

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

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

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

William R. Gallagher, Arbitrator
ICArbDec p 2

May 24, 2017
Date

MAY 30 2017

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on February 10, 2016. According to the Application, Petitioner "...hit pothole on fork truck" and sustained an injury to his "Back" (Arbitrator's Exhibit 4). Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner testified he began working for Respondent in January, 1999. On February 10, 2016, Petitioner was driving a fork truck at Respondent's facility in Mapleton. Petitioner stated the fork truck was gas powered, had a maximum speed of eight miles per hour, did not have any suspension and the padding on the driver's seat was worn out and torn. He also stated that if the driver of the fork truck attempted to accelerate faster than eight miles per hour, a safety device would cause the engine to die.

On February 10, 2016, Petitioner stated he was driving the fork truck over a bridge which connected two areas of the plant. The wheels of the fork truck struck a pothole which, according to Petitioner, felt like a punch in the mid right back and knocked the wind out of him.

At trial, Petitioner was shown a photograph of the area of the bridge between the two areas of the plant. Petitioner testified that the photograph did not show the offset between a metal plate and the concrete surface; however, Petitioner marked the photograph with an oval and the letter "A" designating the offset where he drove the fork truck (Respondent's Exhibit 4). Petitioner stated that as he drove across the offset, it felt like the seat went out from underneath him.

Petitioner stated that on the date of the accident he informed his supervisor that Respondent should fix some potholes and he had the wind knocked out of him. However, Petitioner did not report having sustained an injury at that time and he did not request to go to the medical department.

Petitioner initially sought medical treatment at Advanced Physicians Healthcare on February 12, 2016, when he was seen by Dr. Christina Durbin, a chiropractor. At that time, Petitioner complained of severe rib pain in the mid back radiating into the chest area as well as neck and low back pain. Petitioner did not inform Dr. Durbin of the work-related accident (Petitioner's Exhibit 1).

Petitioner was subsequently seen by Dr. Durbin on February 17, 2016, and his complaints were essentially the same as they were previously. Again, Petitioner did not inform Dr. Durbin of having sustained a work-related accident.

On February 19, 2016, Petitioner reported the accident to Respondent and he prepared an "Employee Incident Report." In that report, Petitioner stated he was driving a fork truck, he hit a pothole which knocked the wind out of him and he went to his chiropractor. The chiropractor (who was not named in the report) purportedly informed Petitioner that he had a rib out of place (Respondent's Exhibit 3).

On February 24, 2016, Petitioner was again seen at Advanced Physicians Healthcare by Dr. Durbin as well as Katherine Cazilas, a Physician Assistant. At that time, Petitioner informed both Dr. Durbin and PA Cazilas of the work-related accident of February 10, 2016. Petitioner complained of rib and middle back pain to both Dr. Durbin and PA Cazilas (Petitioner's Exhibit 1).

Dr. Durbin treated Petitioner from February 12, 2016, through May 17, 2016, with adjustments, chiropractic manipulation and electrical stimulation. PA Cazilas treated Petitioner from February 24, 2016, through March 14, 2016, with trigger point injections and medication (Petitioner's Exhibit 1).

Petitioner did not lose any time from work as a result of the accident of February 10, 2016. At trial, Petitioner agreed that he worked out on a regular basis and had done so in excess of 30 years. Respondent introduced into evidence a video of Petitioner working out at a gym on February 25 and March 6, 2016. Prior to this case being tried, Petitioner reviewed the video and agreed that it was of him and an accurate portrayal of his activities. The Arbitrator reviewed the video and noted that Petitioner performed, in an extremely vigorous manner, various exercises involving his legs, lower abdomen and core. Petitioner also lifted weights (Respondent's Exhibit 2).

Jarden James testified on behalf of Respondent when this case was tried. James stated he worked for Respondent as an environmental/health associate and he performed an investigation of the accident. James stated he met with Petitioner and Petitioner's supervisor on February 19, 2016, and Petitioner reviewed the same photograph that he identified at trial. He stated that Petitioner identified the area where the metal plate met the concrete as being where the accident occurred. James personally inspected the area in question and measured the offset which he said was one inch to one and one-half inches deep (Respondent's Exhibit 4).

As part of his investigation of the accident, James stated that in either April or May, 2016, he and Dr. Don Mehr, a member of Respondent's medical staff, observed traffic on the bridge for approximately 15 to 30 minutes. James stated that they observed either one or two fork trucks go over the area in question without any particular difficulty. James stated that the fork trucks had a maximum speed of either six or seven miles per hour and did not have any suspension, but that there was a spring underneath the seat. James also stated that no other drivers had reported having sustained any accidents or injuries in the manner described by Petitioner.

Conclusions of Law

In regard to disputed issue (C) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner did not sustain an accidental injury arising out of and in the course of his employment for Respondent on February 10, 2016.

In support of this conclusion the Arbitrator notes following:

Petitioner complained of potholes in need of repair on February 10, 2016, but he did not report having sustained an accident to Respondent until February 19, 2016.

When Petitioner first sought medical treatment on February 12, and February 17, 2016, he complained of rib, neck and low back pain, but did not inform Dr. Durbin that he had sustained a work-related accident.

Petitioner did not inform Dr. Durbin and PA Cazilas of the work-related accident of February 10, 2016, until he was seen by them on February 24, 2016.

Petitioner's claim that he sustained a disabling injury is questionable given the frequency and intensity of his working out.

The fork truck had a maximum speed of six to eight miles per hour and the gap in question was only one inch to one and one-half inches. This suggests that the likelihood of Petitioner having sustained an injury while operating the fork truck while driving across that gap was highly questionable.

In regard to disputed issues (F), (J) and (L) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issue (C).

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF 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

Alberto Davila,

Petitioner,

vs.

No. 15 WC 36149

18IWCC0123

Chicago Heights Police Department,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical care 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).

Among other benefits, the Arbitrator awarded "the outstanding medical bill of ATI Physical Therapy in the amount of $4,618.23," pursuant to sections 8(a) and 8.2 of the Workers' Compensation Act (the Act) and subject to appropriate credit. The Commission notes that the "bill" in question is actually a letter from ATI dated December 5, 2016, claiming an outstanding balance of $4,618.23 "for service starting 05/24/2016 and ending on 08/04/2016." There is no corresponding bill in evidence. It is well established that the Act and the Rules Governing Practice Before the Illinois Workers' Compensation Commission require an itemized medical bill to be tendered into evidence. Accordingly, the Commission strikes the award of medical

expenses, without prejudice. On remand, Petitioner may submit into evidence a properly itemized medical bill from ATI. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 26, 2017, 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.

DATED: FEB 28 2018
o-02/15/2018
SM/sk
44

Stephen Mathis

David L. Gore

Deborah Simpson

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

DAVILA, ALBERTO
Employee/Petitioner

Case# **15WC036149**

18IWCC0123

CITY OF CHICAGO HEIGHTS
Employer/Respondent

On 6/26/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2675 COVEN LAW GROUP
LARRY J COVEN
180 N LASALLE ST SUITE 3650
CHICAGO, IL 60601

4217 DELGADO LAW GROUP
GEORGE SPATARO
1441 S HARLEM AVE
BERWYN, IL 60402

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

18IWCC0123

☐ 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)

ALBERTO DAVILA,
Employee/Petitioner

v.

CITY OF CHICAGO HEIGHTS,
Employer/Respondent

Case # **15** WC **36149**

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 **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **4/12/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **9-22-15**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$74,144.20**; the average weekly wage was **$1,425.85**.

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

Petitioner ***has not*** received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$49,429.12** for peda benefits paid, for a total credit of **$49,429.12**. Respondent is entitled to a credit of **$all amounts it paid either by WC or BC/BS** under Section 8(j) of the Act.

ORDER

Respondent shall pay to Petitioner temporary total disability benefits of **$950.56/week** for **81-1/7th weeks**, commencing **9/23/15** through **4/12/17**, as provided in Section 8(b) of the Act. Against this award period, Respondent shall be given a credit of **$49,429.12** benefits paid under 5 ILCS 345/1, for a total credit of **$49,429.12**.

Respondent shall be liable for the outstanding medical bill of ATI Physical Therapy in the amount of **$4,618.23**, subject to Sections 8(a) and 8.2. Respondent is entitled to a credit of **$all amounts it paid either by WC or BC/BS** under Section 8(j) of the Act and shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize and pay for the recommended right total knee replacement as recommended by Dr. Jimenez, including any and all incidental care thereto.

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

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

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

Signature of Arbitrator

6-22-2017
Date

ICArbDec19(b)

JUN 26 2017

BACKGROUND

Alberto Davila ("Petitioner") alleged injuries on 9/22/15 to the right knee arising out of and in the course of his employment with City of Chicago Heights ("Respondent"). Ax2. On 4/12/15, by agreement of the parties, this matter proceeded to arbitration on the disputed issue of causal connection, liability for unpaid medical bills, Section 8(j) credit, temporary total disability, PEDA credit and prospective medical treatment under Section 8(a). Ax1. Each party was afforded an opportunity to make an opening statement. The following is a recitation of the facts adduced at trial.

FINDINGS OF FACT

Petitioner testified that he was employed as a police officer for Respondent for over nineteen years. The Petitioner testified prior to this accident, he had a right torn meniscus for which he underwent surgery on January 10, 2014. He eventually returned to work full duty on June 2, 2014. Between June 2, 2014 and September 22, 2015, he had not seen any doctor for his right knee, did not miss any time from his job because of his right knee, did not take any medication for his right knee, was working full-duty as a police officer and except for a mild ache occasionally his right knee, was otherwise fine for over 15 months prior to this accident. Petitioner testified that his job as a police officer was a heavy labor job. Petitioner had to often chase, restrain, or get physical with people in the course and scope of his employment. At the time of the accident Petitioner was 50 years old. Between June 2, 2014 and September 22, 2015, Petitioner led a very active life style of cardiovascular workouts of jogging 2-3 miles a day plus weight training five days a week.

It was undisputed at trial that on 9/22/15 Petitioner worked for Respondent in his usual capacity as a police officer and that on that date suffered accidental injuries arising out of and in the course of his employment. Specifically, Petitioner testified that date he was on an emergency call for shots fired. Petitioner was forced to give foot chase to a suspect across a field. While running, and giving chase, Petitioner stepped into a hole or a ditch that was about that was about a foot deep with his right foot causing him to twist his knee to pop and experience significant pain. The hole was not visible as it was filled in with grass. Petitioner experienced immediate significant pain in his right knee. Petitioner was working with his captain at the time, who witnessed this accident. Petitioner reported the incident and was sent for care.

Petitioner was sent by Respondent straight to Ingalls Occupational Clinic where he treated regularly until December 2, 2015. Treatment included medication, therapy and a right knee MRI. MRI suggested tearing of the posterior horn of the medial meniscus. Eventually Petitioner was referred to Dr. Aribindi, where he gave the same history of accident. Dr. Aribindi reviewed the history, MRI and gave an injection for pain. The doctor also recommended physical therapy and consideration was given for arthroscopy. PxB.

Petitioner then sought out his own treatment began treating with Dr. Matthew Jimenez at Illinois Bone & Joint. PxC. Petitioner saw Dr. Jimenez for the first time on November 12, 2015. Petitioner presented to Dr. Jimenez with significant right knee pain with clicking, popping and swelling, problems rising from a chair, walking any great distances. Petitioner reported that the pain was severe enough to interfere with activities of daily living, work, and recreation. Petitioner did report to Dr. Jimenez that he had a prior meniscectomy that was completely rehabbed and asymptomatic. Based on the history, physical exam and MRI, Dr. Jimenez recommended a right knee partial medial meniscectomy as a direct result of this accident. Dr. Jimenez opined that: "The patient does have some preexisting degenerative changes in his knee and therefore he is at the higher risk for exacerbation or worsening of his preexisting arthritis as a function of medial meniscus tear. Therefore, these changes likely change the natural course of history of his knee arthritis as a function of this new meniscal damage from 9/2016." X-rays showed early mild tri-compartmental degenerative changes.

On 12/11/15, Dr. Jimenez performed arthroscopy, partial medial meniscectomy, right knee microfracture technique, chondroplasty of the patellofemoral joint. The post-surgical diagnosis was right knee multidirectional medical meniscal tear and right knee grades 1,2,3 chondromalacia of the patellofemoral joint. He was noted to be bone-on-bone in the medial joint line. On 12/22/15, Petitioner returned to Dr. Jimenez's office. Intra-operatively, Petitioner was noted to have considerable cartilage damage with exposed bone-on-bone in the medial compartment as well as a significant medial meniscus tear and osteophyte along the patella articulating with the patellofemoral joint.

On 1/19/16, Petitioner returned to see Dr. Jimenez. Petitioner was complaining of clicking, popping, and swelling, problems rising from a chair, walking any great distances or going up and down stairs. Petitioner had some pre-existing degenerative changes which have been worsened or exacerbated by the work-related event. Dr. Jimenez opined further that the documented acute trauma to his meniscus and cartilage damage from exacerbated or worsened his preexisting problem. He opined that Petitioner will likely develop further arthritis in his knee related to the work-related event. The plan was for more therapy and most likely arthroplasty due to the work accident.

On 2/16/16, in follow up, Petitioner continued to complain of clicking, popping, and swelling, problems rising from a chair, walking any great distances or going up and down stairs. There was mild varus alignment. Therapy was to continue with a one month follow-up. On 3/15/16, Petitioner returned to Dr. Jimenez largely unchanged in complaints.

On 4/14/16, Petitioner again returned, complaining of clicking, popping, and swelling, problems rising from a chair, walking any great distances or going up and down stairs. Dr. Jimenez stated again that Petitioner has posttraumatic changes which is clearly exacerbated by work. Dr. Jimenez recommended a series of injections to Petitioner's knee of lidocaine, Marcaine, and Depo-Medrol. The first one was completed that day. Dr. Jimenez now stated that arthroplasty is required and causally related to the work accident. x-rays showed medial joint space wear with subchondral sclerosis, subchondral cysts, osteophytes and joint space narrowing. On 4/28/16, Petitioner returned to see Dr. Jimenez for the second injection with lidocaine, Marcaine and depo-Medrol. He remained off work.

On 5/5/16, Petitioner underwent the first Orthovisc injection. He remained off work. On 5/12/16 and 5/19/16, Petitioner underwent a second and third Orthovisc injection. On 6/2/16, Petitioner underwent a third Orthovisc injection and was to begin work conditioning. Petitioner continued to complain of clicking, popping, and swelling, problems rising from a chair, walking any great distances or going up and down stairs.

On 6/16/16, Petitioner returned to Dr. Jimenez with the same complaints and work conditioning was continued and a functional capacity evaluation was ordered. X-rays showed medial joint space wear, bone-on-bone. Exam showed positive joint line tenderness, varus alignment and 1+ effusion. On 7/12/16, Petitioner underwent an FCE with ATI Physical Therapy, which showed the results to be valid, placing Petitioner at the medium physical demand level. PxD. Petitioner was noted to meet the capabilities of the levels stated by the dictionary of occupational titles.

On 7/14/16, Dr. Jimenez reviewed the FCE and opined that medium work may be a permanent restriction for Petitioner. Dr. Jimenez kept Petitioner off work as he did not think it was safe for Petitioner to return as police officer because of the condition of his knee. On 8/11/16, Petitioner returned to see Dr. Jimenez, who again recommended an arthroplasty. On 9/8/16, Petitioner returned to see Dr. Jimenez, who noted that Petitioner had been sent for a Section 12 exam on 8/12/16. The doctor believed Petitioner met all clinical and radiographic criteria for surgical intervention. Dr. Jimenez also recommended an injection which could next be done in November 2016 as injections can only be done every three months. Petitioner remained off work.

On 10/6/16, Petitioner and Dr. Jimenez reviewed the Section 12 report. Dr. Jimenez disagreed with Dr. Karlsson's opinion that Petitioner's need for arthroplasty was not work related based upon history and onset of symptoms.

Petitioner followed up with Dr. Jimenez on 11/8/16, 12/6/16 and 1/10/17. Dr. Jimenez continued to recommend surgery. Petitioner testified he saw Dr. Karlsson for approximately 5 minutes at the time of the Section 12 exam. Petitioner wishes to proceed with the recommended surgery. Petitioner confirmed he received PEDA payments for approximately one year and says he was forced into early retirement.

Testimony of Dr. Matthew Jimenez

On 1/17/17, the parties took the evidence deposition of Dr. Matthew Jimenez, treating doctor for Petitioner. the doctor took Petitioner's history of accident and noted that he presented at initial exam with clicking, popping, swelling, and problems rising from a chair, walking distances, going up and down stairs. The doctor noted Petitioner stated that these problems started immediately following the 9/22/15 accident. Petitioner had a previous right knee surgery in 2014 and worked 16 months full duty and without restriction prior to the 9/22/15 work accident. the doctor diagnosed Petitioner with a torn medial meniscus for which surgery was performed. He stated that with such a complex tear, Petitioner would not be able to perform his regular work duties. The doctor testified that the meniscal tear predisposes the pre-existing degenerative changes to more aggressive, faster loss of cartilage and faster progression of arthritic changes. Dr. Jimenez believed that the multidirectional tear aggravated the arthritis. Specifically, there was a worsening or exacerbation of the pre-existing arthritis from the meniscal tear. The doctor testified that Petitioner failed to improve in symptoms of swelling, popping, clicking, trouble with stairs, walking distances despite therapy and injections. The doctor testified that in April 2016, he began discussing arthroplasty with Petitioner and that following Petitioner's FCE, Dr. Jimenez elected to remove Petitioner from work beginning 5/19/16. Dr. Jimenez did not believe Petitioner could return to work without such total knee replacement. He further testified that as of September 2016, Petitioner was at severe end-stage arthritis.

Dr. Jimenez disagreed with Dr. Karlsson on causation because Petitioner was pain free before this accident and since that time he has had clicking, popping, swelling, problems rising from a chair, walking stairs or any great distances. The doctor opined that the work accident and resultant loss of much of the meniscus as a function of the complex multidirectional tear, has worsened, exacerbated and aggravated that preexisting condition and now mandates a knee replacement. He did not believe the issue of whether there were fragments was relevant to the issue of causation.

Dr. Jimenez stated that when he first examined Petitioner he did not think Petitioner's knee was bone-on-bone but rather noted some preexisting degenerative changes. Radiographs from November 2015 noted early mild tri-compartmental degenerative changes. The doctor testified that up to and including the date of surgery, there was no evidence of bone-on-bone arthritic changes. Those changes came later and as a result of the surgery. The doctor stated that the surgery, which included the micro fracture procedure, was necessary to try and halt the progression of the arthritis. By the time of the December 2016 x-rays, Petitioner was now bone-on-bone. The doctor, in reviewing the radiographs live during his testimony, explained that at the December 2015 follow up visit, his physician assistant was mistaken that there were bone-on-bone changes. Dr. Jimenez only appreciated mild to moderate tri-compartmental changes. He stated these findings were consistent with his intra-operative findings.

Testimony of Dr. Troy Karlsson

On January 23, 2017, the parties took the evidence deposition of Respondent's examining doctor, Dr. Troy Karlsson. Rx1. Dr. Karlsson agreed that Petitioner sustained a meniscal tear as a result of the work

accident and that it necessitated the arthroscopic procedure performed by Dr. Jimenez in December 2015. The doctor testified that Petitioner needed an arthroplasty and that he thought it would be a very reasonable thing to consider. He said his exam was consistent with degeneration or arthritis. However, Dr. Karlsson testified that he did not believe that the need for the arthroplasty was caused by the accident but rather the progression of Petitioner's degenerative or arthritic changes of the right knee.

Regarding Petitioner's ability to work, Dr. Karlsson agreed that following surgery, Petitioner had significant restrictions that would have prevented him from returning to full duties as a police officer. He agreed that such duties included the need to run or sprint at times. The doctor believed Petitioner was capable of light duty desk type or sedentary work.

The doctor agreed that a finding of grade 4 chondromalacia was sufficient criteria to find or determine the need for arthroplasty. In reviewing the operative report, Dr. Troy noted that Petitioner presented or had grades 1, 2 and 3 chondromalacia but not a grade 4. However, Dr. Troy testified that Petitioner did have a microfracture performed at the time of the surgery, which he said would typically be done for grade 4 chondromalacia or near grade 4 chondromalacia.

Regarding medical records, the doctor agreed he had no pre-accident records that would suggest Petitioner was symptomatic in the right knee and that he had no medical records after May 2016. Likewise, there was no evidence of Petitioner having any clicking, popping or swelling or difficulty getting up from a chair or problems walking long distances before the work accident.

The doctor further agreed that trauma can aggravate pre-existing asymptomatic degenerative changes depending on the level of trauma and structural change. He also agreed that tearing a meniscus while running and stepping into a hole or ditch could be a dramatic event. Such a mechanism could be significant enough to aggravate pre-existing degenerative changes in the long term. In addition, one would not necessarily have to be bone-on-bone for replacement to be indicated. He reviewed the November 2015 x-rays live during his deposition and stated the scans were equivocal as to whether there were bone-on-bone changes. Dr. Karlsson then reviewed the December 2016 x-rays for which he observed bone-on-bone on both knees. The doctor concluded that based on a comparison of the November 2015 x-rays to the December 2016 x-rays it was fair to say that there were arthritic degenerative changes that had progressed. The attorney(s) elected not to move the x-rays into evidence and deposition exhibits 4-5 were retained by the attorney(s).

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

Petitioner was the only witness to testify at trial. The Arbitrator had an opportunity to carefully observe Petitioner during trial and finds Petitioner to be credible and forthright witness concerning the mechanism of injury, his course of treatment before and after the accident and his current complaints.

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The parties' dispute as to causation centers only on whether Petitioner's right knee condition as it relates to his pre-existing degenerative arthritic changes and the need for a total knee replacement is causally related to Petitioner's undisputed work accident. Ax1. Respondent does not seriously challenge or dispute that Petitioner's work accident resulted in a torn medical meniscus for which he underwent appropriate surgical intervention in December 2015 and received usual post-operative care in relation thereto. The Arbitrator notes both Drs. Jimenez's and Karlsson's opinions in this regard in support thereof.

The Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that is current condition of ill-being as it relates to the right knee/leg is causally related to the undisputed work accident. It is well established that under Illinois law, when an employee has a preexisting condition, "recovery will depend on [his] ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that [his] 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, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 204-205, 797 N.E.2d 665 (2003). 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. Id. at 205. "Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was *a* causative factor in the resulting condition of ill-being." (Emphasis in original.) *Id.* In the instant case, Petitioner established via Dr. Jimenez that his undisputed work accident was a causative factor in the aggravation and/or acceleration of his pre-existing right knee degenerative arthritis to the point of requiring an arthroplasty and that it was not simply the result of a normal degenerative process.

Petitioner testified that prior to 9/22/15, he underwent a right knee surgery but was essentially without symptoms, treatment or restrictions for 16 months leading up to the work accident. Incidentally, Petitioner's prior right knee surgery in 2014 was to the lateral meniscus whereas the instant work accident resulted in a medial meniscal repair. See PxA.

Dr. Jimenez noted not only that the injury predisposed Petitioner to aggravation or exacerbation of the pre-existing arthritic degeneration in the right knee but also that the complex multidirectional medial meniscal tear itself exacerbated Petitioner's pre-existing condition. The record showed that Petitioner's initial x-ray with Dr. Jimenez did not yet show bone-on-bone or evidence of end stage arthritis but rather mild to moderate arthritis. Dr. Jimenez noted that this in fact developed later and because of the work injury. Intra-operatively, Dr. Jimenez noted Grades 1-3 chondromalacia and delamination in all three compartments, consistent with MRI findings of pre-existing degenerative changes. Eventually, subsequent radiographs in December 2016 showed bone-on-bone changes. These x-ray changes or progression Dr. Karlsson acknowledged in his deposition when he viewed the x-rays live.

The Arbitrator notes that Petitioner's operative report did note that he had "bone-on-bone on the medial joint line," despite Dr. Jimenez's testimony that Petitioner did not have that until later, explaining that the injuries exacerbated or aggravated or accelerated the degeneration. Whether Petitioner was bone-on-bone at the time of the first radiographs taken following the work accident, at the time of the meniscal repair in the medial compartment (only one of the four compartments) as noted in the operative report or whether he gradually progressed to bone-on-bone, the Arbitrator concludes that any of these equally plausible bases is sufficiently supported by the record to conclude that Petitioner's pre-existing degenerative right knee condition was aggravated, accelerated or exacerbated by the accident and resultant need for the current recommended surgical intervention. Further, the evidence demonstrates that Petitioner was full duty and asymptomatic in the right knee for at least 16 months before the instant work accident. Thus, the undisputed work accident constitutes a cause and an aggravating factor sufficient under Illinois law to render Petitioner's current condition of ill being causally related.

In evaluating Dr. Troy's opinions as to whether Petitioner's current condition as it relates to his pre-existing degenerative changes and arthritis, the Arbitrator notes Dr. Karlsson conceded that Petitioner's mechanism of injury could be traumatic sufficient to aggravate degenerative changes over the long term. While Dr. Karlsson testified that the micro fracture procedure suggested to him that Petitioner already had severe near grade 4 chondromalacia, Dr. Jimenez persuasively explained that the micro fracture procedure was designed to prevent further progression of arthritis. Indeed, it would appear reasonable to prevent progression to grade 4

rather than perform a procedure for a condition which was already grade 4 or for an end-stage condition that already needed arthroplasty. In this way, the Arbitrator is persuaded that Petitioner had not yet reached grade 4 as suggested by Dr. Karlsson. In addition, Dr. Karlsson did not identify any other risk factors associated with osteoarthritis such as obesity, BMI, smoking and/or age that would account for Petitioner's rapid advancement of his knee arthritis or the need for a total knee replacement. Dr. Karlsson conceded that he had no evidence Petitioner was symptomatic in the right knee or treating for the right knee in the 16 months leading up to the work accident. Thus, in the Arbitrator's view, the evidence shows that Petitioner's work accident was at least a causative factor in the advancement of his pre-existing degenerative right knee arthritis and the resultant need for arthroplasty.

In summary, the Arbitrator finds Petitioner's current condition of ill-being with respect to the right knee, including the degenerative changes and arthritis to be causally related to the work accident as it was aggravated, accelerated and/or exacerbated by same. This is based upon the chain of events, the testimony of Dr. Jimenez for which greater weight is given over Dr. Karlsson and the treating records as well as Petitioner's credible testimony. See generally, *Norris v. Ill. Workers' Comp. Comm'n*, 14 IWCC 971 (Nov. 13, 2014).

ISSUE (K), (O) ***Is Petitioner entitled to any prospective medical care?***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. After reviewing all evidence, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that he is entitled to the prospective medical care as prescribed by Dr. Jimenez. The record demonstrates that Petitioner has attempted surgical repair, physical therapy, Depo-Medrol injections, and Orthovisc injections.

The medical record shows Petitioner remains symptomatic, exhibiting antalgic gait, clicking, popping and swelling of the knee. Dr. Jimenez noted Petitioner's injuries pre-disposed him to exacerbation or aggravation of the pre-existing arthritic changes in the knee and the record demonstrates that such exacerbation or aggravation has occurred. Dr. Jimenez began discussing the need for arthroplasty as early as June 2016 and the doctor continues to recommend such prospective medical care. The Arbitrator adopts Dr. Jimenez's opinions on the need for a total knee replacement/arthroplasty surgery due to the work accident. The record shows that Petitioner's right knee condition has not yet stabilized or otherwise reached maximum medical improvement and that he remains a surgical candidate for a total knee replacement, all related to the work accident. The Arbitrator notes that other than causal relationship, Dr. Karlsson otherwise agrees with the medical necessity for a total knee replacement. Respondent shall authorize and pay for the recommended total knee replacement as recommended by Dr. Jimenez, including any and all incidental care thereto.

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. After reviewing all evidence, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that the medical services provided to Petitioner for the knee have been reasonable and necessary. At trial, Petitioner submitted the unpaid bill of ATI Physical Therapy in the amount of $4,618.23 and alleged it to be part of Respondent's liability. Based on the record, Respondent did not dispute its share of liability as to medical bills up through the Section 12 exam date of 8/12/16. Therefore, Respondent shall be liable for the outstanding medical bill of ATI Physical Therapy in the amount of **$4,618.23**, subject to Sections 8(a) and 8.2.

ISSUE (L) ***What temporary benefits are in dispute?***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. After reviewing all evidence and having found Petitioner has not yet reached MMI, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that he is entitled to temporary total disability.

In so finding, the Arbitrator adopts and relies upon the medical opinions of Dr. Jimenez, who credibly explained that Petitioner was unable to return to his full duty work as police officer following the work accident as a result of the meniscal tear. Dr. Karlsson similarly testified that he agreed that Petiioner would not be able to perform his regular full-duty work as a police officer following the work accident and a result of the meniscal tear. He recommended light duty or sedentary work however the Arbitrator notes that none has been provided by Respondent. Finally, although the doctors disagree over whether the degenerative and symptomatic arthritic knee is causally related to the work accident, it is evident that both doctors similarly testified that Petitioner is unable to return to his full duty pre-injury employment based upon his current condition of ill-being as it relates to that degenerative arthritic knee and based upon the ongoing need for a total knee replacement.

Dr. Jimenez went further and opined that Petitioner remains unable return to his pre-injury employment at least until he undergoes a total knee replacement to have a chance at such a return. Specifically, an FCE was performed in July 2016 that rated Petitioner at the medium job level. Dr. Jimenez elected to remove Petitioner completely from work until completion of the total knee replacement. Having found Petitioner's current condition of ill-being as it relates to his right knee, which includes the medial meniscal tear and degenerative arthritic changes to the knee, which were made symptomatic and which were otherwise aggravated or exacerbated following the accident, the Arbitrator concludes that Petitioner's condition has not reached maximum medical improvement or otherwise stabilized that that he is entitled to temporary total disability benefits. Therefore, Respondent shall pay Petitioner temporary total disability benefits of $950.56/week for 81-1/7th weeks, commencing 9/23/15 through 4/12/17, as provided in Section 8(b) of the Act.

There is a dispute over whether Respondent is entitled to a credit or offset against the above award. The facts show that Petitioner was paid his full salary for one year under the Public Employee Disability Act, which provides that:

> "Any salary compensation due the injured person from workers' compensation or any salary due him from any type of insurance which may be carried by the employing public entity shall revert to that entity during the time for which continuing compensation is paid to him under this Act."

5 ILCS 345/1(d). Thus, the amount to be reverted to Respondent is the equivalent of Petitioner's TTD benefit. Per Ax1, Petitioner was paid a total of $56,282.20 in PEDA benefits, representing his "full salary." Ax1. However, because PEDA provides for a credit equal to the TTD benefit Respondent would have paid rather than the salary actually paid and received under PEDA, the Arbitrator concludes that Respondent's credit is $950.56 (TTD Rate) x 52 weeks (one year salary) or **$49,429.12**. In summary, the Arbitrator concludes that Respondent shall pay to Petitioner temporary total disability benefits of **$950.56/week** for **81-1/7th weeks**, commencing **9/23/15** through **4/12/17**, as provided in Section 8(b) of the Act. Against this award period, Respondent shall be given a credit of **$49,429.12** benefits paid under 5 ILCS 345/1, for a total credit of **$49,429.12**.

ISSUE (M) ***Should penalties or fees be imposed upon Respondent?***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Based upon the record as a whole, the Arbitrator declines to impose penalties and/or fees against the Respondent. The Arbitrator reaches this conclusion based upon the reasonable dispute that existed as to

whether Petitioner's current condition pre-dated the undisputed work accident and dispute over whether Petitioner would have needed a total knee replacement regardless of the work accident.

Signature of Arbitrator

6-22-2017
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kathleen Ladik,

Petitioner,

vs. NO: 15WC 25051

Health Care Services,

Respondent.

18IWCC0124

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 16, 2017 is hereby affirmed and adopted.

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

18IWCC0124

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 28 2018
SJM/sj
o-2/15/2018
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LADIK, KATHLEEN
Employee/Petitioner

Case# **15WC025051**

HEALTH CARE SERVICES
Employer/Respondent

18IWCC0124

On 6/16/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1804 RONALDSON & KUCHLER
MARK KUCHLER
19 S LASALLE ST SUITE 1402
CHICAGO, IL 60603

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

18IWCC0124

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

KATHLEEN LADIK
Employee/Petitioner

v.

HEALTH CARE SERVICES
Employer/Respondent

Case # **15** WC **025051**

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 **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Wheaton**, on **3/24/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0124

FINDINGS

On 6/22/15, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$56,037.28**; the average weekly wage was **$1,077.64**.

On the date of accident, Petitioner was **61** 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 is entitled to a credit of **$46,995.88** under Section 8(j) of the Act.

ORDER

Petitioner's 6/22/15 accident did not arise out of her employment with Respondent and her current condition of ill-being is not causally related to the 6/22/15 accident. Therefore, all claims for compensation are denied.

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

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

Jason C. Knotts

Signature of Arbitrator — 6/13/17 Date

JUN 16 2017

18IWCC0124

ILLINOIS WORKERS' COMPENSATION COMMISSION

KATHLEEN LADIK	)	
	)	
Petitioner,	)	
vs.	)	**15 WC 025051**
	)	
HEALTH CARE SERVICES	)	
	)	
Respondent.	)	

ADDENDUM TO RESPONDENT'S PROPOSED DECISION

Petitioner worked for Respondent as an associate paralegal. (T. at 9). Her job duties consisted of maintaining regulatory filing and requesting checks for filing, registration and certificate of authority fees. (Id.).

Petitioner testified that she used the printer in the print room when she needed to print documents in color. (T. at 13). Petitioner described that the print room had "a shiny tile floor, like a no-wax." (T. at 12). She testified that "because there was some employee self-repair...sometimes there would be little pieces of paper that always tear off," and "just opening the machine, you know, there was carbon dust which would come out on you and sometimes the floor." (T. at 16). She stated that shards of paper or carbon dust would "fly out all over the counter, all over the floor. Particles that you couldn't even see." (T. at 19).

On 6/22/15, Petitioner sent a document to the print room. (T. at 14). Petitioner testified that she was not paying attention because she was doing an activity that she often did. (T. at 57). While Petitioner was walking into the print room, she greeted Julie Lee and her foot "slipped out and flew up." (T. at 19). Petitioner testified that she "didn't notice if anything was down there," on the floor when she slipped. (T. at 20). She did not see any shards of paper on the floor prior to her fall. (T. at 56).

At trial, when asked "as you sit here today, you don't know what that was, correct?" (T. at 59). Petitioner responded "correct." (Id.). When asked "you can't say it was dust particles, you can't say it was paper, you can't say it was water, a banana peel, you have no idea, correct?" (Id.). Petitioner responded "correct." (Id.).

Petitioner testified that she did not have any prior incidents involving falling at work. (Id.). She testified that because she fell on that day, there must have been something on the floor. (Id.). Petitioner admitted that she never complained to anyone, at work, about the condition of the floor. (T. at 67).

Petitioner went to Advocate Good Samaritan Hospital complaining of "pain to right hip, inner thigh and tailbone after sliding out of a chair at work." (PX 3 at 42, 46). X-rays revealed "degenerative changes at L4-L5. 3." (PX 3 at 41). Petitioner remained in the hospital until 6/26/15. (T. at 23-24, PX 3). Petitioner participated in a rehabilitation program from 6/26/15 to 7/8/15. (PX 5).

Petitioner attended 18 sessions of outpatient physical therapy at ATI from 7/14/15 to 8/27/15. (PX 6). On 8/27/15, Petitioner "denie[d] pain in R hip/groin or buttock that limits activities" and she was discharged with a pain level of "at rest 0/10; during activity 0/10." (Id.).

On 8/18/15, Dr. LaReau released Petitioner to "return to regular work/activity with no restrictions." (T. at 38; RX 2). Petitioner last treated with Dr. LaReau on 8/25/15. (RX 3). She reported that "her hip/pelvis pain has improved" and she went "back to work full time without any pain issues." (T. at 70; RX 3 at 1).

On 7/1/15, Petitioner gave a recorded statement to Jeannine Marciniak. (Id.). At the hearing, Petitioner testified that her memory was impaired when she gave this statement because [she] "was on drugs" when Ms. Marciniak called her. (T. at 63-64). She said that she had the flu, which impacted her ability to recall what happened. (T. at 66).

With respect to permanency, Petitioner testified that "there was a change in my center of gravity. (T. at 35). She "tend[s] to look at the ground a lot more ...walking with your head down changes the center of gravity." (T. at 40). She testified that she continues to have back pain, specifically when she is in the "same positions. Like sleeping, when I wake up it's stiff. Sitting in the car for periods of time...The change in flexing from, you know, leaning back to leaning forward...a bit of an ache...it's always there." (T. at 42).

Julie Lee

Julie Lee testified that on 6/22/15, she was employed by Respondent as Facility Manager. (T. at 77-78). Her job duties included maintaining the facility and workspace, including equipment functionality and keeping the office clean and safe. (T. at 78).

As part of her job, Ms. Lee was responsible for the cleanliness, maintenance and safety of the print room. (T. at 79). She inspected the print room floor multiple times a day. (T. at 87). Ms. Lee described the print room floor as "a VCT, a vinyl composition tile, which is a very common type of flooring that's used in office space in particular for that type of room, print rooms." (T. at 90).

On 6/22/15, Ms. Lee was in the print room when Petitioner slipped and fell. (T. at 81). Immediately before the fall, Ms. Lee inspected the print room floor. (T. at 88). The floor was in good condition with nothing on it. (Id.). If there had been a defect or issue, Ms. Lee would have closed off the room and called building maintenance. (T. at 89). If there had been pieces of paper or other debris on the floor, she would have cleaned it up herself. (Id.). Ms. Lee did not see any dust particles or paper on the floor before or after the accident. (T. at 86).

After the fall, Ms. Lee and Petitioner discussed Petitioner's shoes. (T. at 83). She was wearing a "wedge type heel" with a "slippery looking sole" and "plastic appearance to the surface of" them. (Id.). Ms. Lee remarked that maybe they caused her to slip, to which Petitioner did not disagree. (T. at 83-84). Petitioner did not mention any debris or defect. (T. at 85).

A few days after the fall, Ms. Lee took 2 photographs of the area and floor where Petitioner fell. (RX 4a and 4b). She testified that the photographs depicted the condition of the floor as it was on 6/22/15. (T. at 91; RX 4a and 4b).

She testified that there was never an issue with or any complaints of "debris on the floor, particles, papers." (T. at 89). She testified that there have never been other incidents where employees slipped on dust particles or paper. (Id.). She also testified that Respondent has not had any other workers' compensation claims involving this type of incident. (T. at 90).

Heather Hink

Heather Hink testified that on 6/22/15, she was employed as a security officer at Respondent's building. (T. at 111). Her job duties included responding to accidents, "taking down statements, recording the incident as it happened and writing a report." (T. at 112).

She received training on inspecting floors after an accident occurs, which consisted of making sure there were no liquids or obstructions. (T. at 113). Prior to HCSC, Ms. Hink worked as a mall security officer for 4 years. (T. at 115). During that time, she received training on inspecting floors and accident scenes, and she inspected multiple accident scenes and floors. (T. at 115-116).

She testified that "if there were any debris on there, [she] would take care of that" or "just clean it up [herself] seeing as there was no reason not to as it was part of [her] job." (T. at 125). "If there was liquid, [she] would sanction that off, call the day porter, have them clean that up." (Id.).

On 6/22/15, she received a call from Ms. Lee informing her of a slip and fall in the print room. (T. at 111). After she arrived at the scene, Ms. Hink performed an independent inspection of the floor and noticed that it was clear, dry and free of debris. (T. at 113, 123-124). She did not see any paper or dust particles, or anything that would have caused Petitioner's fall. (Id.).

Petitioner told Ms. Hink that "the floor was dry and she suspected that she fell due to her shoes." (T. at 121; RX 5). As part of her inspection, Ms. Hink looked at Petitioner's shoes, which were "high-heeled shoes" with "a black, smooth bottom." (T. at 122). Immediately after the paramedics took Petitioner away from the scene, Ms. Hink filled out an incident report. (Id.) (RX 5).

Ms. Hink testified that there had never been any other incidents involving someone slipping and falling in the print room. (T. at 125). There were never any complaints involving debris in the print room. (Id.).

Jeannine Marciniak

Jeannine Marciniak was the claims adjuster assigned to Petitioner's claim. (T. at 136). She has worked as a claims adjuster for 37 years. (Id.).

On 7/1/15, Ms. Marciniak took Petitioner's recorded statement. (T. at 138-139; RX 6). In her recorded statement, Petitioner told Ms. Marciniak that she did not know what caused her fall and she "was just puzzled, like what happened?" (T. at 145, RX 5 at 4). Petitioner stated that there was nothing on the floor that she could see. (Id.).

In response to Ms. Marciniak's question regarding whether she was taking any medications, Petitioner informed her of statin and blood pressure medication. (T. at 160 -161). Petitioner did not tell Ms. Marciniak of any other medications, specifically she did not tell her of any medications that she was on as a result of her fall. (T. at 159, 161-162.). Petitioner did not tell Ms. Marciniak that her memory, ability to communicate or cognitive ability was impaired in any way. (T. at 162).

When Ms. Marciniak informed Petitioner that her claim was denied and the reasoning for it, Petitioner stated "...I mean I'm gonna lose a pile of money," and that she would need to hire an attorney. (T. at 148).

At trial, Ms. Marciniak clarified that, in a recorded statement, three dots after a sentence indicated that "there's a pause, someone has paused talking," and it did not indicate that words were not transcribed. (T. at 155). She testified that she has seen statements "where there will be a bracket and it will say 'inaudible.'" (T. at 156.) She also testified that the transcript of the recorded statement was not altered or edited in any way, "other than like headings." (T. at 144).

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner failed to prove an accident which arose out of and in the course of her employment with Respondent.

Petitioner testified that her "foot slipped out and flew up," and she "didn't notice if anything was down there" on the floor. (T. at 19-20). She testified that she did not see any shards of paper on the floor prior to her fall. (T. at 56). Petitioner's 7/1/15 recorded statement in response to Jeannine Marciniak's question, "Do you know why you fell?" Petitioner answered, "No. I mean [laughs], I was just puzzled, like, what happened?" (RX 6 at 4).

Immediately after the accident, Petitioner talked with Ms. Lee and Ms. Hink, and did not mention that paper, dust, debris or water caused her fall. (T. at 85, 121; RX 5). The Arbitrator notes she did mention the type of shoe she was wearing, telling Ms. Hink that her shoes may have caused her fall. (T. at 118; RX 5).

At Advocate Good Samaritan Hospital, where Petitioner sought initial treatment on 6/22/15, she told the physicians that she was injured "after sliding out of a chair at work." (PX 3 at 42, 46).

On 7/1/15, Petitioner told Ms. Marciniak that she did not know how she fell. (RX 6 at 4).

During Petitioner's testimony, she alleged one of two possible inferences: she fell because of dust, debris or shards of paper or because she was in a hurry. However, she did not present any evidence to support either of these claims. In fact, the evidence clearly shows that neither of these inferences could have caused her fall, and her testimony about dust particles was pure conjecture.

Regarding debris, Ms. Lee testified that the print room is covered in vinyl composition tile, which is commonly used in office spaces specifically for print, file or storage rooms. (T. at 90). Ms. Lee also testified that part of her job as the Facility Manager was to inspect the print room floor multiple times a day to ensure it was clean and safe. (T. at 87). Both Ms. Lee and Ms. Hink conducted inspections of the floor after Petitioner fell and observed that it was clean, dry and free of debris and dust. (T. at 85, 113, 123-124).

Regarding her allegation that she was in a hurry, Petitioner did not mention that she was in a hurry to any of the individuals who interviewed her regarding her accident. Petitioner testified that she "immediately left [her] cubicle and went and guarded the printer" because she "didn't want anyone else to see" her documents. (T. at 11). Petitioner testified that she "viewed everything [she] did as confidential" yet she provided no evidence to show that Respondent considered the documents she was retrieving as confidential or that Respondent required her to immediately obtain them. Further, Petitioner did not discuss being in a hurry or claim that was the reason for her fall with Julia Lee, Heather Hink or Jeannine Marciniak. Given the numerous other inconsistencies with Petitioner's testimony, this inference is not credible and cannot be relied on as a cause of Petitioner's fall.

Both Ms. Hink and Ms. Lee testified that Petitioner was wearing a high heel or wedge shoe that appeared to be plastic and slippery. (T. at 83-84, 122).

The photographs that Ms. Lee took show that there was nothing on the floor that indicated there was a defect or debris that caused a dangerous condition. (RX 4a and 4b).

Petitioner testified that dust particles were on the floor. (T. at 19). She then testified that you could not see them. (Id.).

At trial, for the first time, Petitioner brought up the cleanliness of the print room floor as an issue although she never discussed this issue with Julie Lee, Heather Hink or Jeannine Marciniak nor is any mention of this issue contained in the incident report or the histories in the medical records (PX 3, 5 – 7; RX 5).

At trial, Petitioner testified that she did not notice pain immediately after her fall. (T. at 35). Moments later, she testified that her lower back pain was immediate. (Id.). Petitioner then reiterated that she "didn't notice it immediately." (Id. at 35-36). The Arbitrator pointed out that "you just testified to 2 things that were completely contradictory." (T. at 36).

Petitioner provided at least 4 different histories:

- To Heather Hink on 6/22/15, when she stated that "the floor was dry and she suspected that she fell due to her shoes." (RX 5).
- To the emergency room department, on 6/22/15, when she reported that she slid "out of a chair at work." (PX 3 at 42, 46).
- To Jeannine Marciniak on 7/1/15, when she stated that she did not know what caused her fall. (T. at 145, RX 5 at 4).
- Under oath on 3/24/17, when she speculated that she slipped on shards of paper or dust particles that were not visible.
- At trial, Petitioner complained of continued pain in the small of her back, yet she did not provide any evidence that she treated after 8/27/15 for any problems related to this injury.

Given the totality of evidence, including Petitioner's lack of credibility, the Arbitrator finds that Petitioner has failed to sustain her burden with respect to the issue of accident.